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

Child Therapy Client History

Client Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

School: _____ Grade: _____ Teacher: _____

Parent/ Guardians Information

Name: _____Age: _____ Relationship:_____

Phone: _____ □ Ok to leave message Email:_____

**Email will be used for appointment reminders or scheduling purposes only, not for therapeutic work.*

Name: _____Age: _____ Relationship:_____

Phone: _____ □ Ok to leave message Email:_____

**Email will be used for appointment reminders or scheduling purposes only, not for therapeutic work.*

Parents: □ Single □ Married □ Domestic Partnership □ Separated □ Divorced □ Widowed □ Other:_____

Are you currently or have plans to enter into the divorce process? □ Yes □ No

Legal Custody: □ Joint □ Sole □ None Physical Custody: _____

Other People in Child's Home(s)

Name: _____ m/f Age: _____ Relationship: _____

Name: _____ m/f Age: _____ Relationship: _____

Name: _____ m/f Age: _____ Relationship: _____

Name: _____ m/f Age: _____ Relationship: _____

Name: _____ m/f Age: _____ Relationship: _____

Name: _____ m/f Age: _____ Relationship: _____

Name: _____ m/f Age: _____ Relationship: _____

Your answers to the following questions may provide additional information that will benefit the counseling sessions. Please answer the questions below as honestly and completely as you feel comfortable. All answers will be kept confidential. Thank you for answering these questions, they will assist me in our work together.

About current needs…

Please mark any of the areas that are currently or has been a concern about your child:

□ Activity Level	□ Aggression/ Fights	□ Alcohol/ Drug
□ Anxiety/ Worry	□ Bedwetting	□ Behavior
□ Change in Appetite / Eating	□ Destructiveness	□ Distractibility
□ Fears	□ Fire Setting	□ Foster Care/ DHS
□ Height	□ Hurting Animals	□ Hygiene
□ Hyperactivity	□ Irritability/ Anger	□ Lying
□ Mood	□ Motor Skills	□ Nervous Habits
□ Nightmares	□ Play Behavior	□ Potty Training
□ Relationships with others	□ Response to Discipline	□ Sadness/ Depression
□ School Problems	□ Self-Harm	□ Separation Anxiety
□ Sexual Activity	□ Sleep Problems	□ Stealing
□ Suicidal Thoughts	□ Suspicious/ Paranoia	□ Temper Tantrums
□ Truancy	□ Weight	□ Other: _____

Please provide further details regarding the items selected above:

Briefly describe the concern that brings the child to counseling:

When did you first notice the concerns?

Child's Information

- Describe your child's strengths.

- How does the child get along with siblings?

- Describe child's relationship with caregivers.

- Describe any special activities the family does together.

- Please describe your child's temperament.

- What are child's interactions with others like?

- Does your child have friends?

- What are those relationships like?

- Please describe your child's academic strengths?

Is your child on an IEP or IFSP? □ No □ Yes for _____

Has your child worked with the School Psychologist? □ No □ Yes (dates) _____

How many times has the child moved/ switched schools throughout childhood?

How has the child reacted?

Would you say your child enjoys school? □ Yes □No (specify) _____

Is your child currently receiving special services in school?

□No □ Yes (specify) _____

Has your child ever failed a class or been held back for academic reasons? □No □ Yes: Grade_____

Is your child expected to pass this school year? □ Yes □ No

Family/ Relationship History

(Please check any current struggles.)

□ Death of Family Member/ Pet

□ Differences in Child Rearing

□ Drinking/ Drug Abuse

□ Marital Problems

□ Mental Health of Family Member(s)

□ Physical Health of Family Member(s)

□ Prolonged Absence

□ Separation or Divorce

□ Other _____

□ Other _____

Please elaborate on any concerns selected above.

Medical History

- Please describe your child's general health.

- Are there any medications your child is currently taking/ prescribed?

- Please describe any serious illnesses, accidents, or injuries.

- Please describe any conditions that require regular medical care.

- Has your child been previously or currently in therapy or under the care of a psychologist/psychiatrist?

  □Yes □No Agency / Professional: _____

  Dates: _____ Type: _____

CHILD/ ADOLESCENT DEVELOPMENTAL HISTORY

- What was your child's birth weight? _____lbs. _____oz. □ Unknown

- Was delivery normal?

  □ Yes □ Unknown □ No (specify) _____

❖ Did the birth mother experience any physical or emotional problems during pregnancy?
□ No □ Unknown □ Yes (specify) _____

❖ Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?
□ No □ Unknown □ Yes (specify) _____

❖ Did the baby experience any problems immediately after birth?
□ No □ Unknown □ Yes (specify) _____

❖ Did caregivers feel bonded to child throughout infancy?
□ Yes □ No (specify) _____

❖ Has your child ever required hospitalization?
□ No □ Unknown □ Yes (specify) _____

❖ Is there any history of physical, sexual or emotional abuse?
□ No □ Unknown □ Yes (specify) _____

❖ Is there a history of prolonged separations or traumatic events?
□ No □ Yes (specify) _____

❖ Any disruptions in child's caregiving relationships?
□ No □ Yes (specify) _____

❖ How would you describe your child's approach to new situations?
□ Positive, jumps right in □ Withdrawn, tends to not participate □ slow to warm up, cautious

❖ How would you generally describe your child's overall mood?
□ Positive (happy, laughing, upbeat, hopeful) □ Negative (depressed, cranky, angry, hostile)
□ Mixed but more positive than negative □ Mixed but more negative than positive

❖ At what age did your child do the following: (Italicized areas reflect normal development)

_____ smiled (6months)

_____ sat alone (6 to 10 months)

_____ talked in sentences (30 to 36 months)

_____ walked by self (12 months)

_____ held head up (3 to 4 months)

_____ fed self (2 years)

_____ crawled (6 to 10 months)

_____ rode a bike (6 years)

_____ rolled over (6 months)

_____ talked in single words (18 to 24 months)

_____ pulled self-up (6 to 10 months)

_____ established toilet training (2 ½ to 4 years)

Academic Information

Would you say your child enjoys school? □ Yes □No (specify) _____

Is your child currently receiving special services in school? □No □ Yes (specify) _____

Has your child ever failed a class or been held back for academic reasons? □No □ Yes (specify grade) _____

Is your child expected to pass this school year? □ Yes □ No

- Is there anything else you feel is important for me to know about your child?

Signature of Client: _____ Date: _____

Signature of Parent/Legal Guardian:_____ Date: _____

Signature of Therapist: _____ Date: _____