Dayspring Center for Christian Counseling
123 Sand Mountain Dr. NW
Albertville, AL 35950

New Patient Information

Please Complete All Information

Last Name_____ First Name_____

Middle Name_____ Date of Birth_____

Gender? O Male O Female SSN_____

Relationship/Marital Status? _____ Partner Name _____

Address 1_____

Address 2_____

City_____ State_____ ZIP Code_____

Phone Cellular/Mobile _____ Home Telephone_____

Can we text you? _____

Email: Preferred email_____

Emergency Contact Name & Number _____

Emergency Contact Relationship to Patient_____

Insurance Information: Insurance Company_____

O Patient is Subscriber O Patient is Spouse of Subscriber O Patient is a Dependent of Subscriber

Name and Date of Birth of Subscriber _____

Member ID for Patient_____

I authorize payment of medical benefits to the provider/provider organization indicated above for services provided. O Yes O No

I authorize the release of any medical or other information necessary to process claims for service by the provider/provider organization above. I also request payment of government benefits to myself or to the party who accepts the assignment. O Yes O No

Signature_____ Date _____

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Adult Self-Report Form

Date:_____ **Patient's Name:**_____

Patient's Date of Birth:_____

Please describe the main difficulty that has brought you to see me:

_____

_____

Your medical care: From whom or where do you get your medical care?

Clinic name:_____ Phone:_____

Address:_____

Doctor's name:_____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? o Yes o No

Your current employer:

Employer:_____ Work phone:_____

Address:_____

Occupation:_____ Length of time with this employer:_____

Please indicate any restrictions on calls:_____

Present relationships:

How do you get along with your spouse or partner?_____

How do you get along with your children?_____

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Past Psychological/Psychiatric Treatment:

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? O Yes O No

Please indicate which type of treatment: O Inpatient O Outpatient O Both

If yes, please indicate:

When:_____ From Whom:_____

For What:_____ Results:_____

Have you ever taken medications for psychiatric/emotional problems? O Yes O No

If yes, please indicate:

When:_____ From Whom:_____

For What:_____ Results:_____

List of Symptoms

Please check any of the following that have been bothering you lately:

O Abused as a child	O Agoraphobia	O Alcohol use	O Ambition
O Anger	O Anxiety	O Appetite	O Being a parent
O Bowel trouble	O Career choices	O Children	O Compulsions
O Compulsivity	O Concentration	O Confidence	O Conflict
O Depression	O Divorce	O Drug use/abuse	O Eating problem
O Education	O Energy (hi/low)	O Extreme fatigue	O Fears
O Fetishes	O Finances	O Friends	O Guilt
O Headaches	O Health problems	O Homicidal	O Impotence
O Inferiority feeling	O Insommia	O Legal Matters	O Loneliness
O Making decisions	O Marriage	O Memory	O My thoughts

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O Nervousness	O Nightmares	O No interests	O Obsessive think
O Overweight	O Painful thoughts	O Panic attacks	O Perfectionism
O Phobias	O Relationships	O Relaxation	O Sadness
O Self-control	O Self-esteem	O Separation	O Sexual abuse
O Sexual orientation	O Sexual problems	O Short temper	O Shyness
O Sleep	O Spacing out	O Stomach trouble	O Stress
O Suicidal thoughts	O Tiredness	O Unhappiness	O Work
O _____	O _____	O _____	O _____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / relationship? O 1 - No effect O 2 - Little effect O 3 - Some effect O 4 - Much effect O 5 - Significant effect O Not Applicable

Family? O 1 - No effect O 2 - Little effect O 3 - Some effect O 4 - Much effect O 5 - Significant effect O Not Applicable

Job/school performance? O 1 - No effect O 2 - Little effect O 3 - Some effect O 4 - Much effect O 5 - Significant effect O Not Applicable

Friendships? O 1 - No effect O 2 - Little effect O 3 - Some effect O 4 - Much effect O 5 - Significant effect O Not Applicable

Financial situation? O 1 - No effect O 2 - Little effect O 3 - Some effect O 4 - Much effect O 5 - Significant effect O Not Applicable

Physical health? O 1 - No effect O 2 - Little effect O 3 - Some effect O 4 - Much effect O 5 - Significant effect O Not Applicable

Anxiety level / nerves? O 1 - No effect O 2 - Little effect O 3 - Some effect O 4 - Much effect O 5 - Significant effect O Not Applicable

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Mood? O 1 - No effect O 2 - Little effect O 3 - Some effect O 4 - Much effect
O 5 - Significant effect O Not Applicable

Eating habits? O 1 - No effect O 2 - Little effect O 3 - Some effect O 4 - Much effect
O 5 - Significant effect O Not Applicable

Sleeping habits? O 1 - No effect O 2 - Little effect O 3 - Some effect
O 4 - Much effect O 5 - Significant effect O Not Applicable

Sexual functioning? O 1 - No effect O 2 - Little effect O 3 - Some effect
O 4 - Much effect O 5 - Significant effect O Not Applicable

Alcohol / drug use? O 1 - No effect O 2 - Little effect O 3 - Some effect
O 4 - Much effect O 5 - Significant effect O Not Applicable

Ability to concentrate? O 1 - No effect O 2 - Little effect O 3 - Some effect
O 4 - Much effect O 5 - Significant effect O Not Applicable

Ability to control anger? O 1 - No effect O 2 - Little effect O 3 - Some effect
O 4 - Much effect O 5 - Significant effect O Not Applicable

Substance Use?

Do you currently consume alcohol? O Yes O No

If yes, on average how many drinks per occasion do you consume?_____

How many days per week do you consume alcohol?_____

Do you have a history of problematic use of alcohol? O Yes O No

Have family members or friends expressed concern about your drinking? O Yes O No

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Do you currently use non-prescribed drugs or street drugs? O Yes O No

Do you have a history of problematic use of prescription or non-prescription drugs?
O Yes O No

Do you have a family history of alcohol or drug problems? O Yes O No

If yes, please describe:_____

_____

Other?

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use more paper if needed,

_____

_____

_____

_____

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Telebehavioral Health Informed Consent

Telebehavioral health is the delivery of behavioral health services using interactive technologies between a Dayspring Center for Christian Counseling practitioner and a client who are not in the same physical location, but who are still located within the state of Alabama.

Dayspring Center for Christian Counseling utilizes a HIPAA/HITECH compliant platform that incorporates security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

This service is provided by video and phone technology. There are benefits and limitations to this service.

The laws and professional standards that apply to in-person counseling services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Requirements of Client: I understand that I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided and agree to obtaining access to this technology in order to participate in Telebehavioral Health Services.
It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications. I will agree not to record telebehavioral health sessions without the knowledge and consent of the provider.

Exchange of Information: Any paperwork exchanged for telebehavioral health services will likely be provided through electronic means via HIPAA/HITECH compliant portal or through postal delivery. Details of a client's medical history and personal health information may be discussed during the use of interactive video, audio or other telecommunications technology.

In-person Appointments: If a need for direct, in-person services arises, it is my responsibility to contact Dayspring Center for Christian Counseling’s office/provider for an in-person appointment to be scheduled. I understand that an opening may not be immediately available in their office.

Self-Termination: I understand that I may decline any telebehavioral health services at any time without jeopardizing my access to future care, services, and benefits.

Risks of Technology: These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

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Modification Plan: Dayspring Center for Counseling provider will regularly reassess the appropriateness of continuing to deliver services through the use of the technologies agreed upon and modify our plan as needed.

Emergency Protocol: In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means. An emergency is considered a response or behaviors exhibited by the client during the telebehavioral health session that initiate a concern for safety. Examples may include, but are not limited to, expressions of suicidal ideation, homicidal ideation, reports of abuse to child or vulnerable adult. In emergency situations, providers will follow general practice policies to address the emergency (please reference Daysprings Notice of Privacy Practices).

Disruption of Service: Should service be disrupted, Dayspring Center for Christian Counseling provider will follow up with an alternate form of contact that meets the criteria outlined in this consent. For example, if there is disruption of service during a video session, the provider will promptly follow-up with the client via phone. It will then be determined by provider and client if the session will continue as scheduled or be rescheduled for another day/time.

Client Printed Name_____

Date_____

Client Signature_____

Dayspring Center for Christian Counseling
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256-878-3809

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)
This notice describes how your health information may be used and disclosed, your rights pertaining to that information, and how you can gain access to that information. Please review it carefully.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others.
Your record is the physical property of the Dayspring Center for Christian Counseling, Inc, while the information within the record belongs to you. In using and disclosing your protected health information, it is our objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464, even if this is not required. The contents of a counseling, intake, or assessment session are considered to be confidential as required (and except as limited) by law. Discussions with your therapist, as well as your record and testing material, are kept confidential. Any information you provide in therapy is never released to anyone, including your spouse/partner or family, without your written consent, except as required by law or ethical guidelines as described below:

Duty to Warn and Protect
Consistent with legal statutes and ethical guidelines, we may disclose your health information as necessary to avert a serious threat to the health or safety of you or others, although disclosures are limited if information is obtained through counseling or therapy.

Abuse of Children and Elderly or Developmentally Disabled Adults
As allowed by law, we may disclose your health information to social service or other government agencies if you report that you are abusing a child or vulnerable adult, that you have recently abused a child or vulnerable adult, or that a child or vulnerable adult is in danger of abuse.

Law Enforcement and Court Orders
We may disclose health information to law enforcement in the following circumstances: 1) information required by law, 2) limited information for identification and location purposes, 3) information regarding suspected victims of crime, though staff will usually attempt to first obtain your agreement to release the information, 4) information about a deceased client if staff suspect that the death resulted from criminal conduct, and 5) information that staff believe in good faith establishes that a crime has been committed on the premises. We may also disclose health information to others as required by court or administrative order, or in response to a valid summons or subpoena.

OTHER PROVISIONS OF HIPAA

We may use or disclose your protected health information for treatment, payment, operations, and purposes described below:
Health information may be used for treatment: e.g. We will use information obtained to determine your best course of treatment. The information obtained from you or from other providers will become part of your mental health records. Your therapist may share pertinent information (e.g. diagnosis, treatment plan, safety concerns, etc.) with your other health care providers in order to collaborate care. In addition, in order to provide the best possible treatment, your therapist will regularly consult with other professionals about clients; no identifying information will be given in these consultations.
Health information may be used for payment: e.g. We may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used as necessary to obtain payment.
Health information may be used for regular health care operations: e.g. We may use your information to assess the care and outcomes of your care in an effort to improve the quality of the care you receive or for educational purposes.

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YOUR HEALTH INFORMATION RIGHTS

You have the right to:
1. Request a restriction on certain uses and disclosures of protected health information as described in this notice, though we are not required to agree to the restriction you request. You should address your request in writing to Dayspring Center for Christian Counseling, Inc. at P.O. Box 859, Albertville, AL 35950. You will be notified within 30 days if we cannot agree to the restriction.
2. Obtain a paper copy of this notice and upon written request, inspect and obtain a copy of your health record for a fee of $1.00 per page and the actual cost of postage.
3. Amend your health record by submitting a written request with the reasons supporting the request. In most cases, you will receive a response within 30 days. We are not required to agree to the requested amendment.
4. Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
5. Request in writing that communication with you be done with a specific method at a specific location. We will typically communicate with you in person or by letter and/or telephone.
6. Revoke an authorization to use or disclose health information at any time except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Dayspring Center for Christian Counseling, Inc are required to:
1. Maintain the privacy of your protected health information and provide you with notice of his or her legal duties and privacy practices with respect to your protected health information.
2. Abide by the terms of the notice currently in effect. We have the right to change the notice of privacy practices in which case a new copy will be given to you. These changes will apply to all of your protected health information, including information obtained prior to the change.
3. Accommodate reasonable requests to communicate with you about your protected health information by alternative means or locations.
4. Use or disclose your health information only with your authorization except as described in this notice.
In some circumstances, state or federal law may prohibit or further restrict the disclosure of your health information. If that is the case, we are required to follow the more stringent law.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

For more information or to report a problem, you may contact the Dayspring Center for Christian Counseling, Inc at 256-878-3809. If you feel your rights have been violated, you may file a complaint in writing. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Dayspring Board of Directors by mailing such complaint to Directors, P.O. Box 859, Albertville, AL 35950. You will not be retaliated against for filing a complaint.

DISCLOSURES REQUIRING AUTHORIZATION

All other disclosures of protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.

ACKNOWLEDGMENT OF RECEIPT

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices.

By signing this document, you agree and acknowledge that you have received this Notice of Privacy Practices.

Signature of Receipt _____ Date _____

Client Printed Name_____

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Permission to Charge
Credit Card Information

Cardholder Name (as it appears on card):_____

Billing Address:_____

City:_____State_____Zip_____

Card Type:

0 American Express 0 Discover 0 MasterCard

0 Visa 0 HSA 0 FSA

Card Number:_____

Expiration Date (MM/YY):_____

CVV:_____

Authorization & Agreement
I authorize Dayspring Center for Christian Counseling to charge my credit card for any services provided that are not covered or reimbursed by my insurance provider, including but not limited to: session fees, co-pays, late cancellation or no-show fees, and outstanding balances.

This authorization will remain in effect until I provide written notice of cancellation. I understand I may request a receipt for any transaction processed with this card.

REQUIRED SIGNATURE
By signing below, I acknowledge that I have read, understand, and agree to the terms of this authorization.

Client Printed Name_____

Date_____

Client Signature_____