PERSONAL & BILLING INFORMATION

PATIENT INFORMATION

Name: _____ Birth Date: _____ Age: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone - Home: _____ May we leave messages for you there? yes no

Phone - Work: _____ May we leave messages for you there? yes no

Phone - Cell: _____ May we leave messages for you there? yes no

E-mail: _____ May we send messages about appointments to you? yes no

SS Number:_____ Employer/School:_____ Position/Grade: _____

Marital Status: single married widowed domestic partner significant other divorced legally separated

Who referred you to our office? _____

Emergency Contact Name: _____ Relationship:_____

Emergency Contact's Phone – Home: _____Work: _____Cell:_____

Family Doctor/PCP:_____ Phone:_____

Doctor's Full Address, City & State:_____

FINANCIAL RESPONSIBLE PARTY INFORMATION

Same as above or: Name: _____ Relationship to Patient: _____

Resp. Party's Full Address: Same as above, or: _____

Responsible Party's Birth Date: _____Social Security Number: _____

Phone - Home: _____ Work: _____ Cell:_____

Employer: _____ Position: _____

INSURANCE INFORMATION *We will need to copy your insurance card(s).*

I. Insurance Company: _____

Subscriber/Policy Holder: _____ Birth Date: _____ SSN: _____

Ins ID #: _____Group #: _____

Subscriber Employer: _____Co-pay amount? _____ Deductible amount?_____

***Don't be surprised - call to get this info if you do not know it.**

II. Insurance Company: _____

Subscriber/Policy Holder: _____ Birth Date: _____ SSN: _____

Ins ID #: _____Group #: _____

Subscriber Employer:_____ Co-pay amount? _____ Deductible amount? _____

I certify that the insurance coverage or Employee Assistance Program coverage described above is valid for the above named patient and I assign all insurance & EAP benefits directly to Sara Wegrzyn MA, LPCC, if any, for services rendered. I accept financial responsibility for all charges whether or not covered or paid by insurance.

I authorize Sara Wegrzyn MA, LPCC to release information necessary to any party to secure payment for services provided. I authorize the use of this authorization & signature on claims for insurance or EAP payment. I certify that I am legally authorized to make this agreement on behalf of the patient named above and the responsible party named above.

- **I understand co-payments are due at the time of service; charges for collections efforts, if any, shall be paid by the responsible party above; there is a charge for appointments missed or cancelled with less than 24 hours notice.**

_____ _____

Signature of Adult Patient or Guardian Date Signed

CONSENT FOR TREATMENT AND OFFICE POLICY

*Patient Name:*_____

CONSENT FOR PSYCHOLOGICAL SERVICES

Counselors provide services relating to mental health and mental and emotional disorders, including evaluation, assessment, diagnosis and psychotherapy. Counselors might also make referrals or consult with other service providers (with your permission). All services involve finding out about the client's thoughts, feelings, and behaviors in an effort to help the client resolve problems or concerns.

Evaluations help identify the nature of psychological or emotional problems or concerns. Psychotherapy is used to help the patient identify and work through past or present situations that cause concern. Many different techniques can be utilized to help the patient reach goals, including dialogue, interpretation, cognitive reframing and restructuring, journaling, self-exploration, behavioral modification and catharsis.

Risks of psychological services may include experiencing uncomfortable feelings like guilt, anxiety, sadness, anger and frustration. It may mean talking about painful events from your life. Potential benefits of psychological services, and psychotherapy in particular, include improved self-satisfaction, improved mood, increased autonomy, empowerment, decreased stress and distress, improved relationships, improved day-to-day functioning and resolution of specific problems.

As part of treatment, the client may be referred for other related services. For example, medication prescribed by a psychiatrist or primary care physician, a support group or inpatient care may be suggested.

All findings and recommendations made as a result of an evaluation will be based on the evaluation alone. The outcome of an evaluation cannot be determined in advance and is not guaranteed. In no case will the counselor agree to render specific findings or make specific recommendations as a condition of the client's participation or for any other reason. The results of psychological treatment cannot be guaranteed either but the likelihood of a positive outcome is greatly enhanced by the patient's active participation.

All services provided by Sara Wegrzyn MA, LPCC are voluntary. The patient may end treatment at any time. However, planned transitions (such as discontinuing therapy) are generally thought to be in the client's best interest. The client has the right to refuse any suggestion made by the counselor at any time without being penalized in any way.

➢ **Please initial to verify you understand & agree to the above: _____**

OFFICE POLICY

I. Confidentiality: Information revealed by a client to a counselor in the course of a professional relationship is confidential and privileged. The privilege is intended to protect the interests of the client by encouraging free disclosure to the counselor and by preventing disclosure (by the counselor) to others. The client, rather than the counselor, holds and may assert the privilege. Counselors have a primary responsibility to protect the client's right to confidentiality in accordance with law and professional standards of practice.

With few exceptions, confidential information may be disclosed only with informed written consent of the client, or another person legally authorized to give consent on behalf of the patient. Confidential information may be disclosed without written consent: 1) to protect against clear, substantial risk of imminent serious harm being inflicted by the patient on him or herself or another person; 2) to comply with a court order; 3) to comply with regulatory mandates to report actual or suspected abuse/neglect of a child/vulnerable adult; and 4) to get medical care in a medical emergency while at the counselor's office.

When it is necessary to disclose confidential information to respond to a specific situation, the disclosure shall be made only to appropriate authorities, a potential victim, professional/healthcare workers, and/or your family.

To protect client/ clinician privilege to confidentiality, counselor WILL NOT accept social media requests, contact or affiliations. The only acceptable contact is thru phone or email, to ensure protection of emotional, personal, professional and ethical boundaries that are healthiest for the therapeutic relationship.

II. Fees, Billing and Payments: Standard service charges are: evaluation: $180.00; 38–52 min therapy: $150.00; ≥ 53 min therapy: $160.00; family/marital therapy: $160.00. Fees may be charged at the discretion of the counselor for services such as paperwork completion, telephone calls and communication with consented individuals at a rate of $50.00 per hour after the first hour. Extended evaluations, extended therapy and crisis sessions are subject to additional charge. Copies of records are charged in accordance with Ohio law.

The patient/responsible party is responsible for deductibles and copayments, and ALL charges not covered by insurance or EAP, unless prohibited. The co-pay is due at the time of service. Any balance unpaid after 45 days is subject to a $5.00 per month rebilling charge. If financial problems make it difficult for you to keep current with your bill, please discuss them to work out alternative arrangements for billing. If you do not pay your bill, services may be put on hold so you can catch up. Balances are collected thru a HIPAA guarded app called IVY. This app allows for credit card information to be held in their system, so that balances can be charged at the time of appointment. Please discuss with the counselor if you request a different method of payment.

Collections and/or legal action will be used if your account is more than 60 days in arrears unless suitable arrangements for payment are made and honored. If such action is necessary, the costs of collection by the agency/attorney, filing the claim, or bringing the proceeding will be added to the balance due. Collection charges are often based on a percentage of the balance and may equal 50% of the unpaid balance or more**.**

If you use insurance to cover the costs of psychological services that means you give permission for the insurance company, or their designee, to access clinical information about you. Insurance is billed weekly. Please inform us immediately of any change in insurance coverage or eligibility. You must provide all documentation necessary to insure payment by insurance and if you do not, you will be responsible for all fees.

➢ **Please initial to verify you understand & agree to the above: _____**

III. Cancellations and Timeliness: When you schedule an appointment, time is specifically reserved for you. Twenty-four hours notice is required for all appointment cancellations. You (not the insurance company) may be charged the session charge for missed or skipped appointments and for appointments cancelled with less than 24 hours notice.

If you need to reschedule an appointment, you may do so by telephone (419-537-0900) or email (sarawegrzyn.therapist@yahoo.com) but **please do not rely on email for confidential information**.

The answering service accepts calls 24 hours per day, 7 days a week. All messages are date and time stamped to keep track of cancellations. Under rare circumstances, such as extreme weather conditions or an emergency hospitalization, the no show/late cancellation fee may be waived, at the discretion of the counselor.

Please be on time for all appointments. Sessions cannot be extended into other appointment times because of late arrivals.

Please ask and resolve any questions you may have about the consent for treatment and the office policy before you sign. Your signature below signifies that you 1) consent to psychological treatment and 2) understand and agree to the office policies as outlined above. It also serves as 3) an acknowledgement that you have received the "Notice of Counselors' Policies and Practices to Protect the Privacy of Your Health Information

_____ _____

Patient's Signature Today's Date

_____ _____

Guardian/Authorized Representative's Signature Today's Date

PERSONAL HISTORY

Patient Name:_____ Age:_____

Highest educational level **finished**: 1, 2 or 3 4, 5 or 6 7 8 9 10 11 12 HS Grad GED College:_____

PROBLEM List - Check any that are a problem for you **NOW**

	Abuse of a child			Grief, loss or bereavement			Low energy, tired or fatigue			Mania or hypomania
	Abuse of an adult			Panic attacks			Sexual behavior or problem			Suicidal thoughts
	Anger or temper control			Depression			Gender identity concern			Intentional self-injury
	Criminal behavior or legal			Hopeless/helpless feelings			Eating problem			Sexual abuse/assault/rape
	Poor impulse control			Loneliness			Intentional vomiting			Domestic violence
	Negative or irritability			Social isolation			Weight gain or loss			Violence or violent behavior
	Lying, sneaking & cheating			Self esteem problems			Excessive exercise			Alcohol and/or drug abuse
	Anxiety and worry			ADD/ADHD			Sleep			School problem
	Extreme fears			Concentration problem			Family problem			Job or employment problem
	Stress			Memory problem			Marital/partner problem			Suspiciousness/paranoia
	Compulsive behaviors			Mood swings or moodiness			Divorce or separation			Hallucinations
	Obsessive thoughts			Too much energy or hyper			Social/relationship problem			Concerns about health

PERSONAL Medical History -check all that applies to you – now or in the past. **N=NOW P=PAST**

	Epilepsy or seizure			Kidney problem			Joint or bone problem			Vision problem
	Head or brain injury			Thyroid problem			Arthritis or gout			Hormonal problem or PMS
	Neurological problem			Liver problem			Fibromyalgia			Reproductive problem
	Headache & migraine			Diabetes			Auto-immune problem			STD or HIV/AIDS
	Stroke or TIA			Pancreatitis			Chronic pain			Mental illness
	Lung or pulmonary disease			Stomach or bowel problem			Cancer			Self-injury
	Asthma			Urinary problem			Sleep apnea			Suicide attempt
	High or low blood pressure			Blood related problem			Dental problem			Learning disability
	Heart trouble			Skin problem			Hearing problem			Developmental disability

Serious accidents, hospital stays, operations & other health or medical problems or disabilities: _____

_____

_____

Medications (include prescription, over-the-counter, "borrowed" and herbal preparations):

Medication Name	Dose & Frequency	What do you take this medication for?

Medication changes over the **past six months**? None, or _____

Current doctors or clinics OTHER than PCP, and the city of his or her office: None, or _____

_____

_____

Date of last PCP visit:_____ # of physician visits in last 18 months:_____

Drug Allergies: No known drug allergies, or _____

Cigarette/tobacco use (over last year): None, or _____

Caffeine use (present): None, or _____

Alcohol & drug use (over last two years): None, or _____

_____

Military service: None, or _____ Type of Discharge: _____

Legal history (pending and past): None, or_____

_____

_____

_____

History of traumas (as you define "trauma"), abuse or domestic violence: None, or _____

_____

_____

_____

Mental Health, Counseling, Psychological or Psychiatric Treatment History - list ALL prior treatment & support groups: None

Treatment Provider	Start & End Dates	Reason for Treatment	Treatment Outcome

Alcohol or Drug Abuse Treatment History - list ALL prior treatment & support group (AA, NA, etc.) involvement: None

Treatment Provider	Start & End Dates	Reason for Treatment	Treatment Outcome

FAMILY History - check all that apply

	Neurological/brain problems			Cancer			Dementia/Alzheimer			Mood swings
	Heart disease			Diabetes			Learning disability			Depression
	Thyroid disease			Fibromyalgia			Developmental disability			Suicide gestures/attempts
	Liver disease			Chronic pain			Anxiety			Alcoholism/drug abuse
	Pancreatitis			Disability			Anger control problems			Mental illness
	Other:						Other:			

Anything else you would like to add:_____

_____

_____

_____

_____ _____

Patient or Guardian's Signature Date

14 QUESTIONS ABOUT ALCOHOL & DRUG USE

Name:_____

Please CHECK YES or NO for each of the following questions about your drinking or drug use ***OVER THE PAST THREE YEARS.***

	YES	NO
Can you stop drinking alcohol (beer, wine, liquor, etc.) without a struggle after 1 or 2 drinks every time?	yes	no
Have you been unable to remember what happened while you were drinking or had a blackout?	yes	no
Has your drinking or drug use caused a problem between you and any family member or friends?	yes	no
Have you been in trouble at home, school, or work because of your drinking or any other drug use?	yes	no
Have you been told you have pancreatitis, liver trouble or cirrhosis?	yes	no
Have you gotten sick, had shakes or DTs (delirium tremens) when you stopped drinking or after drinking a lot?	yes	no
Have you had medical problems *(such as memory loss, hepatitis, seizures, bleeding)* because of drug use?	yes	no

	YES	NO
Have you had withdrawal symptoms or felt sick when you stopped taking drugs or when a drug was wearing off?	yes	no
Have you used drugs or medications that were prescribed for someone else (except those you can buy in a drug store)?	yes	no
Have you used your medicine in a way that differs from how your doctor told you to take it?	yes	no
Have you gone to anyone for help (including treatment, AA, NA and CA) about your drinking or drug use?	yes	no
Have you done things you would not normally do or done illegal things while you are drinking or using any drug?	yes	no
Have you failed a urinary drug screen or refused to take a urinary drug screen for any reason?	yes	no
Have you had an addiction to gambling, sex, spending or anything else?	yes	no

SARA WEGRZYN MA, LPCC
Licensed Professional Clinical Counselor
4930 N HOLLAND SYLVANIA ROAD, SUITE B
SYLVANIA, OHIO 43560
PHONE: 419-537-0900 • FAX: 419-537-1300
E-MAIL: sarawegrzyn.therapist@yahoo.com

Complete this form to allow Sara Wegrzyn MA, LPCC to exchange basic information about your visit here with your primary care physician and to obtain records from your physician.

CONSENT FOR THE RELEASE OF INFORMATION

Patient Name:_____ Birth date:_____

Social Security Number:_____

I authorize **Sara Wegrzyn MA, LPCC 4930 N Holland Sylvania Road, Suite B, Sylvania, Ohio 43560,** to release, obtain and/or exchange protected health care information obtained in the clinical, medical, hospital, school or related records, including alcohol and drug abuse information, if any, as well as information regarding communicable diseases and serious communicable diseases and infections such as AIDS, HIV, or ARC, if any, of the client named above with:

Name:_____

Address:_____

City:_____ State:_____Zip:_____

Fax number:_____

Specific information is to be released or exchanged: (please circle all that apply)

1) **Relevant history**
2) **Results of psychological evaluation**
3) **Medical history and status, lab results, treatments and interventions**
4) **Treatment plan and progress**

Approximate date(s) of treatment/services: **All, unless specified here**:_____
_____

Specific information to be EXCLUDED: **None, unless specified here**:_____
_____

Purpose and need for information release/exchange: **Coordination of care & to facilitate further care and treatment**

This authorization can be revoked with written notice at any time except to the extent that action has already been taken in reliance on it. Upon revocation of consent, no further release of information shall occur. If not previously revoked, this authorization will expire the later of 12 months from the date signed or 60 days from the date services are terminated with Sara Wegrzyn MA, LPCC. Information provided under the terms of this authorization shall be held as confidential and may not be re-released without written authorization to do so.

Patient's Signature :_____Today's Date_____

Guardian/Legally Authorized Representative's Signature:_____Today's Date_____

Witness's Signature, if needed:_____Today's Date_____

THIS IS YOUR COPY. PLEASE REMOVE IT AND KEEP IT FOR YOUR RECORDS.

CONSENT FOR TREATMENT AND OFFICE POLICY

CONSENT FOR PSYCHOLOGICAL SERVICES

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If you need to reschedule an appointment, you may do so by telephone (419-537-0900) or email (sarawegrzyn.therapist@yahoo.com) but please do not rely on email for confidential information.

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Please be on time for all appointments. Sessions cannot be extended into other appointment times because of late arrivals.

Please ask and resolve any questions you may have about the consent for treatment and the office policy before you sign. Your signature below signifies that you 1) consent to psychological treatment and 2) understand and agree to the office policies as outlined above. It also serves as 3) an acknowledgement that you have received the "Notice of Counselors' Policies and Practices to Protect the Privacy of Your Health Information

THIS IS YOUR COPY. PLEASE REMOVE IT AND KEEP IT FOR YOUR RECORDS

Notice of Counselors' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT. PLEASE REVIEW IT CAREFULLY.
The terms of this Notice of Policies and Practices to Protect the Privacy of Your Health Information apply to Sara Wegrzyn MA, LPCC and authorized designees ("Counselor") seeing and treating patients at 4930 N Holland Sylvania Road, Suite B, Sylvania, OH and all other locations where Counselor's services are provided.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Counselor may use or disclose your protected health information ("PHI"), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

A. "*PHI*" refers to information in your health record that could identify you.
B. *"Treatment"* is when Counselor provides, coordinates or manages your health care and other services related to your health care, such as counseling to you or consultation with another health care provider, such as your family physician or another psychologist.
C. *"Payment"* is when Counselor obtains reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
D. *"Health Care Operations"* are activities that relate to the performance and operation of Counselor's practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
E. *"Use*" applies only to activities within Counselor's practice group such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
F. "*Disclosure*" applies to activities outside of Counselor's practice group such as releasing, transferring or providing access to information about you to other parties.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

Counselor may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Counselor asked for information for purposes outside of treatment, payment and health care operations, she/he will obtain an authorization from you before releasing this information. Counselor also needs to obtain an authorization before releasing your psychotherapy notes.

"Psychotherapy notes" are notes Counselor has made about a conversation with you during a private, group, joint or family counseling session, which have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided the revocation is in writing. You may not revoke an authorization to the extent that (1) information has already been released in reliance on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

Counselor may use or disclose PHI without your consent or authorization in the following circumstances:

A. CHILD ABUSE: If Counselor knows or suspects that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, she/he is required by law to immediately report that knowledge or suspicion to the public children services agency, or a municipal or county peace officer.
B. ELDERLY ADULT AND DOMESTIC ABUSE: If Counselor has reasonable cause to believe that an elderly adult is being abused, neglected, or exploited, or is in a condition that is the result of abuse, neglect or exploitation, she/he is required by law to immediately report such belief to the county Department of Job and Family Services. A Counselor who knows or has reasonable cause to believe that a patient has been the victim of domestic violence must note that knowledge or belief in the patient's records; such information may not be privileged.
C. JUDICIAL OR ADMINISTRATIVE PROCEEDINGS: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law. Counselors may not release this information without written authorization from you or your legally authorized representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
D. SERIOUS THREAT TO HEALTH OR SAFETY: If Counselor believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, she/he may disclose your relevant confidential information to appropriate public authorities, the potential victim, other professionals and/or your family in order to protect against such harm. If you or a knowledgeable person communicates an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and Counselor believes you have the intent and ability to carry out the threat, then she/he is required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
E. WORKER'S COMPENSATION: If you file a worker's compensation claim, you will be required to permit release of information, records and reports; Counselor may be required to give your mental health information to relevant parties and officials.
F. APPOINTMENTS AND SERVICES: We may contact you to remind you of appointments or to discuss other treatment related matters with you. You have the right to request that messages not be left on voice mail or sent to a particular address.

IV. PATIENT'S RIGHTS AND COUNSELOR'S DUTIES

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Counselor will consider your request but is not required to accept it. Any agreements regarding restrictions must be documented in writing.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to ask to receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. Upon your request, your bills will be sent to another address or faxed, if we agree.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (at your expense) of PHI and psychotherapy notes in Counselor's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record.
- *Right to Amend* – If you believe there is an error in your PHI or that information is missing, you have the right to request that the PHI be amended for as long as the PHI is maintained in the record. Counselor will consider but may deny your request.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have provided neither consent nor authorization (as described in Section III of this Notice).
- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice upon request.

Counselor's Duties:

- Counselor is required by law to maintain the privacy of PHI, to provide you with a notice of his or her legal duties and privacy practices with respect to PHI and to notify you at your last known address of any breech in PHI.
- Counselor reserves the right to change the privacy policies and practices described in this notice. Unless Counselor notifies you of such changes, however, she/he is required to abide by the terms of the notice currently in effect.
- If policies and procedures are revised, the counselor will provide you with a copy of the revisions at your next appointment after the effective date of the change.

V. QUESTIONS AND COMPLAINTS

If you have questions about this notice, disagree with a decision made about access to your records or have other concerns about your privacy rights, you may contact Sara Wegrzyn MA, LPCC are the address indicated on this notice. If you believe that your privacy rights have been violated and wish to file a complaint with this office, you may send your written complaint to Sara Wegrzyn MA, LPCC at the address indicated on this notice. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation against you for exercising your right to file a complaint regarding concerns about privacy rights violations with this office or with the Department of Health and Human Services.

VI. EFFECTIVE DATE, RESTRICTIONS AND CHANGES TO PRIVACY POLICY

Effective date of these notices is July 7, 2021. Counselor reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that Counselor maintains, including information collected before the change. Should the terms of this notice change, the new notice will be posted at Counselor's place of business.