



Today's Date: _____

PERSONAL INFORMATION

*(If couple/family therapy please indicate with an * which client should be billed for insurance purposes)*

Client Name: _____
DOB: _____ Primary Phone: _____
Gender: _____
E-Mail: _____

Client Name: _____
DOB: _____ Primary Phone: _____
Gender: _____
E-Mail: _____

Address: _____
City: _____
State: _____ Zip: _____

Alternate Phone: _____

If we need to reach you, may we leave/send you a message?

Primary Phone: Yes No
Alternate Phone: Yes No
Email: Yes No

Any specific instructions: _____

Employment Status:

Employed Unemployed Disabled
 Retired Student

EMERGENCY CONTACT

Relative or friend to contact in case of an emergency:

Relationship to Client: _____
Phone: _____

REFERRAL INFORMATION

Whom may we thank for referring you:

Self-Referred Primary Care Physician School
 Psychiatrist Friend Relative
 Web/Social Media

INSURANCE/PAYMENT

Primary Insurance

Policy Holder's Name: _____
Relationship to Client: _____
Policy Holder's DOB: _____
Policy Holder's Gender: _____
Policy Holder's Home Address (if different):

Insurance Company: _____
Insurance Company Phone: _____
Policy Holder's ID#: _____
Group #: _____
Employer Name: _____

Secondary Insurance (if applicable)

Policy Holder's Name: _____
Relationship to Client: _____
Policy Holder's DOB: _____
Policy Holder's Home Address (if different):

Insurance Company: _____
Insurance Company Phone: _____
Policy Holder's ID#: _____
Group #: _____
Employer Name: _____

I prefer to pay directly for services and will not be using insurance. I will discuss my payment preferences and rates with my individual clinician.

Responsible Party: _____
SSN: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____
E-Mail: _____

1. **APPOINTMENTS:** Each appointment is approximately 45-60 minutes in duration. Frequency, duration, and goals of therapy will be based on the individual, couple, or family's needs and discussed during your first few appointments. If you would like to receive appointment reminders **please initial next to ONLY ONE OPTION.**

- (please initial)* Via text message to the following cell phone number: _____
 (please initial) Via email to the following email address: _____
 (please initial) Via automated phone message to home or cell phone number: _____

By signing up for appointment reminders, you are waiving your right to keep this information completely private and are requesting that it be handled as you have indicated above.

2. **PAYMENTS AND INSURANCE:** All fees (co-pays, deductibles, document preparation, etc.) are due at the time of service, unless other arrangements are documented in writing. A valid credit or debit card will be stored securely in your electronic account and will be charged following each session for the amount equal to your copay or payment due. You may change your stored payment method at any time or you may choose to pay by cash or check at the time of service. HRCPLLC will bill your insurance for you; however, it is the client's responsibility to verify insurance coverage, as well as additional fees or amounts owed toward deductible. Failure to obtain pre-authorization for services may result in client responsibility for full fee. It is the responsibility of the client for full payment of services if insurance denies payment. Any balances not paid within 3 months may be subject to collection by a third party agency. By signing this document, the client authorizes the disclosure of personal information necessary for debt collection.

<p>Credit/Debit card number: _____ Expiration date: _____ CCV: _____ Name on card: _____ Address on card: _____</p> <p><i>By initialing you authorize this card to be stored and used as a method of payment for co-pays, deductible payments, missed appointments/late cancellations, document preparation, and/or participation in legal/court proceedings.</i></p>

3. **CANCELLATIONS:** If an appointment needs to be rescheduled or canceled, a 24-hour notice is required. If such notice is not provided a fee equal to the session cost will be added to your account balance. Payment of this fee is due prior to any further services rendered. Insurance companies do not reimburse for missed appointments, and you will be directly responsible for the cancellation/missed appointment fee.

<p><i>By initialing you authorize Heather Remmert Counseling, PLLC to charge your credit/debit card the fee as indicated above for any cancellations/missed appointments.</i></p>
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4. **EMERGENCY PROCEDURES:** If you are experiencing a mental health emergency please contact Gryphon Place by calling (269) 381-HELP (4357). You may also contact 911 or go to your local emergency room.

5. **CONFIDENTIALITY:** Confidentiality is of the utmost importance in clinical care. All information regarding your treatment, including documentation such as clinical notes, evaluation reports, and process notes will be held in a locked and secured file within the premises. You may request in writing that this information be shared with any source you deem necessary. Please also be aware that your information may be used for consultation between the HRCPLLC clinical staff.

Please initial (if couple/family therapy, please include all adults)

- Yes No I authorize benefits to be paid directly to my treatment provider.
 Yes No I consent to the use of electronic account usage and communications (email etc.).
 Yes No I have received a copy of the HIPAA Privacy Notice.
 Yes No I authorize the release of any medical information necessary to process my insurance claims.
 Yes No I consent to the exchange of treatment information between HRCPLLC and primary care physician.
 Yes No I authorize cross clinician communication for the purposes of consultation/supervision.

I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

Client/Responsible Party Signature and Printed Name: _____ Date: _____



TELEHEALTH/TELETHERAPY CONSENT

Telehealth/Teletherapy offered at HRCPLLCC is a secure way to receive counseling services through the use of video or phone call from the comfort of your own home. The terms telehealth and teletherapy are considered synonymous and are used interchangeably to describe the use of electronic information and telecommunications technologies to support clinical mental health care and professional mental health-related education.

The telehealth system used (<https://doxy.me/hremmert>) meets HIPAA standards of encryption and privacy protection but privacy cannot be fully guaranteed due to limitations involving telehealth. Risks/limitations involving telehealth include but are not limited to the following: disruptions or delays in counseling sessions due to technology dropping or glitching, discomfort utilizing virtual sessions in lieu of in-person, and breach of confidentiality outside of clinician's control. These risks and limitations can be discussed in further detail with Heather Remmert.

Copays and deductible requirements based on your individual insurance policy will still be in effect. Please direct questions regarding billing/statements to your insurance company or directly to Heather Remmert.

By signing this document, you are giving permission to Heather Remmert to contact the necessary authorities in the event of an emergency. In the following section, please include the names and telephone numbers of your local emergency contacts (including local physician, crisis hotline, family member, friend, or confidant).

EMERGENCY CONTACTS

_____ Physician or Psychiatrist Number	_____ Telephone Number
_____ Crisis Hotline and local Crisis Center Names	_____ Telephone Number
_____ Family Member Name(s) & Relationship	_____ Telephone Number
_____ Friend Name(s)	_____ Telephone Number

I acknowledge that I have read and understand all of the foregoing statements related to Telehealth/Teletherapy and that my signature below indicates that I agree to receive Telehealth/Teletherapy sessions with Heather Remmert.

Client/Responsible Party Signature and Printed Name: _____

Date: _____

MEDICAL INFORMATION

Primary Care Physician (PCP): _____

PCP Location: _____

PCP Phone Number: _____

List any current health concerns: _____

Current Medications (Including Vitamins/Supplements): _____

List any prior surgeries or major injuries: _____

Any family history of:

- Thyroid Problems Diabetes Pituitary Problems

MENTAL HEALTH INFORMATION

What brings you in for services now?

List any prior counseling/psychological services:

- Individual Counseling Psychological Testing
 Couples/Family Counseling Psychiatric
 Hospitalization
 Prescribed Psychiatric Medication

Providers and Approximate Dates Seen:

How would you describe your current concerns?

- Mild Moderate Severe A Crisis

CURRENT CONCERNS (Please Mark All That Apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Excessive crying
<input type="checkbox"/> Unable to have fun
<input type="checkbox"/> Decreased energy
<input type="checkbox"/> Feelings easily hurt
<input type="checkbox"/> Lacking confidence
<input type="checkbox"/> Feeling overwhelmed
<input type="checkbox"/> Difficulty making decisions
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Feeling panicky
<input type="checkbox"/> Feeling grouchy
<input type="checkbox"/> Excessive worrying
<input type="checkbox"/> Skin picking, hair pulling, or nail biting | <input type="checkbox"/> Feeling worthless
<input type="checkbox"/> Poor appetite
<input type="checkbox"/> Overeating or bingeing/purging
<input type="checkbox"/> Feeling sad
<input type="checkbox"/> Feeling tense or on edge
<input type="checkbox"/> Feeling angry
<input type="checkbox"/> Difficulty concentrating
<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Can't sit still or antsy
<input type="checkbox"/> Acts without thinking
<input type="checkbox"/> Problems handling money
<input type="checkbox"/> Nightmares
<input type="checkbox"/> Flashbacks
<input type="checkbox"/> Mood swings | <input type="checkbox"/> Unmotivated, procrastinating
<input type="checkbox"/> Avoiding things
<input type="checkbox"/> Parenting concerns
<input type="checkbox"/> Sexual concerns
<input type="checkbox"/> Threatens or bullies others
<input type="checkbox"/> Fast heartbeat
<input type="checkbox"/> Struggles to make/keep friends
<input type="checkbox"/> Avoiding going places
<input type="checkbox"/> Problems with parents
<input type="checkbox"/> Problems with partner
<input type="checkbox"/> Fighting and quarreling
<input type="checkbox"/> Family conflict
<input type="checkbox"/> Relationship issues | <input type="checkbox"/> Dislike my body
<input type="checkbox"/> Restricting eating
<input type="checkbox"/> Hearing voices
<input type="checkbox"/> Excessive drinking
<input type="checkbox"/> Drug use
<input type="checkbox"/> Legal problems
<input type="checkbox"/> Excessive exercising
<input type="checkbox"/> I don't feel safe at home
<input type="checkbox"/> Thoughts of hurting others
<input type="checkbox"/> Self-injurious behaviors
<input type="checkbox"/> Thoughts of suicide
<input type="checkbox"/> Issues related to sexuality or gender identity
<input type="checkbox"/> _____ |
|---|---|--|---|

FAMILY INFORMATION

*(Please indicate with an * who lives in the home)*

NAME	GENDER	AGE	EDUCATION	OCCUPATION
CLIENT (S)				
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
SPOUSE/PARTNER				
	<input type="checkbox"/> M <input type="checkbox"/> F			
PARENTS				
_____	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Step Parent				
_____	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Step Parent				
_____	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Step Parent				
_____	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Step Parent				
CHILDREN IN THE HOME				
_____	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step Child				
_____	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step Child				
_____	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step Child				
_____	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step Child				

HEATHER REMMERT COUNSELING, PLLC
5400 Holiday Terrace, Suite 200A Kalamazoo, MI 49009
Phone (269) 520-0033 Fax (269) 520-0051
Email: heather@hremmertcounseling.com

THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. * PLEASE REVIEW IT CAREFULLY. Effective April 14, 2003

HIPAA & RECIPIENT RIGHTS: A federal act called the Health Insurance Portability and Accountability Act (HIPAA) gives you some additional rights to what you have through state laws. This notice gives you information on these additional rights through HIPAA.

UNDERSTANDING THE TYPE OF INFORMATION WE HAVE: We obtain information about you when you receive services through Heather Remmert Counseling, PLLC (HRCPLLC). It includes your date of birth, gender of record, and other personal information.

OUR PRIVACY COMMITMENT TO YOU: We care about your privacy. The information we collect about you is private. We are required to give you a notice of our privacy practices. Only people who have both the need and legal right may see your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment/services, payment, business operations or when we are required by law to do so. We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy or security of your information.

*Treatment/Services: We may disclose information about you with your written consent to coordinate your services. For example, we may give information to your other healthcare providers.

*Payment: We may also use and disclose information so the care you get can be properly billed and paid for. For example, we will submit bills to your insurance company or other entities.

*Business Operations: We may need to use and disclose information for our business operations. For example, we may use information to review the quality of the services you receive.

*Exceptions: For certain kinds of records, your permission may be needed even for release for treatment, payment, and business operations.

*As Required By Law: We will release information when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, workers' compensation claims, medical examiner or funeral director if an individual dies, subpoenas or other court orders, communicable disease reporting, review of our activities by government agencies, to avert a serious threat to health or safety, reporting suspected abuse, neglect, or domestic violence, or in other kinds of emergencies.

*With Your Permission: If you give permission in writing, we may use and disclose your personal information. If you give permission, you have the right to change your mind and revoke it. This must be in writing also. We cannot take back any uses or disclosures already made with your permission.

YOUR PRIVACY RIGHTS: You have the following rights regarding the health information that we have about you. Your requests must be made in writing to the Privacy Officer at HRCPLLC.

*Your Right to Inspect and Copy: In most cases, you have the right to look at or get copies of your paper or electronic health records. We will provide a copy or a summary of your health information, usually within 30 days of your request. You may be charged a fee for the cost of copying records.

*Your Right to Amend: You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we will give you a written reason for our denial within 60 days.

*Your Right to a List of Disclosures: You have the right to ask for a list of disclosures of your health information for six years prior to the date you ask, who we shared it with and why. This list will not include the times that information was disclosed for treatment, payment, or business operations. This list will not include information provided directly to you or your family, or information that was sent with your authorization.

HEATHER REMMERT COUNSELING, PLLC
5400 Holiday Terrace, Suite 200A Kalamazoo, MI 49009
Phone (269) 520-0033 Fax (269) 520-0051
Email: heather@hremmertcounseling.com

***Your Right to Request Restrictions on Our Use or Disclosure of Information:** You have the right to ask for limits on how your information is used or disclosed. We are not required to agree to your request if it would affect your care. If you pay for your services out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer unless a law requires us to share that information.

***Your Right to Request Confidential Communications:** You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You do not have to explain the basis for your request.

***Your Right to Choose Someone to Act on Your Behalf:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that person has this authority and can act for you before we take any action.

***Your Right to Share Health Information:** You have both the right and choice for me to share information with your family, close friends, or others involved in your care or share information in a disaster relief situation. I never share psychotherapy notes unless you give me written permission or in response to a complaint filed against the clinician. I never market or share personal information.

CHANGES TO THIS NOTICE: I reserve the right to reserve this notice. A revised notice will be effective for information I already have about you as well as any information I may receive in the future. I am required by law to comply with whatever notice currently in effect. Any changes to my notice will be published on my website. If the changes are material, a new notice will be mailed to you before it takes effect.

HOW TO USE YOUR RIGHTS UNDER THIS NOTICE: If you have questions or would like more information, you may contact our Privacy Officer at (269) 520-0050. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or the Department of Health and Human Services. You will not be penalized for filing a complaint.

COMPLAINTS AND COMMUNICATIONS: Heather Remmert Counseling, PLLC, 5400 Holiday Terrace Suite 200A, Kalamazoo MI 49009. (269) 520-0050, or email at heather@hremmertcounseling.com

COMPLAINTS TO THE FEDERAL GOVERNMENT: You may write: Office of Civil Rights, Dept. of Health and Human Services, 200 Independence Ave., SW, Washington, DC 20201. (877) 696-6775. Website: www.hhs.gov/ocr/privacy/hipaa/complaints/

COPIES OF THIS NOTICE: You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to request a paper copy. This adds to your protections through Recipient Rights