Hand In Hand Comprehensive
Therapy Specialists, Inc.

Insurance Information and Release of Information

Insurance Company: _____Phone: _____

PPO Network: _____COPAY: $_____

Group & Policy #: _____Deductible: $_____

Insured Name:_____Soc. Sec. #: _____

Insured D.O.B: _____Employer _____

Secondary Insurance: _____Phone:_____

Additional Benefits: _____

_____

******This release of information is good for the duration of the client's' current insurance or the duration of the client's current therapy at Hand In Hand Comprehensive Therapy Specialists, Inc. – whichever is shorter. ******

I authorize the release of any information to my insurance company when necessary to process my claims. I also authorize payments under my insurance programs to be made directly to me or the Hand In Hand Comprehensive Therapy Specialists, Inc. for any services furnished by Hand In Hand Comprehensive Therapy Specialists, Inc. I agree that if the amount is insufficient to cover the bill, I will be responsible for payment of the difference, and, if my treatment is not covered by my insurance policy, I will be responsible to Hand In Hand Comprehensive Therapy Specialists, Inc. for the entire amount. I understand that a 24 hour notice is required for cancellations of a scheduled session. If I do not meet this requirement, I agree to pay the full session fee. I understand that this will be my responsibility, no that of the third-party payer. I further permit copies of this authorization to be used in place of the originals.

Client Signature/Guardian of Client's Signature Date

Client Signature/Guardian of Client's Signature Date

Witness Signature Date

Please note the following points regarding confidentiality:
(A) This information has been disclosed to you from records whose confidentiality is protected by stated and federal law. Federal regulations (42C.F.R Section 2.31 (a) and 2.33) and state regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Federal and state rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.
(B) Please restrict the availability of these records to those persons in your employment who have the training and experience to interpret and understand the information contained in them. This ethical and perhaps legal responsibility is yours.

Hand In Hand Comprehensive
Therapy Specialists, Inc.

Client Handbook

Your Rights and Responsibilities as a Client(s):

1. You have the right to ask questions about any procedures used during therapy; if you wish your therapist will explain his/her approach and methods to you. If a child is seen under the age of consent, all custodial parents have a right to information shared in the session. Custodial parents should be aware that exercising this right may be detrimental to some therapeutic processes, and so may wish to allow confidentiality between the child and therapist.
2. You have the right to decide not to receive therapeutic assistance from your therapist; if you wish, your therapist will provide you with the names of other qualified professionals whose services you may prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. Please contact your therapist by phone if you make such a decision without consulting with your therapist.
4. You have a right to review your records in the files. I do not keep any "secret notes" so please do not ask me to. Should you be interested in reviewing your file, please inform your therapist and he/she will assist you in the process.
5. One of the most important rights involves confidentiality. Within limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other agency or persons outside of this facility without your written permission. There are certain situations which your therapist is required by law to reveal information obtained during therapy to other persons or agencies without your permission. This facility is not required to inform you of his/her actions in this regard. These situations are as follows: (a) if you threaten grave or bodily harm or death to another person, I am required by law to contact the proper authorities; (b) If a court of law issues a legitimate court order – signed by a judge, I am required by law to provide the information specifically described in that order; (c) If you reveal information related to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authorities; (d) If you are in therapy by order of a court of law, the results of the treatment order must be revealed to the court; and (e) If you are seeking payment through an insurance company, The company will be required to reveal confidential information to them based on the insurance company's specific needs/demands.
6. If you request it, parts of your record in the files can be released to any person or agency you designate. Your therapist can assist you in determining if releasing the information in question may be harmful to you in any fashion.
7. While it would be ideal that every client experience beneficial change, in reality some individuals experience no improvement in their situation. Depending on the treatment, some may even feel that things are worse after treatment.
8. Data from client records may sometimes be used for program evaluation or for other kinds of research. Confidentiality – as described above - still applies.
9. This company encourages and promotes training experiences for therapists in training. There may be times sessions will be observed by therapists in training and their supervisors. These measures are necessary to insure clients receive a high quality of treatment. Confidentiality – as described above – still applies.
10. Should there be any questions or complaints about any aspect of treatment you are encouraged to discuss them with your therapist. If this does not resolve the concern or does not seem appropriate you many contact Phil Furnas who will respond to your concerns. It is requested that contact, with regard to this nature, be in writing.
11. Your therapist will uphold the ethics set forth by his/her specific discipline. Should there be additional regarding ethical behaviors it is requested that you contact Phil Furnas. It is requested that contact, with regard to this nature, be in writing.
12. You have the right to understand your therapist's qualifications; such as state licensure/certifications, educational background, specialized training, professional associations/organizations or limitations. Please feel free to discuss this with your therapist.
13. All clients are expected to conduct themselves in a responsible, reasonable manner. A session should not be held when anyone is under the influence of a non-prescription drug. This includes alcohol. Violence – either physical or verbal – is never acceptable. Either behavior may result in discontinuing a session or, if necessary, calling the proper authorities.
14. Should there be any issues related to Hand In Hand Comprehensive Therapy Specialists, Inc., that is not able to be addressed within the facility, clients have the ability to contact the Indiana State Licensing Board and/or the professional organizations. Hand In Hand Comprehensive Therapy Specialists, Inc. request that any issues a client may have please be brought to the attention of Hand In Hand Comprehensive Therapy Specialists, Inc. first in order for the facility to attempt to resolve.

The Therapeutic Process:

Therapy will seek to meet goals established by all persons involved. Goals are typically related to the presenting problems. Therapeutic methods will be determined by the domain of treatment being utilized. The length of therapy will be determined in the evaluation phase and re-evaluated throughout treatment. As the client progresses, goals may change. Goals will be re-addressed throughout the treatment process. Once all goals have been met, termination of treatment will be discussed with the client and with no additional concerns termination of treatment will occur. Should, at any time, this facility not be able to provide required treatment – or based on the client's request – a referral will be made to another facility to assist the client in obtaining goals.

Fees of Treatment:

1. I agree to enter into therapy with Hand In Hand Comprehensive Therapy Specialists, Inc.
   (a) I understand that payment is due at the render of each service
   (b) I understand that no balance will be carried
   (c) I understand that co-payment is due at the render of each service. I understand that I am responsible for cooperating with my insurance company to support prompt payment.
   (d) I understand that if my insurance company does not pay for treatment that I will be responsible for payment in full
2. I understand that I can leave therapy at any time and that I have no moral, legal, or financial obligations to complete the maximum number of session discussed during the evaluation process.
3. A 24 hour notice is required for cancellations of a scheduled session. Without this notification, my session will be considered a "NO SHOW". If I accrue a NO SHOW, I agree to pay the full $100 no show fee. I understand that this will be my responsibility, not that of the third-party payer.
4. Due to therapists having full schedules, if I am late to my scheduled appointment I understand that I will not have the option to add that time at the end of the scheduled session and I will be charged the full session fee. I understand that if I am more than 20 minutes late Hand In Hand Comprehensive Therapy Specialists, Inc. holds the right to consider this session as a "NO SHOW".

5. I understand if I have 2 consecutive cancellations or "no shows", I may lose my standing appointment time slot.
6. I understand that Hand In Hand Comprehensive Therapy Specialists, Inc. has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, Hand In Hand Comprehensive Therapy Specialists, Inc. will disclose the information required to assist in recouping the unpaid fees. This would include, but not limit to, demographic information and amount owed. This will assist in ensuring confidentiality.
7 Should there be a need for court testimony any time spent in preparation for, participation in, travel to, and time waiting while on court date will be charged to the client at the current court fee hourly rate. In the amount of $250 maybe required prior to service's being rendered. I understand that this will be my responsibility, not that of the third-party payer.
8. I recognize that fees are subjected to change. Should this occur, I understand that I will be notified of this change to allow time to determine if I wish for services to continue.

SMS TEXT MESSAGE & EMAIL CONSENT:
1. Hand in Hand Comprehensive Therapy Specialists sends reminders regarding scheduled appointments via text messages and/or email reminders for your appointments. Signing this form gives up permission to do so. Space below is for office convenience only. Hand In Hand Comprehensive Therapy Specialists, Inc. may gather texting/email information from other forms you have submitted.
2. The SMS and/or email service should not be solely relied upon, as the responsibility of attending and cancelling appointments still rests with you.
3. Messages are generated through a secure system, however they are transmitted over a public network to a personal phone. Messages will be generic in nature.
4. You will be responsible *Ito ensure that* Hand In Hand Comprehensive Therapy Specialists, Inc. has up to date mobile number and email information at all times, including if the number or email is no longer active. Hand in Hand Comprehensive Therapy will not be responsible for information going to illegible or changed information when not provided by the client.
5. IF AT ANYTIME YOU DECIDED TO OPT OUT OF THESE SERVICES WE WILL NEED A RREQUEST FROM YOU IN WRITING.

By signing below, I am acknowledging that I have carefully read the Client Handbook. I have had the ability to ask any questions to assist with my comprehension of this document and understand its contents entirely. I agree to comply with all expectations set forth by this document. I have received a copy of the Client Handbook for my own use. *Signing below provides consent to Hand In Hand Comprehensive Therapy Specialists, Inc. to administer appropriate assessments to determine appropriate treatment/services. If client is a minor, I attest, by signing below, that I have the legal authority to sign the necessary paperwork allowing services to occur.*

Client Name (Printed): _____

Email Address: _____

Cell Phone number: _____

Client Signature/Guardian of Client's Signature Printed Name Date

Witness Signature Printed Name Date

I have been offered the HIPPA guidelines. Below, by initialing, I have either accepted a HIPPA pamphlet or declined it. By initialing either, I agree that all questions related to how this facility operates have been answered for me. Please initial only one.

_____ Accepted HIPPA pamphlet _____ Declined HIPPA pamphlet

It is requested that emergency contacts be provided in case of any unforeseen crisis so this facility can best assist the client in his/her safety. By providing the information below, I agree to allow Hand In Hand Comprehensive Therapy Specialists, Inc. to contact the person I have listed below in the event of an emergency. An emergency situation may be defined by Hand In Hand Comprehensive Therapy Specialists, Inc. I understand that Hand In Hand Comprehensive Therapy Specialists, Inc. will divulge limited information to ensure safety/well being.

Emergency Contact Name Relation to Client Contact Number

Client Signature/Guardian of Client's Signature Date

Hand In Hand Comprehensive
Therapy Specialists, Inc.

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: (Client Name): _____ D.O.B _____

Guardian Name (If Client is a Minor):_____

Client Address: _____
Street City Zip

I authorize Hand In Hand Comprehensive Therapy Specialists, Inc. to release/request information as marked below to/from:

_____
Agency/Individual's Name

_____
Address

Information to be disclosed is: (please initial all that apply)

_____ Evaluation Report
_____ Treatment Plan
_____ Progress Report
_____ Discharge Plan
_____ Discharge Summary
_____ Other (specify) _____

For the process of: (please initial all that apply)

_____ Facilitating Treatment
_____ Following Treatment Progress
_____ Other (Specify) _____

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purposes this consent will automatically expire without my express revocation. If the purpose be for following treatment progress this release of information will be valid for one year prior to expiring. A PHOTO COPY OF THE CONSENT & RELEASE SHALL BE AS VALID AS THE ORIGINAL.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Notice: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Section 2.31 (a) and 2.33) and the Health Insurance Portability and Accountability Act (the HIPAA Privacy Rules). The Federal Rules prohibit this agency from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2 and HIPAA. A general authorization for the release of medical or general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Social Media Consent/Release Form

For News Media, Promotional Materials, Written Articles, Research and/or Photographs

I hereby authorize Hand In Hand Comprehensive Therapy Specialists, Inc. to use my child's photo and/or information related to my experiences with Hand In Hand Comprehensive Therapy Specialists, Inc. I understand this information may be used in publications, including electronic publications, audio-visual presentations, promotional literature, advertising, community presentations, letters to area legislators and media and/or other similar ways. I understand that this release allows Hand In Hand Comprehensive Therapy Specialists, Inc. to release at anytime and without notice.

My consent is freely given as a public service to Hand In Hand Comprehensive Therapy Specialists, Inc., without expecting payment. I release Hand In Hand Comprehensive Therapy Specialists, Inc. and their respective employees, officers and agents from any and all liability, which may arise from the use of such news media stories, promotional materials, written articles, videotape and/or photographs.

I hereby release Hand In Hand Comprehensive Therapy Specialists, Inc., your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said "Materials", including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights

I understand that I can revoke this release any time in writing and that the use of any of my photos or other information authorized by this release will immediately cease.

Please print or type:

Child's Name: _____
Address: _____
City, State, Zip: _____
Phone: _____

Email: _____

Guardian Signature: _____

Date: _____

Hand In Hand Comprehensive Therapy Specialists

Client Social History

Date:_____

Client Name:_____

Address: _____
Street City State Zip Code

Date of Birth: _____ Social Security Number: _____

Phone Numbers: _____
Home Cell Work

If client is under 18 years of age, complete this section for parents. If over 18 complete for significant other

Father: _____ Date Of Birth: _____

Address (if different than above): _____

Employer: _____Occupation:_____

Mother: _____ Date Of Birth: _____

Address (if different than above): _____

Employer: _____Occupation:_____

Insurance information

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date Of Birth: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date Of Birth: _____

☐If there is additional coverage please check box and list on back of page.

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Sex: ☐Female ☐Male **Age**: _____ years

Marital/Relationship Status:

☐Single (never married)
☐Significant Other
☐Cohabitating (living together)
☐First Marriage
☐Separated
☐Divorced
☐Widowed
☐Remarried (after divorce)
☐Remarried (after spouse's death)

Current Employment

☐Full-time
☐Part-time
☐Homemaker
☐Unemployed
☐Full-time student
☐Part-time student
☐Retired

If Working:
Employer:_____
Occupation: _____

Approximate current annual household income:

☐$1,000-9,999
☐$10,000-19,999
☐$20,000-49,000
☐$50,000-74,999
☐$75,000-99,999
☐$100,000-149,999
☐$150,000 and above

Education:

☐Grade school or junior high
☐Attending/attended high school
☐High school graduate
☐Attending/attended college
☐College graduate
☐Attending/attended grad. school
☐Technical school degree
☐Graduate degree (Masters)
☐Graduate degree (Doctoral)

Race:

☐Black (African American)
☐White (European American)
☐Mexican American (Latino)
☐Asian American
☐Native American
☐Multiracial
☐Black (Other)
☐Other Latin or Spanish Heritage
☐Other:_____

How did you hear about this office?

☐Friend ☐Physician ☐Internet ☐TV
☐Spouse ☐Publication ☐Phonebook ☐Other
☐Teacher (school) ☐Client of office ☐Radio _____

Are you presently under a physician's care? ☐Yes ☐No

If yes, explain: _____

List current any medications & dosages: _____

_____

Physician Name **Physician Address** **Physician Phone Number**

_____
_____
_____

Please list all people living in the client's household.

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Name	Age	Relationship
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____

List additional on back

Please indicate why you have come to therapy (check all that apply)

Decision Making:

☐Whether to marry
☐Whether to divorce or separate
☐Whether to have children
☐ Life goals that affect my family
☐Career
☐Other _____

Adjustments To New/Different Life Style or Way Of Living:

☐Being divorced or separated
☐Being remarried
☐Living in a remarried family with children (step-family)
☐Other _____
☐Moving to a new location
☐Parenting a new born
☐Being a single parent
☐Other _____
☐Addition to the household
☐Employment difficulties/stress
☐Midlife crises/difficulties related to growing older
☐Other _____

Personal Struggles:

☐Grief/mourning following loss
☐Suicide attempt
☐Lack of trust
☐High anxiety
☐Poor relationships with opposite sex adults (other than marital partner)
☐Sexual difficulties
☐Physical problem(s)/illness
☐ Nightmares
☐Financial problems
☐ Work related problems
☐Depression/feeling blue
☐Anger or difficulty controlling temper
☐Feeling rejected
☐Guilt/Shame
☐ Sexual identity/sexual orientation concerns
☐Alcohol or drugs
☐Difficulty thinking clearly
☐ Legal problems
☐ Unreasonable fears
☐Other _____
☐Suicidal thoughts
☐Loneliness
☐Low self-esteem
☐Financial difficulties/stress
☐ Domestic tasks/who does what around the house
☐Intellectual differences
☐ Rape
☐ Flashbacks
☐ Impulse control
☐Other _____

Family/Marital Problems:

☐One or both of us is not spending enough time with the family
☐Custody or visitation problems
☐Poor communication among one or more family members
☐Disagreement with partner about
☐One or more family member(s) does/do not get along
☐Not sure what to expect of

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	childrearing and/or discipline	children
☐Don't feel I'm a good parent	☐Physical abuse of child(ren)	☐Fear of abusing child(ren)
☐Emotional abuse of child(ren)	☐Sexual abuse of child(ren)	☐Difficulty allowing child(ren) to grow up
	☐Arguing or handling conflict	☐Differences in personality
☐Infidelity or running around	☐Amount of time spent together	☐Use of leisure time or shared activities
☐The role of men and women	☐Religion	☐Emotional abuse of/by partner
☐Physical abuse of/by partner	☐Careers of both partners conflict	☐Problems with relatives
☐Different expectations of marriage or intimate relationship	☐One or both of us no longer feel in love with the other	☐One or both of us do not feel emotional support from the other
☐One or both of us can't accept faults in spouse	☐One or both of us are jealous of partner's relationships with others	☐Problems with friends
☐ One partner is domineering/ controlling	☐Contact from ex-spouse or former partners upsetting our relationship	☐Relationship takes second place to children
☐Poor communication	☐Arguing or handling conflict	☐Differences in personality
☐Infidelity or running around	☐Amount of time spent together	☐Use of leisure time or shared activities
☐Other _____	☐Other _____	☐Other _____

Issues Concerning Children:

☐Arguing	☐Being bullied or bullying	☐Competitiveness
☐Complaining	☐Crying	☐Talking back
☐Fearfulness	☐Masturbation	☐Eating issues
☐Peer pressure	☐Overweight/underweight	☐Fighting
☐Hitting others	☐Irritableness	☐Lying
☐Negativism	☐Noisiness	☐Not doing chores or assignments
☐Sadness/unhappiness	☐Suicidal thoughts	☐Suicide attempts
☐Teasing	☐Temper tantrums	☐Bossiness
☐Threatening	☐Whining	☐Yelling
☐Inappropriate attention getting	☐Destructiveness	☐Fire setting
☐Not following rules or curfews	☐Running away	☐Stealing
☐Truancy from school	☐Academic problems	☐Poor peer relations
☐Undesirable friends	☐Bed wetting	☐Pants wetting
☐Soiling pants	☐Not eating properly	☐Excessive worrying
☐Obesity	☐Physical or mental disability	☐Hyperactiveness (too active)
☐ Difficulty in response to parents' divorce	☐Sexual behavior	☐Sexual identity/sexual orientation concerns
☐Trouble with the law	☐Misusing driving privileges	☐Problems with dating
☐ Difficulty with parents' sexual orientation	☐Drugs or alcohol	☐Difficulty with parent's new marriage
☐ Pregnancy	☐Other _____	☐Other _____

Parenting Concerns:

☐Parenting skill enhancement	☐Limit setting	☐Authority issues
☐Parent/adolescent	☐Sibling conflict	☐Runaway
☐School problems (behavior / academic / peer)	☐Inappropriate sexual behavior in child	☐Drug/alcohol abuse
☐Anger control/aggression in child	☐Inability of child to focus attention	☐Other: _____

Family Concerns:

☐Marital/partner conflict	☐Decision making	☐Problem solving
☐Verbal abuse	☐Physical abuse	☐Divorce issues
☐Pregnancy	☐Sexual problems	☐Grief
☐Major loss	☐Time management problems	☐Other

_____

Of the problems indicated above, which would you most want help with and briefly explain why:

_____
_____
_____
_____

What recently happened to make you decide to seek help now?:

_____
_____
_____
_____

PERSONAL HISTORY

Family History:

You were raised by:_____

Number of brothers/sisters: _____ # living: _____ # older than you: _____

Family members you are close to now: _____

Has any family member/loved one ever had a drinking or drug problem? ☐ Yes ☐ No

Who? _____ Please describe:_____

Has anyone in your FAMILY ever been hospitalized for depression or any other mental or emotional problems? ☐ Yes ☐ No

Explain:_____ _____

Has anyone in your family attempted or committed suicide? ☐ Yes ☐ No

Explain: _____

Rate your level of support:

□ Excellent □ Good □ Adequate □ Minimal □ None

Health History:

(Please check all that apply)

☐Appetite problems	☐Chronic physical/mental issues	☐Low energy
☐Chest pain	☐Rapid heart rate	☐Trembling/shaking
☐Dizziness	☐Shortness of breath	☐Nausea
☐Headaches	☐Eating disorders	☐Weight problems
☐Other	☐Other	☐Other
_____	_____	_____

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(For Women)
Number of pregnancies? _____ Number of Live births: _____ Number of Adoptions: _____

Number of Miscarriages? _____ Number of Abortions? _____

Are you currently pregnant?_____

Have you experienced:

Premenstrual syndrome? _____ Menopause? _____ Hormone therapy? _____

Previous Mental Health history:
Were you ever HOSPITALIZED for depression, hearing voices or other mental/emotional problems? ☐Yes ☐No

(if yes, please complete following questions)

How many times? _____ Any involuntary? _____ Year of first admission:_____ Where: _____

Reason: _____

Year of last admission: _____ Where: _____

Reason: _____

Was treatment helpful? ☐Yes ☐No

Explain: _____

Have you received any OUTPATIENT Mental Health counseling? ☐Yes ☐No

(if yes, please complete following questions)

Where/when: _____

Reason: _____

Current mental health diagnosis: _____

Current psychiatric medication(s): _____

Was treatment helpful? ☐Yes ☐No

Explain: _____

Military Service:

Any military service involvement? ☐Yes ☐No

Type: _____When involved:_____

Honorable discharge? _____ If not, why? _____

Describe any combat experience:_____

Are you troubled now by your experience in the military? _____

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Client Signature	Date
Therapist Signature	Date

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