1617 Monument Ave, Ste. 301
Richmond, VA 23220
Phone: 804.562.6604 Fax: 804.308.0551
www.helpyourway.com

INTAKE INFORMATION FORM

Please bring to your first appointment, or plan to arrive 10-15 minutes early for your first appointment.

Today's Date_____/_____/_____ Seeking service for: ____Individual ____ Couple _____ Family

Referred by:________________________________ Internet Source:________________________

Client Name: Last __________________________First _______________________________ Middle _______________

Birth date: _______/_________/________ Marital Status _______

Email Address: ____ Cell #____________________________

Employer:_________________________Occupation:___________________________(W)_________________________

Home Address: ____City _________________________________

State _______________ Zip Code _______________________________________ (H)_____________________________

Client Name: Last __________________________First ____________________________ Middle ________________

Birth date: _______/_________/________ Marital Status _______

Email Address: ____ Cell #____________________________

Employer:_________________________Occupation:___________________________(W)_________________________

Home Address: ____City _________________________________

State _______________ Zip Code _______________________________________ (H)______________________________

NAMES OF OTHER FAMILY MEMBERS

____ **M F DOB** ___________________ **Relationship** ____________

____ **M F DOB** ___________________ **Relationship** ____________

____ **M F DOB** ___________________ **Relationship** ____________

____ **M F DOB** ___________________ **Relationship** ____________

____ **M F DOB** ___________________ **Relationship** ____________

Please describe the problem(s) that you want help with: ____

____

What is your best hope about how seeing a therapist at Help Your Way can be beneficial to you and your family?

____

____

____

Is there anything else that you think important for us to know as we begin (e.g., major life events; issues of substance misuse; etc.):

____

____

Information for Clients

Welcome to Help Your Way. We appreciate you giving us the opportunity to be of help to you. Help Your Way's motto is "Customer Friendly Mental Health." To this end, we believe you need to have as much information about us, how we work, and what we believe as possible. This brochure attempts to answer the questions most therapy clients bring. Please review this document and come prepared with any questions you may have. We will work with you until you are satisfied with the answers to your questions.

The Benefits and Risks of Therapy

While therapy is usually helpful (80% of people who receive therapy services report being better off than a matched group who did not get therapy), there are risks, which should be considered as you begin this process. Anytime we change behavior, there can be difficulties. Old and familiar patterns are disrupted and can cause anxiety, frustration and even anger. While these emotions are not necessarily going to arise in your treatment, if they do, you should know that they are normal and even healthy reactions to the change process. These difficulties need to be shared with your therapist and, if seeking services with a partner or family member, they should be a part of the conversation during your sessions. A second area that sometimes arises and causes participants to wonder if therapy is really working is that old memories or events may come to mind that can be upsetting and can cause feelings of depression, anger and anxiety. Again, these potential events, which do not occur most of the time, are perfectly normal when they do and become important sources of information that, in fact, enhance the therapy experience. The main message is to not allow any unpleasant feelings or behaviors to block your willingness to discuss with your provider and the need not be barriers to a successful outcome. The continuous measurement of progress that we described in the opening section offers the perfect opportunity for you to discuss any of these uncomfortable events should they occur for you.

In short, we believe that your experience at Help Your Way will be a positive one for you and a positive outcome will be even more likely if you are willing and able to remain open with your therapist if any of the difficulties begin to interfere.

Consultations

The therapists at Help Your Way are well trained, and are also aware of the limits of their training. If you or we begin to encounter issues that are outside our range of expertise, we will seek consultation from either another therapist at Help Your Way or from any other agency that either we or you identify. We also may consult and communicate with other health care providers that you are working with, but only with your permission and only about issues that are relevant to your therapy with Help Your Way. We also consult with clinical supervisors and team members at Help Your Way in order to improve the treatment we provide to you.

What to Expect from Our Relationship

Our relationship with you must be limited to the professional relationship we establish in our therapy together. If we should meet in public, we will not acknowledge you unless you initiate contact with us. We are limited by law, regulation and professional ethics to establishing only this therapy relationship and cannot establish an outside friendship, partnership, or business relationship with you, even after treatment ends. We also cannot accept gifts of any significant monetary value. We also cannot accept "friend" requests on online social networks. These restrictions may, at times, seem awkward, but are necessary to maintain the boundaries that have proven to be essential to success in the therapeutic process. In summary, we do not intend seem rude or disinterested, but are bound by our professional ethics to keep the therapy relationship "pure."

About Confidentiality

Included in this information package is a description of the rules about handling the information about your therapy. Your relationship with your therapist is a confidential one and we are obligated to maintain that confidentiality. There are some limits to the extent of this confidentiality and it is important for you to know and understand those limits.

1. If you were sent to us by a court or an employer for evaluation or treatment, the court or employer will expect a report from us. If this is your situation, please talk with us before you tell us anything you do not want the court or your employer to know. You have a right to tell us only what you are comfortable with telling.

2. If you are involved with a lawsuit, custody battle, or if you have been charged with a crime, and you tell the court that you are seeing us, we may be ordered to show the court our records. If we are ordered by a court to release information about you, we will make every legal effort to have the order vacated (and we are often able to do so), but we cannot guarantee that outcome.

3. We are legally obligated to report you to law enforcement officials if you make a credible threat to harm yourself or another person. We may also be obligated to inform the other person if such a credible threat is made. We are also legally bound to report you if you make a threat (even if not credible) against a public official.

4. If we believe a child has been or will be abused or neglected, we are legally required to report this to the authorities.

Your therapist may will discuss your treatment with their clinical supervisor or consult with other professionals about your treatment within the Help Your Way organization. We provide this supervision to all of our staff. The purpose of these consultations is to assure you are receiving the best service we can give you. As a part of these consultations, we may ask you if we can make audio or video recordings of your sessions. We review the recordings with the supervisor or clinical team to assist with your treatment. We will always ask for your written permission to make any recording. We will destroy each recording as soon as we no longer need it. You may refuse to allow this recording, may view the recording, and require that the recording be edited or erased.

In order for your records need to be seen by another professional outside of our agency you will need to sign a release form. This form states exactly what information is to be shared, and with whom, and it also sets time limits. You may read this form at any time. If you have questions, please ask.

We are required to maintain a copy of your record for 7 years after the completion of the therapy. We then destroy the record in accordance with state and federal laws. If the client is a child, the record is destroyed 7 years after a child reaches the age of 18. Until then, we will keep your case records in a secure, locked place.

If we must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, we ask you to agree to our transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

If we do family or couples therapy (where there is more than one client), and you want to have our records of this therapy sent to anyone, all of the adults participating in the therapy will have to sign a release.

You can review your own records in our files at any time. You may add to them or correct them, and you can have copies of them. We ask you to agree to not examine records created by anyone else and sent to Help Your Way, but to obtain those records from the person or agency where they were created.

In some very rare situations, we may temporarily remove parts of your records before you see them. This would happen if we believe that the information will be harmful to you, but we will discuss this with you before any such action is taken.

We will ask you for permission before using text or email to remind you of appointments, send you receipts, and so forth. Please do not use text messages or unencrypted emails to communicate about personal or clinical issues with your therapist, as the security of the information cannot be assured.

About Our Appointments

The very first time we meet with you, we will need to give each other much information. For this reason, we usually schedule 90 minutes for this first meeting. Following this, we will usually meet for a 45-50-minute session once a week, then less often. We will schedule meetings at both your and our convenience and availability. We will tell you at least two weeks in advance of our vacations or any other times we cannot meet. Please attempt to notify us two weeks in advance when making your own plans that will interfere with a regularly scheduled appointment.

An appointment is a commitment to our work. We agree to meet here and to be on time. We will be respectful of your time and commitment and will make every effort to inform you if, for any reason, we are unable to meet at a scheduled time. We also assure you that you will receive the full time agreed to. If you are late, we will generally be unable to meet for the full time, because it is likely that we will have another appointment after yours.

A cancelled appointment delays our work. We consider our meetings important and ask you to do the same. Please try not to miss sessions if you can possibly help it. When you must cancel, please give us at least a week's notice. Your session time is reserved for you. We are rarely able to fill a cancelled session unless we know a week in advance. You will be charged the full fee for sessions cancelled with less than 24 hours' notice for other than the most serious reasons.

We request that you do not bring children with you if they are young and need babysitting or supervision. While we do love and appreciate children, we are unable to provide the needed supervision.

Billing and Payment Information

Payment for services is an important part of any professional relationship. You are responsible for meeting the obligation to pay for our services.

Telephone consultations: we believe that telephone consultations may be suitable or even needed at times in our therapy. If so, we will charge you our regular fee, prorated for the time needed. If we need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. You will, of course, be included in the decision before any such telephone conversation occurs. If you are concerned about any of these arrangements, please be sure to discuss it with us in advance so we can set a policy that is comfortable for both of us. Of course, there is no charge for calls about appointments or similar business.

Extended sessions: Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes, we will tell you, because sessions that are extended beyond 10 minutes will be charged on a prorated basis.

Reports: we will charge you for our time spent making reports to other agencies or professionals.

Other services: Charges for other services, such as hospital visits, home visits, or any court-related services (such as consultations with lawyers, depositions, or attendance at courtroom proceedings) will be based on the time involved in providing the service, including travel time, at $150/hour. Consultations with other mental health or health professionals are billed at the regular session rate, pro-rated for the amount of time spent. Some services may require payment in advance.

We will assume that our agreed-upon fee-paying relationship will continue as long as we provide services to you. We will assume this until you tell us in person, by telephone, or by certified mail that you wish to end it. You have a responsibility to pay for any services you receive before you end the relationship.

Because we expect all payment at the time of our meetings, we usually do not send bills. However, if we have agreed that we will bill you, we ask that the bill be paid within 5 days of receipt.

If you think you may have trouble paying your bills on time, please discuss this with your therapist. We will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches $75.00 we will notify you by mail. If it then remains unpaid, we must stop therapy with you. However, the best assurance that we will not have problems in this area is our open conversations with each other if fees become a problem.

At the end of treatment, we will send you a final statement for your tax records, at your request.

Health Insurance

Help Your Way does not bill insurance for our service. If you wish to seek reimbursement from your insurance company, please let us know when you make your first appointment. You are responsible for the full cost of services regardless of whether or not you are able to receive reimbursement.

Additional Points of Information

If you ever become involved in a divorce or custody dispute, we want you to understand and agree that we will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) Our statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship and we must put this relationship first.

If, as part of your therapy, you create and provide to us records, notes, artworks, or any other documents or materials, we will return the originals to you at your written request but will retain copies.

Statement of Principles and Complaint Procedures

In our practice as an agency, we do not discriminate against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is our commitment, which extends beyond any requirement by federal, state, and local laws and regulations. We will always take steps to advance and support the values of equal opportunity, human dignity, and cultural diversity.

Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with your therapist. Your therapist will ask you to complete a brief rating scale at the end of each session, which is an excellent vehicle for raising any concerns you may have. You may also contact our Director, Kathy Levenston, LCSW, at 804-562-6604 to make a complaint. If you believe your provider has broken a law or professional regulation, you should also contact the Virginia Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 300 Henrico, VA 23233-1463, tel. 1-800-533-1560 or (804) 367-4691 to make a complaint.

Contacting Your Therapist

Therapists usually do not take phone calls when they are with a client. Please leave a message with our receptionist, and your therapist will return your call as soon as he or she can. Generally, we will return messages daily, except on weekends and holidays. If you have an emergency, or if you are in crisis and cannot reach your therapist, please call 911 or go to the nearest emergency room.

Consent for Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the “Client Information” brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

My signature below shows that I understand and agree with all of these statements.

____ _______________

Signature of client (or person acting for client) Date

____ ______________________________

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____ __________

Signature of Therapist Date

Help Your Way

Notice of Privacy Practices for

Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Help Your Way is providing this Notice of Privacy Policies & Practices because the privacy of your health information is very important to you and to us. This Notice complies with the Federal regulations regarding the privacy of your health information. By “your health information” we mean the information that we maintain that specifically identifies you and your health status.

Summary

This Notice describes how we use your health information within Help Your Way and disclose it outside Help Your Way, and why.

The Notice covers:

A. Uses or disclosures which do not require your written authorization;

1. Treatment, payment, and health care operations.
2. Uses or disclosures of your health information to which you may object.
3. Uses or disclosures required or permitted.

B. Uses or disclosures which require your written authorization.

C. Your rights as a client regarding privacy of your health information.

D. Our duties in protecting your health information.

E. Uses of your health information to which you may object.

F. Uses or Disclosures Required or Permitted

G. Requests, complaints, contact person, effective date, and acknowledgment.

Uses or disclosures which do not require your written authorization

A. Treatment, Payment, and Health Care Operations

We use or disclose your health information to carry out your treatment; to obtain payment for your treatment; and to conduct health care operations. For example:

• For Treatment: we use your health information to plan, coordinate, and provide your care and treatment. We disclose your health information to physicians and other health care professionals outside our agency who are involved in your care. And we disclose your health information to bill Medicaid or other third parties for payment for your care and treatment.

• For payment: we use your health information to prepare documentation required by your insurance company or HMO or by Medicare or Medicaid. We disclose that part of your health information that these organizations require to pay us.

• For health care operations: we use or disclose your health information, for example, to improve the quality of our services, to plan better ways of treating clients, and to evaluate staff performance.

B. Uses or disclosures which require your written authorization

Your written authorization, which you may revoke (in writing), is required if we use or disclose your health information for any purpose other than for treatment, payment or health care operation, unless required by law or otherwise provided in the Federal regulation as set forth below, in particular:

1. Our use of psychotherapy notes beyond treatment, payment, and health care operations.
2. Marketing of goods or services to you.
3. Disclosure to any persons other than those listed in item E, below.
4. Disclosure to persons through the Agency website with a special access code.

C. Your rights as a client to privacy of your health information

1. Right to Request Restrictions

You have the right to request restrictions on our uses and disclosures of your health information; however we may refuse to accept the restriction.

2. Right to Request Confidential Communications

You have the right to request that we communicate with you confidentially, for example to speak with you only in private; to send mail to an address you designate; or to telephone you at a number you designate. Your request must be in writing. We will make every attempt to honor your request.

3. Right to Request Access to Your Health Information

You have the right to request access to your health information in order to inspect or copy it. Your request must be in writing. We may deny your request and, if so, you may request a review of the denial. However, we will make every attempt to honor your request.

You may ask Agency caregiver for an Access Request form and a copy of the Access Procedures at any time.

4. Right to Request an Amendment of Your Health Information

You have the right to request an amendment to your health information. Your request must be in writing and must provide a reason for the amendment. We may deny your request and, if so, you may submit a statement of disagreement. However, we will make every attempt to honor your request.

5. Right to Request an Accounting of Disclosures of Your Health Information.

You have the right to request an accounting of our disclosures of your health information for purposes other than treatment, payment, and health care operations. We will make every attempt to honor your request. We are not required to provide an accounting for disclosures before April 14, 2003 or for more than 6 years prior to the date of your request.

6. Right to Obtain a Paper Copy of this Notice

If you received this Notice electronically, you have the right to receive a paper copy, and you may request a paper copy from the Agency. The Agency has a form for your use in exercising any of these rights. To exercise any of these rights, you may contact the Agency staff; Program Director of Help Your Way, or Administrator for the Agency, or you may write or call the Agency's Compliance/Privacy Officer.

D. Our Duties in Protecting Your Health Information

1. We are required by law to maintain the privacy of your health information.

2. We must inform clients or their legal representatives of our legal duties and privacy practices with respect to health information. This Notice discharges that duty.

3. We must abide by the terms of the Notice currently in effect.

4. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that we maintain. At any time, you may obtain a copy of the current notice from the Agency Director of Clinical Services and Operations or Privacy Officer.

5. The Agency may not require or request you to waive your rights under the Privacy Rule as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

E. Uses or Disclosures of Your Health Information to Which You May Object

We may use or disclose your health information for the following purposes, unless you object and request we not. Your objections, if any, and any restrictions or authorizations you wish to place on the disclosure of your health information will be recorded by the Agency.

1. Informing family and friends: disclosures of your health information to family, friends, or others identified by you who are involved in your care.

2. Assistance in disaster relief efforts.

3. Confirming our visits to your home or other appointments.

4. Informing you about treatment alternatives or other health-related benefits and services that may be of interest to you.

F. Uses or Disclosures Required or Permitted Without Your Authorization

Where we are required or permitted to do so, we may use or disclose your health information in the following circumstances without your written authorization.

1. Federal government investigation, when required by the Secretary of Health and Human Services to investigate or determine our compliance with federal regulation.

2. Federal, state or local law requirements.

3. Public health activities, for example to report communicable diseases or death; or for matters involving the Food and Drug Administration.

4. Reporting of abuse, neglect or domestic violence.

5. Health oversight activities by a health oversight agency. (A health oversight agency is an organization authorized by the government to oversee eligibility and compliance and to enforce civil rights laws.)

6. Judicial or administrative proceedings, for example responding to a court order or subpoena.

7. Law enforcement purposes, for example to report certain types of wounds or other physical injuries or to identify or locate a suspect, fugitive, material witness, or missing person.

8. Use by coroners, medical examiners, or funeral directors.

9. Facilitating organ, eye, or tissue donation.

10. Research, provided that very strict controls are enforced.

11. Averting a serious threat to your health or safety or that of the public.

12. Specialized government functions such as military or veterans' affairs; national security, and intelligence activities.

13. Counselors' compensation.

G. Requests, Complaints, Contact Person, Effective Date, and Acknowledgment

1. You have the right to lodge a complaint with the Agency and/or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

2. You will not be retaliated against for filing a complaint.

3. Complaints must be filed in writing, and may be received by mail, fax, or email. You may make any requests, obtain additional information, or file a complaint with our Agency by writing to the Agency Compliance Officer:

Kathy Levenston, Privacy Officer
Help Your Way
1617 Monument Ave, Suite 301
Richmond, Virginia 23220
804-562-6604
804-308-0551 (fax)
klevenston@helpyourway.com

4. You may file a complaint with the Secretary of Health and Human Services by writing to:

Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Receipt of Notice of Privacy Practices

I acknowledge that I have received, have read (or have had read to me), and understand the **Notice of Privacy Practice**. I have had all my questions answered fully.

My signature below shows that I understand this notification.

____ ________________

Signature of client (or person acting for client) Date

____ ________________________________

Printed name Relationship to client (if necessary)