

Shalom Wellness Center Admission Sheet Confidential

Identifying Information

Name _____ Date _____

Phone home: _____ work: _____ cell: _____

Address _____

Date of Birth ____ / ____ / ____ City _____ State _____ Zip _____
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) _____ 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 _____

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
22251 State Route 2
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 # _____

Please have your insurance card ready at 1st initial visit
*A \$130.00 assessment fee will be assessed for the 1st initial session and will be
billed to insurance if applicable*

Check if insurance is non-applicable at this time

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 55 minute session is \$90.00. 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 entirety.

Shalom Ministries
Notice of Privacy Practices

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 *MASW 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-II 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) 619-0257. **We will not retaliate against you for filing a complaint.**

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