Nicole A. Schild, LCSW, LLC
2128 Chamber Center Drive
Ft. Mitchell, KY 41011
Phone: (859) 331-6525, ext. 4
Fax: (859) 331-6526

Name: ____________________

GENERAL INFORMATION

ALL INFORMATION MUST BE COMPLETED

Patient Information: Date: ______________

Patient Name ____ Gender: [ ] Male [ ] Female
Last First Middle

Primary Address__________________________________City/State_________________Zip__________

Phone Home (_____) _______-___________Cell (_____) _______-___________ Work (_____) _______-___________
OK to leave message at this number? (Y/N) Home:______ Cell:______ Work:______

Email: ______________________________________ OK so send email to this address? Y/N: ________

Patient Social Security # _________________________ Date of Birth ______-_______-__________

Marital Status [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] NA (children)

Employment Status [ ] Employed [ ] Student [ ] Unemployed

Primary Care Physician ___________________________________ Phone (_____)_______-___________

Emergency Contact: Name _______________________________ Phone (_____)_______-___________

Insurance Information: *(The following must be completed for us to bill the insurance company on your behalf.)*

Policy Holder's Information:

Name __________________________________ Relationship to Client ________________________

Social Security # _________________________ Date of Birth ______-_______-________

Insured's place of employment ____

If different from above:

Address _______________________________________City/State _______________ Zip__________

Home Phone (______)________-___________ Cell (______)________-___________

Insurance Information (Information found on Insurance Card)

Insurance Company Name ____

Member ID # ________________________ Group # ______________ Effective Date _____________

Claims Mailing Address: ____

Insurance Benefit/Authorization Information (You must call your carrier for this information)

Insurance Rep Name: ______________________________ Date called ________________________

Phone # called _______________________ office co payment ____________________

Deductible $_________(if any) Amount met $__________ Co - insurance % $__________/session

# of visits allowed per calendar year _________ # used this year __________

Authorization needed ____Yes _____ No Authorization # _________________________

# of visits auth'd _____________ effective dates from___________ to ______________

Are you seeking counseling related to a court order or legal proceedings? [ ] Yes [ ] No

Who referred you to our practice? ____

May we thank them: [ ] Yes [ ] No Phone: _______________________________________

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Informed Consent for Receipt of Psychological Services (Adult)

This form is to document that I, ____ give voluntary permission and consent to receiving psychological services from _________________________ at Nicole A. Schild, LCSW, LLC.

________ **Purpose and Background:**
The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of KY to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise.

While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by my therapist. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

________ **Confidentiality:**
I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

________ **HIPAA**
I understand that this consent form acknowledges my right to privacy and the limitations on my privacy; I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of Nicole Schild LCSW LLC's "Notice of Privacy Practices", I acknowledge I was offered this policy statement on the date indicated by my signature below.

________ **Attendance:**
I understand that regular attendance, a willingness to be open and honest and follow-through on treatment suggestions will produce maximum benefits, but that the final decision on what to do is always up to me. In addition, I understand that I am free to discontinue treatment at any time. A termination session may be requested in order to provide for any continuing areas of concern. . If no therapeutic services are provided for 12 months your case will automatically terminate. I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the rate of $60.00 per missed appointment. Further, I understand that my insurance will not cover these charges in any way, and I will be liable for all charges that result from a missed appointment without sufficient (24 hour) notice.

________ **Contact Information:**
The office address for Nicole Schild LCSW, LLC is: 2128 Chamber Center Drive, Ft. Mitchell, KY 41017. I understand that for routine appointments and information I may call (859) 331-6525. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned as soon as possible by my therapist. If I have an after-hours crisis or need assistance more quickly, I can call my therapist at the crisis contact number provided in their regular voicemail box, however, I understand this number is for crises only. If for any reason I cannot reach my therapist and I feel I need immediate psychiatric admission to a hospital for stabilization, I understand that I may be referred to the nearest hospital emergency room. In the event that I cannot reach my therapist, I understand that it is recommended that I call my primary care physician or 911 or go to the nearest emergency room.

________ **Complaints Procedure:**
If I am dissatisfied with any aspect of the services I receive, I understand that I can and am encouraged to raise my concerns with my therapist immediately. Dissatisfactions will make working together slower and more difficult if not resolved. If I feel that I have been treated unfairly or unethically and cannot resolve this problem directly, a complaint procedure is available through your therapist's state licensing agency, which may be contacted in Frankfort, KY 40602.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.

I release and hold harmless Nicole Schild LCSW LLC from any action or liability arising out of my participation in treatment.

____ _____________________________
Signature of client Date

____ _____________________________
Signature of Witness Date

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Name: ____________________

Consent to Bill Third Party Payer

Use of Insurance:

As a client at Nicole Schild LCSW, LLC, I understand that I will be responsible for the financial expenses incurred as the result of my participation in treatment. I further understand that I may elect to use a third party payer, i.e. medical insurance, to help cover the cost associated with treatment. However, I understand that if I elect to use a third party payer to help offset the cost of my treatment, I will be required to consent to the release of information for billing purposes. This will mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and may additionally constitute the release of treatment planning information.

Charges for Services:

Service	Charge
Diagnostic Assessment	$ 140.00
Psychotherapy Session (45 min)	$ 125.00

The following services are NOT generally insurance reimbursable:

Service	Charge
Billing/Processing fee (Assessed for initial insurance authorization)	$ 25.00
Missed Appointment/Late Cancellation	$ 60.00
Return Check Fee	$ 15.00
Phone calls (lasting longer than 10 minutes)	$ 1.00/minute
Emails requiring response	$ 30.00/15 minutes
Emails to provide information not requiring response	$ 30.00/15 minutes if more than 2 recevied per session
Letter Writing	$ 60.00 / half hour plus postage
Copying Records	$ 1.00 /page plus postage
Disability/Workmans Compensation FMLA paperwork/phone calls	$ 35.00
Court Preparation	$ 95.00 / hour
*Half Day Court Attendance (4 hours or less)	$ 500.00**
*Full Day Court Attendance (over 4 hours)	$ 1,000.00 **

* At least 2 weeks' notice required between delivery of subpoena and court date.
**Half payment for court attendance due at time of subpoena and/or time of scheduling with remaining balance due one week prior to court attendance.
* 48 hour cancellation notice must be given or retainer will be forfeited.

Payment:

If I wish to pay for services out of pocket, or for the purposes of making my co-payment should I elect to use my insurance, I may make payments via cash, check (made out to my treatment provider), credit or debit card. I understand all checks returned unpaid will be subject to a $15.00 service fee. If I have a balance due for more than three months, my account may be turned over to a collection agency for the purpose of recovering lost funds. If my account is sent to collections there will be a 30% fee added to my current balance to cover all associated collection fees.

Use of Insurance and Authorization for Treatment:

If I chose to use medical insurance, it is important that I be aware of my coverage and limits. I am responsible for amounts and/or services not covered by my insurance. I am also responsible for payment of amounts not covered because of failure to obtain a referral or not following necessary guidelines set by my insurance company for accessing mental health benefits**. I understand I will be charged $60.00 for missed or cancelled appointments unless notification is given 24 hours prior to the scheduled time of the appointment.** ***I understand that insurance companies do not cover the costs of missed appointments and I will be billed directly.***

I, ______________________________________,

❑ wish to use my medical insurance to off-set the cost of treatment, and in so doing give my therapist permission to release any information necessary to process this claim and collect payment for the services rendered. I permit direct payment to my therapist any benefits due me for services rendered. I understand I am financially responsible for all services rendered, if not otherwise satisfied through my medical insurance.

❑ do not wish to use any medical insurance benefit to cover services I receive through my therapist. I understand that I am financially responsible for all expenses incurred for my treatment, and will make all payments at the time of service. This option enables me to keep my protected health information confidential.

______________________________ ______________________
Signature of Client/Responsible Party Date

______________________________ ______________________
Signature of Witness Date

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ADULT INTAKE

Name: ____ Date: __________________________

Date of Birth: ______________ Age: ____________

1.Why have you come to Nicole A. Schild, LCSW (Presenting issue for Client)? Please circle all presenting symptoms/problems.

Adjustment issues Aggressive behavior Anxiety Binging/Purging

Can't relate to others Concentration difficulties Defiant behavior Depression

Difficulty making decisions Divorce Employment problems

Financial problems Grieving Hopelessness Impulsive dangerous behavior

Irritability Low/high energy Medical problems Mood swings

Obsessive compulsive Panic attacks Paranoid ideation Parenting concerns

Poor self-care skills Psychotic episode Relationship problems School problems

Self-mutilation Sexual problems Sleep disturbance Stressed

Substance abuse/dependence Tearfulness Other__________________________

2. How long has this been an issue? ____

3. What have you tried to do to resolve this issue? Please include any previous mental health treatment history:

Provider/Facility	Date (start to end)	Response
____________________	__________________	____________________________
____________________	__________________	____________________________
____________________	__________________	____________________________

4. What are your goals for counseling?____

____

____

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5. Has any other member of your family (including extended family) been diagnosed or had significant problems with mental health issues, substance abuse, developmental delay, major medical or legal issues?

Family Member	Issue
____________________	____
____________________	____
____________________	____
____________________	____

6. Who resides with you in your home?

Name	Relationship:	Age:
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________

8. Medical History:
Health (describe your general health as well as any active medical concerns including pain and how you are addressing it)
____
____
____

Please list all current medications including over-the-counter and prescription medications:

Name of Medication:	Dosage:	Date Started:
____________________	________	______________
____________________	________	______________
____________________	________	______________
____________________	________	______________
____________________	________	______________

10. Do you consider yourself (please circle)

Eat regular meals	Eat variety of meals	Change weight frequently
Overweight	Underweight	Special/Restricted Diet

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11. Do you have any functional/social limitations that affect your daily living (Please circle all that apply)

Job Financial stressors Learning disabilities

Living situation Physical impairments Problems with self care/hygiene

Problems with independent living

12. Legal History:
Please place an **"N"** for none, **"C"** for currently experiencing or **"P"** for experienced in the past.

DUI ________ Bankruptcy ______ Divorce ________
Unemployment ________ Domestic Violence ______ Custody Dispute ________
Disability Claim ________ Workman's Compensation ______

13. Educational Background (highest grade completed): ________________________________

14. Employment History (Please describe current job briefly):________________________________

15. Military Service: ____

16. History of Abuse:
Please place an **"N"** for none, **"C"** for currently experiencing or **"P"** for experienced in the past or **"W"** for witness of such:

Verbal Abuse _______ Emotional Abuse _______ Childhood Abuse _______
Physical Abuse _______ Spouse Abuse _______
Sexual Abuse _______ Elder Abuse _______

Please circle if the client is or has been:

Victim Perpetrator Witness

Please name any other traumatic event impacting current/past daily living:____________________
____
____

17. Alcohol and Drug Use:

Use alcohol and/or drugs Yes/No If yes, explain:________________________________

Current abuse/dependence Yes/No If yes, explain:________________________________

Please circle if currently applies: Unstable remission Sustained remission

Nicotine use Yes/No

Past treatment Yes/No If yes: Inpatient Outpatient

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18. Legal History

Currently facing charges Yes/No If yes, explain:________________________________

Currently on probation, parole, or work release Yes/No

Please list any past misdemeanor and/or felony charges:______________________________

19. Religious/Spiritual History:
Do you have an identified religious or spiritual preference? ____________________________

What roles do these beliefs play in your life and how do you think this may affect your treatment? ____

20. History of Harm to Self or Others:
Do you currently have any urges/thoughts of hurting yourself? Yes/ No
Any current urges/thoughts of hurting another? Yes/No
Any history of hurting self or suicide attempt? Yes/No
Any history of physical aggression toward another Yes/No

If yes on any of these questions, please describe:___________________________________
____

Please feel free to provide any additional information you feel may be helpful: ____________
____
____
____
____
____
____