

Heather O'Neil, LCSW

DATE _____

Dx code _____
Office use only

CLIENT INFORMATION:

Name: _____ Age _____ Birth date _____

Street _____ City _____ Zip _____

Education _____ Referred by: _____

Employer _____ Job Title _____

At times, I may need to contact you. Discreet messages will always be left at any number I call.

Home Phone Number: _____ OK to call? Y N

Work Phone Number: _____ OK to call? Y N

Cell Phone Number: _____ OK to call? Y N

Best way to contact you: home work cell all numbers

Marital Status: (circle one) S M D W Other _____ Number of children _____

Who else currently lives with you? _____

EMERGENCY CONTACT – This section must be completed with a LOCAL contact name

I may take some action, such as seek an order for your emergency or involuntary commitment, without your consent if I deem you to be a serious harm to yourself or another. Any action I take without your consent will be discussed with you. I may also decide it's necessary to contact one of your friends or relatives if I become alarmed about your safety. Please write down the name and information of at least one local emergency contact. By providing this information, you are also giving me permission to use it if I feel an emergency situation has developed.

Name: _____ Phone# _____ Relationship: _____

Primary issue you'd like to work on _____

Other issues _____

Medical & Psychological History (If client is 18 or younger, parents or guardian please complete)

Date of last physical: _____

Have you ever been in therapy before? Yes No If yes, when and for how long? _____

Have you ever been hospitalized for psychiatric reasons? Yes No If yes, please list dates & reasons:

Is there a history of mental illness in your family of origin? Yes No If yes, please list who and what illness/es :

List all current medications (for medical issues and psychological issues):

| Medication Name | Dosage | Diagnosis | Symptoms | How Long Diagnosed? |
|-----------------|--------|-----------|----------|---------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| | |
|--|--|
| <p>Have you experienced any of the following in the past two years? (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent colds/flu <input type="checkbox"/> Backaches <input type="checkbox"/> Problems with vision <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Change in eating habits <input type="checkbox"/> Weight loss/gain <input type="checkbox"/> Irritability <input type="checkbox"/> Fatigue <input type="checkbox"/> Sleep problems <input type="checkbox"/> Memory/concentration problems <input type="checkbox"/> Thoughts about suicide <input type="checkbox"/> Attempts of suicide-when? _____ <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety/nervousness <input type="checkbox"/> Stomach problems <input type="checkbox"/> Intrusive thoughts/sounds <input type="checkbox"/> Pre-menstrual problems <input type="checkbox"/> High blood pressure <input type="checkbox"/> Excessive stress <input type="checkbox"/> Problems with hearing <input type="checkbox"/> Sexual problems <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Problems concentrating <input type="checkbox"/> Thoughts of hurting others <input type="checkbox"/> Violence against others <input type="checkbox"/> Chest pain <input type="checkbox"/> Other | <p>Have any of the following events occurred in your life in the past two years? (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Death of friend or family member <input type="checkbox"/> Change in close personal relationship (divorce, separation, etc.) <input type="checkbox"/> Serious problems with friend/family <input type="checkbox"/> Personal injury, illness, accident <input type="checkbox"/> Family injury, illness, accident <input type="checkbox"/> Major change in job status <input type="checkbox"/> Serious job-related difficulties <input type="checkbox"/> Accused of crime <input type="checkbox"/> Victim of crime <input type="checkbox"/> Major geographic relocation <input type="checkbox"/> Sexual/physical abuse or rape <input type="checkbox"/> Sexual harassment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Surgery <input type="checkbox"/> Legal problems <input type="checkbox"/> Financial problems <input type="checkbox"/> Gambling problems <input type="checkbox"/> Other |
|--|--|

FINANCIAL POLICY

I am committed to providing you with the best possible mental health care, and I'm pleased to discuss my professional fees with you. Payment should be ready at the start of each session (cash or check). Make checks out to Heather O'Neil.

Sessions are 50 minutes in length and have a standard fee of \$90. I do work with a sliding fee so please talk with me if you are unable to pay the full amount. Family sessions are usually higher. I am on several insurance panels and would be happy to talk with you about your insurance and whether or not I am an approved provider.

Confidentiality. Insurance companies require release of confidential information. This ranges from identifying information, diagnosis and dates of sessions to a complete description of treatment goals and progress reports. We cannot be in control of the storage of nor access to your confidential information when it is given to a third party.

CANCELATION POLICY – ALL CLIENTS. My standard fee of \$90 will be charged for all missed appointments or those canceled without 24-hours advance notice. Insurance does not cover this.

I have read the above information. I understand and agree that I am responsible for the payment of all professional services rendered. A legal guardian or parent must sign for clients 18 years and younger. Both parties of a couple must sign.

Name/s: _____ Date: _____
Please print

Client Signature or Personal Representative

Client Signature or Personal Representative

We reserve the right to change our financial policy at any time, without advance notification

Heather O'Neil, LCSW

Welcome. I look forward to working with you. This letter outlines my office/practice policies and works in conjunction with the information contained in my disclosure statement, financial policy, and HIPAA policy.

Most clients come on a regular basis, such as weekly, and often work for six months to a year at a time. In therapy, major life decisions are sometimes made. These decisions are a legitimate outcome of the therapy experience and sometimes involve your calling into question some of your beliefs and values. As your therapist, I will be available to discuss any of your assumptions, problems or possible side effects in our work together. Psychological services are best provided in an atmosphere of trust. You expect me to be honest with you about your problems and progress. I expect you to be honest with me about your expectations for service, your compliance with our fee agreement, and any other barriers to treatment.

Confidentiality. The information you discuss during a psychotherapy session is protected as confidential under law (CRS 12,43,214 (1)(d)) with certain limitations:

- It is my policy to report suspected child abuse (physical, emotional, and/or sexual), without an investigation, to the proper authorities who may then investigate.
- If you file an official complaint or a lawsuit against me, according to Colorado law, your right to confidentiality will be waived.
- Clerical persons hired by me may have access to limited confidential information. This information is protected from further disclosure and is used solely for administrative purposes.
- When I am away from my office for a few days, I may ask another licensed therapist to cover emergencies for me. Generally, I will tell this therapist only what he or she needs to know for an emergency.

Availability. Hours for regular phone calls are 8 a.m. to 6 p.m. on business days. I will attempt to return your call within one business day. In the event of an emergency please state the time you called and that it is an emergency when you leave your message. For immediate assistance or life-threatening situations, please call 911 or go to your nearest hospital emergency room.

Records. Records include identifying information, dates and types of sessions, an assessment and diagnosis, a treatment plan, progress notes, and any consultations or collateral contacts made. Your records will be stored safely with attention to your privacy for at least 10 years as required by Colorado Statute. It is my policy to not release an entire record, even with your consent. Instead, I may summarize the content related to the request. The summary will only be released with your written permission and direction, and if you were seen in couple or family sessions, all adults present would have to sign the release. You will be granted reasonable access to your record. You may request, in writing, an amendment to your record. If you choose to read your record, it is my policy to be present in order to respond to any questions or confusion you may have about the recordings. Private psychotherapy notes are kept separate, and are further protected from unauthorized access. Psychotherapy notes are not made available for review. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) the therapist who wrote the notes uses them for your treatment; (b) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; (c) if you bring a legal action and we have to defend ourselves; and (d) certain limited circumstances defined by the law.

Termination. Termination will usually be agreed upon mutually, but you are free to terminate at any time. However, in a few special instances I may decide to stop working with you even though you wish to continue. These include a failure to meet the terms of our fee agreement, a need for special services outside of the area of my competency, and prolonged failure to make progress in our work together. Should this occur, the reason for termination will be discussed with you, and you will be helped to make different plans for yourself, including a referral to a more appropriate resource.

I have read the preceding information and understand my rights and responsibilities as a client. I accept, understand and agree to abide by the contents and terms of this agreement and further consent to participate in evaluation and/or treatment. Both parties of a couple must sign. Parents/Guardians must sign for clients 18 and younger.

Client Name/s (print) _____

Client Signature (or Guardian for Minor)

Date

Client Signature (or Guardian for Minor)

Date

OFFICE USE ONLY

Initial: _____ Final: _____

Heather O'Neil 720 363-5793
1890 Gaylord Street
Denver, CO 80206Date of 1st Session _____**Mental Health Benefits**

Insurance Company _____ Contact Number _____

of sessions still available _____ Treatment Plan required? No Yes

Address to send claims to: _____

INSURANCE INFORMATIONAll Questions Must Be Answered - (please have your insurance card out so that we may make a copy)

Client Name (please print) _____ Client Date of Birth _____ Relationship to Policy Holder _____

Policy Holder - All information below is in reference to the policy holder and must be provided.

Name _____ Birth Date _____ Social Security Number _____

Address: _____
Street City State Zip Phone Number

Name of Employer _____ Position _____

Name Of Insurance Plan _____ Insurance ID / Policy Number _____ Insurance Group Number _____

It is your responsibility to contact your insurance company to understand and verify your benefits. You are responsible for any costs not covered by your insurance company, for any reason.

of sessions for the year _____ Plan renewal date _____ Co Pay _____ Authorization Code (required by some plans) _____

Amount of deductible _____ Has deductible been met for this year? Yes No (If not, you are required to pay the full session fee until the deductible is met.)

Please read our Office Financial Policy regarding insurance payments, coverage, and cancellation.**AUTHORIZATION TO RELEASE INFORMATION**

I authorize the release of any medical or other information necessary to (1) provide for adequate professional coverage in the absence of primary physician, (2) to verify insurance coverage and (3) to file and process a claim for insurance benefits. I also authorize payment of medical benefits to the undersigned physician for professional services rendered.

Client Signature _____ Date _____