

GENERAL INFORMATION

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 _____-____-____

Employment Status Employed Student Unemployed

Custody Status Sole Joint Temporary Other _____

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-Please bring card with you to session)

Insurance Company Name _____

Member ID # _____ Group # _____ Effective Date _____

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: _____

Informed Consent for Receipt of Psychological Services (Child)

This form is to document that I, _____ give voluntary permission and consent for my child, _____ 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 Nicole Schild LCSW LLC. 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 "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 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

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:

Diagnostic Assessment \$ 140.00
Psychotherapy Session (45 min) \$ 125.00

The following services are NOT generally insurance reimbursable:

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 received 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

_____ THIS DOES NOT APPLY TO ME OR MY CHILD

Initial

Divorced/Soon-to-be Divorced/Separated Parent Policy

The professionals and employees of Nicole A Schild LCSW LLC seek to provide a high quality of care to our clients and their families. Divorce can intrude on or complicate services being provided. The following is our policy:

1. We need a copy of the custody agreement or order at your child's first appointment.
2. We ask that both parents schedule an appointment to provide important information regarding the child and to receive periodic treatment updates. Exceptions may be made on an individual basis with legally-bound reasons being provided (ex. Potential for danger, etc.) If we are informed that a parent with decision-making rights does not consent to treatment, we will not continue to provide services.
3. **Our office does not accept responsibility for seeking payment from the non-treatment seeking parent, regardless of your arrangement.** The following are the options for payment of services: a) both parents can sign the new client packet in full and divide costs and pay together at the time of service, or b) the treatment seeking parent is responsible for paying for the services and gaining reimbursement form the other party. Either option requires that monies due be paid at each appointment, or in advance.

Mother's Information

Name _____
 Social Security # _____ Date of Birth ____ - ____ - ____
 Address _____ City/State _____
 Zip _____
 Home Phone (____) _____ - _____ Cell (____) _____ - _____

Father's Information

Name _____
 Social Security # _____ Date of Birth ____ - ____ - ____
 Address _____ City/State _____
 Zip _____
 Home Phone (____) _____ - _____ Cell (____) _____ - _____

I, _____ (parent of legal guardian), have read the divorce policy provided. I understand the policy and agree to its terms and provisions.

Signature

Date

Nicole A. Schild, LCSW, LLC

2128 Chamber Center Drive

Ft. Mitchell, KY 41011

Phone: (859) 331-6525, ext. 4

Fax: (859) 331-6526

Name: _____

CHILD 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
- Playing with fire Poor self-care skills Psychotic episode Relationship problems
- Runaway attempts School problems Self-mutilation Sexual problems
- Sleep disturbance Stealing Stressed Substance abuse/dependence
- Tearfulness Wetting/Soiling 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? _____

Nicole A. Schild, LCSW, LLC

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Name: _____

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

<u>Family Member</u>	<u>Issue</u>
_____	_____
_____	_____
_____	_____
_____	_____

6. Who resides with you in the home?

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Medical History:

Health (describe 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:

<u>Name of Medication:</u>	<u>Dosage:</u>	<u>Date Started:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child born premature? Yes/No

Child exposed to toxins (ie. illicit drugs, alcohol, etc.) while in utero? Yes/No If yes, explain: _____

Birth Weight: _____ lbs. _____ oz.

Child adopted? Yes/No If yes, at what age? _____

Approximate age when your child first began:

Walking: _____ Talking: _____ Toileting: _____

8. Assessment of diet and body image (please circle)

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

9. Functional/social limitations (Please circle all that apply)

Job	Financial stressors	Learning disabilities
Living situation	Physical impairments	Problems with self care/hygiene

10. What grade is your child currently in? _____

Where does your child attend school? _____

Circle any grade(s) failed. K 1 2 3 4 5 6 7 8 9 10 11 12 None

Circle any grades skipped. K 1 2 3 4 5 6 7 8 9 10 11 12 None

What grades does your child normally get in school? (Circle all that apply)
A B C D F

Have there been any tendencies toward improving or deteriorating school performance over the years? No/Yes If yes please provide further details.

What are your child's **strongest** subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies Specials

What are your child's **weakest** subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies Specials

Has your child ever been:

Reprimanded at school: Yes/No

Served detention: Yes/No

Been suspended: Yes/No

Been expelled: Yes/No

If yes to any, please explain: _____

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Name: _____

Has the school ever performed psychological or educational testing on your child? Yes/No
If yes, describe and indicate any special services implemented:

Does your child have many friends? Yes/No

Does your child make friends easily? Yes/No

11. Employment History (Please describe current job briefly): _____

12. 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 _____

Physical Abuse _____ Bullied _____

Sexual Abuse _____ Domestic Violence _____

Please circle if the client is or has been:

Victim Perpetrator

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

13. What are the most common activities that your child engages in? (bike riding, playing with friends, TV, etc.) _____

14. 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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Name: _____

15. Sexuality

To your knowledge, is your child sexually active? Yes/No

Does your child have concerns about his/her sexual orientation, sexual identity or sexual experiences? Yes/No

Is your child pregnant or the parent of a child? Yes/No

16. Legal History

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

Currently have a CDW or DJJ worker? Yes/No

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

17. Religious/Spiritual History:

Religious or spiritual preference? _____

How might these beliefs affect treatment?

18. History of Harm to Self or Others:

Any urges/thoughts of hurting self? 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: _____
