Shalom Wellness Center
Admission Sheet
Confidential

Identifying Information

Name____Date_______________________

Phone home:__________________work:___________________cell:_____________________

Address____
City State Zip

Date of Birth____/_____/______ Sex: M/F Social Security ____________________

Medical History

Are you on any Medication? Yes___ No___

If yes: Physician's name ____________________________________

Name of Practice_____________________________________

List all current medications (dosage, frequency and purpose ____________________

____

____

Do you have any health concerns we should be aware of?__________________________________

What **prescriptions medications** are you are taking presently, as what purpose?

Medication (dosage) Purpose Prescribing Dr.

____

____

____

____

____

What **over the counter drugs and herbal** preparations are you using?

Name Purpose

____

____

____

____

____

Counseling History

Reasons for coming to counseling at this time:____

____

____

____

____

How long have you had this problem?____

Are you currently receiving other counseling services? ___________Yes ___________No
If yes, please describe____

Have you had any previous counseling or psychiatric care? ___________Yes _________No
If yes, what was the outcome?____

Did you receive a diagnosis? ___________Yes ______________No
If yes, what was the diagnosis?____

Who do you consider to be in your support system?______________________________________
____
____
____
____
____

Other issues you may want to address:____
____
____
____
____
____

Symptoms and Attitudes

Who lives in your household in addition to yourself?

Name	Age	Relationship

Present Marital Status:

______1.) Never married
______2.) Engaged to be married
______3.) Married now for the first time
______4.) Married again
______5.) Separated
______6.) Divorced and not remarried
______7.) Widowed and not remarried
8.) Other (specify)__________

If married are you presently living with your spouse? ____Yes ____No
If married, years married to present spouse____
If not married but in a long term relationship, how long?______________________________
Past marriages or long term relationships:____
____
____

Have you ever been a victim of domestic violence? _____Yes _____No
If yes, please explain:____
____

____
Therapists Signature Date

Symptoms and Attitudes

Circle how you would feel today on a scale of 1 (very worst) to 10 (best)?

1 2 3 4 5 6 7 8 9 10

Please check how often the following **thoughts** occur to you:

1) Life is hopeless	__Never	__Rarely	__Sometimes	__Frequently
2) I am lonely	__Never	__Rarely	__Sometimes	__Frequently
3) No one care about me	__Never	__Rarely	__Sometimes	__Frequently
4) I am a failure	__Never	__Rarely	__Sometimes	__Frequently
5) Most people do not like me	__Never	__Rarely	__Sometimes	__Frequently
6) I want to die	__Never	__Rarely	__Sometimes	__Frequently
7) I am so stupid	__Never	__Rarely	__Sometimes	__Frequently
8) I want to hurt someone	__Never	__Rarely	__Sometimes	__Frequently
9) I am so depressed	__Never	__Rarely	__Sometimes	__Frequently
10) God is disappointed in me	__Never	__Rarely	__Sometimes	__Frequently
11) I can't be forgiven	__Never	__Rarely	__Sometimes	__Frequently
12) I can't concentrate	__Never	__Rarely	__Sometimes	__Frequently
13) I can't do anything right	__Never	__Rarely	__Sometimes	__Frequently
14) Why am I so different?	__Never	__Rarely	__Sometimes	__Frequently
15) I have no emotions	__Never	__Rarely	__Sometimes	__Frequently
16) I am out of control	__Never	__Rarely	__Sometimes	__Frequently
17) I am going crazy	__Never	__Rarely	__Sometimes	__Frequently
18) People hear my thoughts	__Never	__Rarely	__Sometimes	__Frequently
19) I hear voices	__Never	__Rarely	__Sometimes	__Frequently
20) Someone is watching me	__Never	__Rarely	__Sometimes	__Frequently

Do you believe you are or have ever been a victim of emotional, physical, or sexual abuse or neglect? No________ Yes____

____

____

Overall Goals

What changes in your behavior and thoughts need to happen for you to consider therapy at Shalom Wellness Center to be successful?

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____

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Therapist Signature Date

Insurance Claims Information and Submission Document
Please have your insurance card available at time of admission

I ____ give my consent for
(Printed Name)
my insurance company ____
to send eligible benefit money directly to:

Shalom Wellness Center
301 Ditto St., Suite C
Archbold, OH 43502
Phone 419-445-1552
Fax: 419-445-1401

Name_______________________________________ Date _____________________
(Signature)

Work and Insurance
Employer_________________________________Address__________________________________

Name of Primary Insurance Policy Holder:
Insurance Policy Name____________________ Effective Date ___________________________
Name on Card____________________________ Date of Birth _____________________________
Group #__________________________________ ID/Policy #_______________________________

Name of Secondary Insurance Policy Holder:
Insurance Policy Name____________________ Effective Date ___________________________
Name on Card____________________________ Date of Birth _____________________________
Group #__________________________________ ID/Policy #_______________________________

CONFIDENTIALITY INFORMATION
Shalom Wellness Center

Clients have a right to expect that information revealed in sessions will not be disclosed without extraordinary justification. Clients are reminded that their progress may be reviewed in Clinical Staffing with the supervising physician, with the Wellness Center Director, and/or a supervising therapist.
The conditions that justify release of information and by law must be reported to the appropriate agencies are the following:

1. Knowledge of child abuse or senior citizen abuse.
2. A client poses a serious risk of suicide, and is an imminent danger to self.
3. A client poses a threat of imminent danger to another person.
4. A Judge, by issuance of a court order, may obtain information.
5. Knowledge of a felony that has been or is being committed.

In other situations, signed authorization for release of information is required.

______________________________ Witness

______________________________ Client

______________________________ Date

______________________________ Date

CONSENT FOR TREATMENT
Shalom Wellness Center

I understand the information provided, as well as given verbally by the Shalom Wellness Center personnel. I hereby agree to enter a counseling relationship with Shalom Wellness Center.

Client signature　　Social Security #　　Date

Shalom Employee signature　　Date

AUTHORIZATION FOR RELEASE OF INFORMATION
Shalom Wellness Center

Authorization to Release Information

I authorize Shalom Wellness Center to release the dates of my treatment, information regarding my diagnosis, assessment and treatment plan, and any other relevant information to my insurance company or other organization paying for the service.

I authorize release of information to the following persons or organizations, with the express purpose of coordinating my mental health treatment:

____

Name Address

____

Name Address

____

Signature date

____

Shalom Wellness Center witness date

This release is valid for 180 days from date of signature.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:____
DOB: ____
SSN:____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Shalom Ministries' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Allen Rutter, Executive Director.

____

Signature of Patient/Client ***Date***

____

Signature or Parent, Guardian or Personal Representative * ***Date***

____

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

❑ ***Patient/Client Refuses to Acknowledge Receipt****:*

____

Signature of Staff Member ***Date***

Shalom Wellness and Mediation Center
Financial Agreement

Shalom Wellness Center accepts most Insurances and Self Pay as forms of payment for services provided. Shalom tries to make the payment process as easy as possible for each client.

Insurance Payment Option **Yes** ☐

If you wish to have Shalom submit your treatment or services received for payment by your insurance company you must complete page four of the admission documents.

I agree to forward to Shalom Ministries any insurance benefits that may be mailed directly to me, unless I have first made direct personal payments and then submitted my personal payments for reimbursement to my insurance company.

Self Pay Option

If you intend to make direct personal payment for services, all fees for service will need to be collected at the time of the visit. Our rate for a 50 minute session is $80.00. Under certain circumstances we can negotiate a discounted fee. All negotiated rates are based on one or all of the following criteria: 1. Combined annual household income. 2. The number of persons living in the household. 3. Current financial hardship. If you need to negotiate your rate of payment indicate below and ask to speak to the director of Shalom Wellness Center at the time of admittance.

I would like to speak to a Shalom representative and see if I am eligible for a reduced fee based on my total family income, current financial hardship, or number of individuals in my family.

Yes ☐ No ☐

If yes after a conversation with a Shalom representative I have agreed to pay ________________ for each counseling session or other unit of service received.

General Statements of Financial Agreement

I agree to inform Shalom Wellness Center of any changes to my income or insurance coverage status.

If I request services requiring significant time outside of the counseling session, I agree to be billed at my regular appointment rate.

If I am unable to keep an appointment I will call to cancel or reschedule. Failure to call or to show up for an appointment will result in a $20 fee which I must pay, and cannot be billed to insurance.

If my services include home visits, and I fail to cancel or reschedule my appointment I agree to pay a $25 fee. When travel expense if incurred it shall be computed as mileage to and from the office at $.46 per mile.

____

Client Signature Date

____

Shalom Representative Date

I understand that I am responsible for the entire bill, including the amount that the insurance company does not pay (based on full fee payment or a negotiated discounted fee amount); and agree to continue the same payments after termination of services until I have paid my bill in its entiry.

Shalom Ministries
<u>Notice of Privacy Practices</u>

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

Your record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with the opportunity to review any revisions will have a copy of the revised Notice of Privacy Practices in the office and can send a copy to you in the mail upon request.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors, supervising physicians or other treatment team members. We may disclose P1-Il to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If you have indicated an outside source of payment such as your employer or congregation, we may disclose information only with your authorization.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that' requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. The types of uses and disclosures that may be made without your authorization are those that are:

• Required by Law, such as the mandatory reporting of child or elder abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
• An acknowledgment of a felony that has been or is being committed
• Required by court order

• Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 301 Ditto Street, Archbold, OH 43502:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice**. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Shalom Ministries, 301 Ditto Street, Archbold, OH 43502 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 6l9-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is April 14, 2003.