Jaye L. Neal Counseling & Therapy, PLLC
Jaye L. Neal, Licensed Clinical Social Worker

CLIENT INFORMATION UPDATE

Commonwealth Therapy Group is updating its information management system, and your completion of this update form will be most helpful. **PLEASE PRINT.**

Date: _____

Name: _____
First Middle Last

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

Birth Date: _____ Social Security Number: _____

Gender: ____ Marital Status: _____ Employment Status: _____
Single, Married, Other Employed, Student, Retired, Other

Highest Level of Education: _____ Occupation: _____
GED, High School Graduate,
College Graduate, Post College, Other

Place of Employment:_____

Contact Information:

Emergency # & Name/Relationship: _____
Phone Name Relationship

Home #: _____ Office # _____

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

Commonwealth Therapy Group is now able to provide appointment reminders via text messaging and/or e-mail messaging. Are you interested in receiving appointment notifications? _____
Yes/No

If yes, preferred method(s) of Automatic Reminders: _____
E-mail Messaging, Text Messaging, or Both

Cell Phone/SMS Provider: _____
Verizon, AT&T, Sprint, T Mobile, Cricket, etc.

E-mail Address: _____

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

_____

_____

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

_____

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.

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RULES OF CONFIDENTIALITY

Communications between you and your therapist are confidential. This means that you have the right to refuse to disclose communications occurring between you and your therapist, and you also have the right to refuse to allow your therapist to disclose these communications to others. Thus, you have the right to decide whether or not your therapist may reveal your communications or your records to any other person. No disclosure may be made without your written consent, with the following exceptions:

1. If you have abused or are abusing a child or an adult;
2. If you are a danger to yourself or to others;
3. If you assert that your mental condition is an issue in a claim or in a defense in civil or criminal legal proceedings;
4. If your assessment or treatment is court-ordered;
5. If you seek reimbursement for the cost of your therapy from an HMO, managed care, or insurance company. Your permission for information to be provided to any of these does not mean that your therapist will no longer protect your communications. However, your therapist cannot control how information provided to these companies may be used. For example, the waiver you sign with your HMO may make your records available to case management, utilization review committees, or other entities which request your records; and
6. If you are involved in entering a hospital for psychiatric or chemical dependency treatment after you and/or your therapist determines you are in need of hospitalization.

I have read and understand the above exceptions to confidentiality. I have discussed any questions I have with my therapist.

_____

Client's Signature Date

_____

Therapist's Signature Date

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E-MAIL SECURITY/CONFIDENTIALITY AGREEMENT

Due to the increasingly frequent use of e-mail as a way of communicating, I feel the need to describe the limits to confidentially that e-mail messaging involves.

Risks of Using E-mail

E-mail messages 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. E-mail transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. I therefore cannot accept liability for errors, omissions or problems which arise as a result of e-mail transmissions.

Your Agreement

Because of the security and confidentiality risks with e-mail communication, I ask you to agree to the following in order for me to respond to e-mail messages:

- **DO NOT USE E-MAIL FOR MEDICAL EMERGENCIES OR OTHER TIME-SENSITIVE MATTERS. PLEASE CONTACT MRS. NEAL IN PERSON OR BY PHONE, OR CALL 911 IN AN EMERGENCY.**
- You understand and agree that Mrs. Neal cannot guarantee the security and confidentiality of e-mail 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 e-mail messages between you and Mrs. Neal may be printed and placed in your clinical file.
- E-mail communication is provided as a convenience, not as a substitute for personal treatment or face-to-face interaction. Although Mrs. Neal will try to read and respond promptly to an e-mail message from you, she cannot guarantee that any e-mail communication will be read and responded to within any particular period of time. If your e-mail message 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 Mrs. Neal received the e-mail message and when she will be able to respond.
- You are responsible for protecting your password or other means of access to your e-mail account. You are also responsible for knowing who can access your e-mail account, such as a spouse or a friend, and should choose to use your e-mail account accordingly. You agree that I am not liable for breaches of confidentiality caused by you or any third party.
- You agree to promptly inform Mrs. Neal of changes in your e-mail address. Mrs. Neal is not responsible for e-mail messages sent to a prior address if she has not been advised of the change in writing.
- You agree to place your name in the e-mail message so Mrs. Neal knows who is sending it.
- You agree to make sure that you have Mrs. Neal's correct e-mail address before sending an e-mail message.

I understand and agree to abide by all of the above during any e-mail communications between Mrs. Neal and me.

_____	_____
Client Name (print)	SSN
_____	_____
Client Signature	Date
_____	_____
Witness Signature	Date

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CONSENT AND PERMISSION
FOR SERVICES AND/OR TREATMENT

I understand that Jaye L. Neal, LCSW, is 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, to provide these services to me, I am aware that she has a duty to protect my confidentiality except where the law requires disclosure of certain information. There are several situations in which she cannot assure confidentiality including, but not limited to, those circumstances when:

- She has a duty to report the abuse or neglect of a dependent adult and/or domestic violence offenses to the Department for Community-Based Services;
- She has a duty to report any instance of child neglect, exploitation or abuse to the Department for Community-Based Services and/or the police;
- She has a duty to report any threats against persons to the intended victim and to the police;
- She has 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, to provide assessment and treatment services to me.

_____ _____
Client Name (print) SSN

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

Jaye L. Neal Counseling & Therapy, PLLC
Jaye L. Neal, Licensed Clinical Social Worker

Notice of My Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*

  – *Treatment* is when your therapist provides, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

  - *Payment* is when your therapist obtains reimbursement for your healthcare. Examples of payment are when your therapist discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

  - *Health Care Operations* are activities that relate to the performance and operation of therapist' practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within the my office & practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office & practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I ask for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes that I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that your therapist have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I have reasonable cause to believe that a child is dependent, neglected or abused, I must report this belief to the appropriate authorities, which may include the Kentucky Cabinet for Families and Children or its designated representative; the commonwealth's attorney or the county attorney; or local law enforcement agency or the Kentucky state police.

  "*Dependent child*" means any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child.
- **Adult and Domestic Abuse**: If I have reasonable cause to believe that an adult has suffered abuse, neglect, or exploitation, I must report this belief to the Kentucky Cabinet for Families and Children.
- **Health Oversight Activities**: The Kentucky Board of Examiners of Psychology may subpoena records from me relevant to its disciplinary proceedings and investigations.
- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety**: If you communicate to me an actual threat of physical violence against a clearly identified or reasonably identifiable victim or an actual threat of some specific violent act, I have a duty to notify the victim and law enforcement authorities.

- **Workers' Compensation**: If you file a claim for workers' compensation, you waive the psychotherapist-patient privilege and consent to disclosure of your health information reasonably related to your injury or disease to your employer, workers' compensation insurer, special fund, uninsured employers' fund or the administrative law judge.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in the my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- *Have the Right to Restrict* certain disclosures of Protected Health Information (PHI) to a health plan if you pay out-of-pocket in full for the healthcare service.
- *Have the right to be notified if there is breach* of your unsecured PHI.
- *Must sign an authorization before I can release your PHI* for any uses and disclosures not described in this Privacy Notice

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, they will notify you by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I have made about access to your records, or have other concerns about your privacy rights, you may phone me at 859-276-0700.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to Jaye L. Neal. at 2365 Harrodsburg Rd., Suite B225 Lexington, KY 40504.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

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

Jaye L. Neal Counseling & Therapy, PLLC
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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**: Sessions are 45-60 minutes long. It will help both of us if you describe significant current problems early in the session.

2. **Fees:** The current fee for the initial consultation, usually lasting 60-90 minutes, is $145. Current fee for ongoing therapy sessions (45 minutes) is $125. 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 Mrs. Neal. In these cases, she may choose to make alternative arrangements with me for payment.

3. **No-Show and Late Cancellation Fees:** If you need to cancel your appointment, please do so at least 24 hours in advance. My policy is to charge a $50.00 fee if a 24-hour notice is not given.

4. **Returned Checks:** In the event a check is returned for insufficient funds, a $15 fee will be incurred by the client to account for the standard service charge that my bank requires for the processing of such a check. You may be asked to pay with cash or a credit card from that point forward.

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

Jaye L. Neal Counseling & Therapy, PLLC
Jaye L. Neal, Licensed Clinical Social Worker

CREDIT CARD GUARANTY OF PAYMENT

(Not required for client who have Medicare)

I understand that Mrs. 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 Mrs. Neal is billing my insurance company as a courtesy to me. I understand that Mrs. 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 Mrs. 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, Mrs. 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 Mrs. Neal is currently using the merchant payment processor, Square, for credit card processing. On my credit card statement, the charge will appear as if coming from Square and from Mrs. 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

Jaye L. Neal Counseling & Therapy, PLLC
Jaye L. Neal, Licensed Clinical Social Worker

PAYMENT AUTHORIZATION and RELEASE OF INFORMATION

Name: _____ SSN: _____

INSURANCE RECIPIENTS:
I hereby authorize payment of my insurance and/or Medigap benefits to **Jaye L. Neal, 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 #: _____

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

ID #: _____

_____
Client Signature Date

_____
Witness Signature Date

OTHER RESPONSIBLE NON-INSURANCE 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 Mrs. Neal to contact the above third party for verification of additional payment responsibility.

_____
Client Signature Date

Jaye L. Neal Counseling & Therapy, PLLC
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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**, 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 the date signed.

Client Medicare Number: _____ *(if applicable)*

Provider Name: Jaye L. Neal, LCSW

Provider Medicare Number: ??CP00203??

Provider NPI Number: 1316133077

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 the date signed.

Client Medicaid Number: _____ *(if applicable)*

Provider Name: Jaye L. Neal, LCSW

Provider Medicaid Number: 7100164450

Provider NPI Number: 1316133077

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

_____
Client Signature Date

_____
Witness Signature Date

Jaye L. Neal Counseling & Therapy, PLLC
Jaye L. Neal, Licensed Clinical Social Worker

PATIENT HEALTH QUESTIONNAIRE

Name _____

Over the *last 2 weeks*, how often have you been bothered by any of the following? *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		

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				

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				