**Commonwealth Therapy Group**
**Jaye L. Neal, LCSW & Laura Slaughter, LCSW**
**2365 Harrodsburg Rd., Suite B225**
**Lexington, KY 40504**

# ***** GROUP *****

## CLIENT INFORMATION QUESTIONNAIRE

Your completion of this questionnaire will be helpful in planning and providing services for you. Thank you for answering each item thoughtfully. **PLEASE PRINT.**

Referred by: ____________________________

Date: ___________________

Name: ____________________________________________________
First MI Last

Address: _________________________________________________________________
(Street) (City, State, Zip code)

Birth Date: _________________ Social Security Number: ______________________________

Gender: ____ Marital Status: ________________ Employment Status: ______________________
Single, Married, Other
Employed, Part time Student, Full Time Student, Other

Education: ___________________________ Occupation: ____________________________________

**Contact Information:**

Home #: _______________________ Office # ______________________

Emergency # & Name: _________________________________________________________________
Phone Name

Mobile #: ____________________ SMS Provider: _______________ Reminders by: ___________
Verizon, AT&T, Sprint, T Mobile, Cricket, etc.
Auto - Email, Text

Preferred Phone #: __________________
None, Home, Office, Mobile

Email: _____________________________________________

Describe briefly why you are seeking therapy at this time. ___________________________________

______________________________________________________________________________________

______________________________________________________________________________________

What, if anything, has helped you deal with this in the past? ________________________________

______________________________________________________________________________________

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# **** GROUP ****

## CLIENT INFORMATION QUESTIONNAIRE

Your Name: ________________________________

Primary care physician name: ___________________________

Primary care physician phone number: _________________________

List any significant health problems for which you are now being treated. ______________________

________________________________________________________________________________

________________________________________________________________________________

List any medications you are now taking. ________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Have you received treatment from a mental health professional in the past? _________ (Y/N)

If so, when and from whom? __________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Has use of alcohol or drugs of any type ever contributed to your problems? __________ (Y/N)

Has anyone in your family ever shown signs of a serious mental problem? __________ (Y/N)

Has anyone in your family ever abused or been dependent on alcohol or drugs? ______ (Y/N)

If the answer to any of the last three questions is yes, please give describe briefly below.

________________________________________________________________________________

________________________________________________________________________________

______ __________________________________________________________________________

________________________________________________________________________________

Thank you.

# Commonwealth Therapy Group

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# **** GROUP ****

## AUTHORIZATION FOR RELEASE OF INFORMATION

| Name of Client | Date of Birth | SSN | Dates of TX / Service |
|---|---|---|---|
| | | | |

- I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of psychiatric disorders/mental health, drug and/or alcohol use, HIV/AIDS or sexually transmitted disease.
- If there is information pertaining to psychiatric disorder/mental health, drug and/or alcohol use, HIV/AIDS or sexually transmitted diseases in my medical record, you are specifically authorized to release it.
- I am giving this consent voluntarily and have been informed of the specific type of information that has been requested.
- Information may be released in written or verbal format. Benefits and disadvantages of releasing information have been explained to me.
- I understand that provision of service does not depend on my decision concerning the release of information.

**TIME LIMITATION OF RELEASE**: This authorization expires one year from the date of signature or until termination of treatment whichever is longer. I understand I may revoke this authorization at any time by signing the bottom of this form,

Information is To be ☐ disclosed to: ☐ received from: Name of Person/Agency: ________________________________

Address: ________________________ (Street) ________________ (City) ________ (State) ________ (Zip)

**** PLEASE CHECK INFORMATION REQUESTED ****

☐ Evaluation/Assessment ☐ Progress Notes ☐ Treatment/Service ☐ History/Physical Exam

☐ Medication/Laboratory ☐ Discharge Summary ☐ Other (specify): ________________________

**I understand that the purpose of this disclosure is for: ☐ Use in future treatment ☐ Other** ________________________

PROHIBITION ON REDISCLOSURE: According to 45 CFR 164.508 c2Ciiii health information may be redisclosed by the recipient. However, pursuant to **KRS 304.17A-555, Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure** mental health/chemical dependency information may not be used and/or shared by the recipient of said information unless specific, written consent for redisclosure is authorized by the person to whom it pertains. Additionally, **Federal Regulation 42 CFR, Part 2**, prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

________________________________ Signature of Client ________________ Date

**Parent/Guardian Signature is required for all minors age 17 years or younger.** Please read the following information before signing I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.

________________________________ Signature of Client's parent/Legal Representative ________________ Relationship ________________ Date

________________________________ Witness (required for ALL ROI authorizations) ________________ Date

******* I wish to revoke the above authorization *******

________________________________ Signature of Client ________________ Date

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## CONSENT AND PERMISSION FOR GROUP SERVICES AND/OR GROUP TREATMENT

I understand that Jaye L. Neal, LCSW and Laura Slaughter, LCSW are providing mental health and/or substance abuse assessment and treatment services to me. I understand that there are no certain outcomes from these services and that individual experiences with treatment may vary. In giving consent to Jaye L. Neal, LCSW and to Laura Slaughter, LCSW to provide these services to me in a group setting, I am aware that they have a duty to protect my confidentiality except where the law requires disclosure of certain information. There are several situations in which they cannot assure confidentiality including:

- They have a duty to report the abuse or neglect of a dependent adult and/or domestic violence offenses to the Department for Community Based Services;
- They have a duty to report any instance of child neglect, exploitation or abuse to Community Based Services and/or the police;
- They have a duty to report any threats against persons to the intended victim and to the police;
- They have a duty to release information to agencies or persons with a need to know when a client is in need of hospitalization; and
- When a client introduces personal mental health or substance abuse issues in court proceedings then confidentiality is waived by the client.

Understanding all of the above possible waivers of confidentiality regarding information about my mental health and/or substance abuse condition and treatment, I give consent to Jaye L. Neal, LCSW and Laura Slaughter, LCSW to provide assessment and treatment services to me in a group setting.

| ______________________________ | ______________ |
|---|---|
| Client Name (print) | SSN |
| ______________________________ | ______________ |
| Client Signature | Date |
| ______________________________ | ______________ |
| Witness Signature | Date |

# Commonwealth Therapy Group

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## EMAIL SECURITY/CONFIDENTIALITY AGREEMENT

**Due to the increasingly frequent use of email as a way of communicating, we feel the need to describe the limits to confidentially that email involves.**

**Risks of Using Email**

Emails from this office are not encrypted and thus offer no security protection. Any messages sent could be viewed by a third party while in transit. Email transmission cannot be guaranteed to be secured or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. We therefore cannot accept liability for errors, omissions or problems which arise as a result of email transmission.

**Your Agreement**

Because of the security and confidentiality risks with emails, I ask you to agree to the following in order for us to respond to emails.

- **DO NOT USE EMAIL FOR MEDICAL EMERGENCIES OR OTHER TIME-SENSITIVE MATTERS – PLEASE CONTACT JAYE L. NEAL BY PHONE OR CALL 911 IN AN EMERGENCY.**
- You understand and agree that Jaye Neal, LCSW r Laura Slaughter, LCSW cannot guarantee the security and confidentiality of email communications and will not be liable for any improper disclosure of confidential information unless such disclosure is caused by intentional misconduct.
- You understand and agree that all emails between you and Jaye L. Neal, LCSW or Laura Slaughter, LCSW may be printed and placed in your clinical file.
- Email is provided as a convenience, not as a substitute for personal treatment or face-to-face interaction. Although Jaye Neal, LCSW or Laura Slaughter, LCSW will try to read and respond promptly to an email from you, she cannot guarantee that emails will be read and responded to within any particular period of time. If your email requires or invites a response and you have not received a response within a reasonable time period (please allow at least 72 hours), you should follow up to determine whether Jaye Neal, LCSW or Laura Slaughter, LCSW received the email and when she will be able to respond.
- You are responsible for protecting your password or other means of access to email. You are also responsible for knowing who can access your email account, such as a spouse or a friend, and should choose your email account accordingly. You agree that we are not liable for breaches of confidentiality caused by you or any third party.
- You agree to promptly inform Jaye Neal, LCSW or Laura Slaughter, LCSW of changes in your email address. Jaye Neal, LCSW & Laura Slaughter, LCSW are not responsible for emails to a prior address if she has not been advised of the change in writing.
- You agree to place your name in the email so Jaye Neal, LCSW or Laura Slaughter, LCSW knows who is sending it.
- You agree to make sure that you have Jaye Neal, LCSW and Laura Slaughter, LCSW correct email address before sending an email.

**I understand and agree to abide by all of the above during my email communications with Jaye L. Neal, LCSW & Laura Slaughter, LCSW.**

________________________________________ ________________________
Client Name (print) SSN

________________________________________ ________________________
Client Signature Date

________________________________________ ________________________
Witness Signature Date

# Commonwealth Therapy Group

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## PRIVACY OF INFORMATION POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

**Our Legal Duties**
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

**Use of Information**
Information about you may be used by the personnel associated with this facility for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this facility such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this facility not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

**Duty to Warn and Protect**
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Public Safety**
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

**Abuse**
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

**Prenatal Exposure to Controlled Substances**
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**In the Event of a Client's Death**
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

**Professional Misconduct**
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

**Judicial or Administrative Proceedings**
Health care professionals are required to release records of clients when a court order has been placed.

**Minors/Guardianship**
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

**Other Provisions**

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the facility or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the facility or by outside sources specializing in (and held accountable for) such procedures.

In the event in which facility staff or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the facility or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the facility. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the facility (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

**Your Rights**

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $10.00, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from Jaye L. Neal, LCSW or Laura Slaughter, LCSW.

**Complaints**

If you have any complaints or questions regarding these procedures, please contact Jaye Neal, LCSW or Laura Slaughter, LCSW. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Kentucky Board of Social Work. If you file a complaint we will not retaliate in any way.

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Direct all correspondence to: Jaye L. Neal, LCSW or Laura Slaughter, LCSW.

**I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.**

Client's name (please print): _______________________________________________________

Signature: ____________________________________________________________________ Date: _____/_____/_____

Signed by: __client __guardian __personal representative

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## TREATMENT CONDITIONS

I am looking forward to working with you. I invite you to take an active, collaborative role in your treatment by knowing, observing and agreeing to the following:

1. **Session Length**: Group sessions are 2.5 hours long.

2. **Promptness:** Please be prompt, and we will also try to be on time.

3. **Fees:** The current fee for the initial consultation prior to group session, usually lasting 55-60 minutes, is $125. Current fee for ongoing group sessions (2.5 hrs) is $60. I understand that these fees or insurance co-payment are payable on the day of service unless there is an extraordinary circumstance, which I will discuss with Jaye Neal, LCSW or Laura Slaughter, LCSW. In these cases alternative arrangements for payment may be made.

4. **Returned Checks:** In the event a check is returned for insufficient funds, I will be charged the standard service charges that Ms. Neal's or Ms. Slaughter's bank charges for the processing of such a check.

5. **Unpaid Balances:** Full payment or insurance co-payment is expected at time of service.

I understand the above and consent to these treatment conditions.

______________________________________________________________

Signature Date

# Commonwealth Therapy Group

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## CREDIT CARD GUARANTY OF PAYMENT

(Not required for clients who have Medicare)

I understand that Jaye L. Neal will either bill my Insurance Company for therapy and/or evaluation services or directly bill me. I further understand that I am responsible for all usual, customary and reasonable fees, such as deductibles or co-pays. I also understand that Ms. Neal is billing my insurance company as a courtesy to me. I understand that Ms. Neal will work with me and my insurance company to receive payment from them. For my convenience, she will wait a reasonable amount of time to be reimbursed by my insurance carrier for services delivered. However, sometimes insurance companies do not pay in a timely manner. Because of this, I am giving Ms. Neal permission to charge my credit card for any services that have not been paid by either me or my insurance company within ninety (90) days of billing. If services have not been paid within 60 days, Ms. Neal will notify me in writing that she has not been paid by either me or my insurance company. If an insurance company is involved she will encourage me to contact the company to get them to pay for the services in a timely manner. I understand that Ms. Neal is currently using the merchant payment processor, Square (SQ), for credit card processing. On my credit card statement, the charge will appear as if coming from them (SQ) and from Ms. Neal. I understand that this form is valid unless I cancel the authorization in writing.

### Please Print

Client Name: ______________________________________________________________________

Cardholder Name (if different from the client): ____________________________________________

Cardholder Billing Address: ________________________________________________________
(Street) (City, State, Zip code)

Type of Credit Card ____________________________________
(Visa, MasterCard, Discover, American Express)

Credit Card Number: _________________________________

Expiration Date: ___________________
MM/YYYY

Card Security Code: _______________

______________________________________________ ________________
Signature Date

**Commonwealth Therapy Group**
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## PAYMENT AUTHORIZATION and RELEASE OF INFORMATION

Name: ________________________________________ SSN____________________________

***Office:** Please attach a copy of Driver's license, passport or other government issued*

**OTHER RESPONSIBLE NONINSURANCE THIRD PARTY:**

If someone other than you is also responsible for payments please enter information here:

Name: ______________________________________________________________

Address ________________________________________________________________________________
(Street) (City, State, Zip code)

Telephone: ______________________________________________________________________________
(Home) (Business) (Mobile)

Relationship: __________________________ Percent/Amount of Responsibility: __________

**I give consent and permission to Jaye L. Neal or Laura Slaughter to contact the above third party for verification of additional payment responsibility.**

____________________________________________________________
Client Signature Date

**INSURANCE RECIPIENTS:**

I hereby authorize payment of my insurance and/or Medigap benefits to Jaye Neal, LCSW or Laura Slaughter, LCSW. I further authorize release of information required by any third-party payer regarding any claim relating to me. A copy of this form can be used in place of the original.

I understand that I am responsible for paying any charges not paid by my insurance.

**1st**. Insurance Company: ________________________________ *(if applicable)*

ID: ___________________________________

***Office:** Please attach a copy of front & back of Insurance card*

**2nd** Insurance Company: ________________________________ *(if applicable)*

ID: ________________________________

____________________________________________________________
Client Signature Date

____________________________________________________________
Witness Signature Date

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**MEDICARE RECIPIENTS:**

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize **Jaye L. Neal, LCSW & Laura Slaughter, LCSW** as appropriate, to release information about me to the Social Security Administration, the Medicare program or their intermediaries or carriers. I request that payment of authorized benefits be made on my behalf.

This statement is effective from January 1, 2008

Client Medicare Number: ______________________ *(if applicable)*

Provider Name: Jaye L. Neal, LCSW__________

Provider Medicare Number: ___9778_____________

Provider NPI Number: ___1104918051_______

Provider Name: _____Laura Slaughter, LCSW______

Provider Medicare Number: ________0452_______

Provider NPI Number: _____1003961806_____

***Office:** Please attach a copy of front & back of Medicare card*

**MEDICAID RECIPIENTS:**

I certify that the information given by me in applying for payment under the Kentucky Medicaid Program is correct. I authorize **Jaye L. Neal, LCSW**, to release information about me to the Medicaid program or their intermediaries or carriers. I request that payment of authorized benefits be made on my behalf.

This statement is effective from January 1, 2008.

Client Medicaid Number: __________________________ *(if applicable)*

Provider Name: _____Jaye L. Neal, LCSW

Provider Medicaid Number: __7100164450__________

Provider NPI Number: ___1104918051_________

***Office:** Please attach a copy of front & back of Medicaid card*

_______________________________________________

Client Signature Date

_______________________________________________

Witness Signature Date

# Commonwealth Therapy Group

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**Lexington, KY 40504**

## CLIENT HEALTH QUESTIONNAIRE

**Name** ____________________________________________

1. **Do you use any type of tobacco (smoke, smokeless, chew, or snuff)?** __________
Yes/No

2. **Over the *last 2 weeks*, how often have you been bothered by any of the following?**
*(Please circle your response)*

| | | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| 1 | Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2 | Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3 | Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4 | Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5 | Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6 | Feeling bad about yourself -or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7 | Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8 | Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9 | Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

| | |
|---|---|
| add columns | + + |
| **TOTAL** | |

3a. **Place an X in the box that is the closest to your *average weekly* consumption of alcohol**

| | **Drinks per Week** | | | |
|---|---|---|---|---|
| | 0 Drinks | 1-7 Drinks | 8-14 Drinks | 15 or more Drinks |
| Women or Persons older than 65 | | | | |
| Men under age 66 | | | | |

3b. **Place an X in the box that is the closest to your *average per occasion* consumption of alcohol**

| | **Drinks per Occasion** | | | |
|---|---|---|---|---|
| | 0 Drinks | 1-3 Drinks | 4 Drinks | 5 or more Drinks |
| Women or Persons older than 65 | | | | |
| Men under age 66 | | | | |