FINDING BALANCE **Counseling Services Application**

Personal Information			
First Name **Middle Initial**		**Last Name**	**Today's Date**
Address	**City**	**State**	**Zip**
Home Phone:	**Cell Phone:**	**Email Address:**	
SSN: (for insurance purposes)			
Birth Date:	**Sex:** ☐ **Male** ☐ **Female**	**Bishop's Name and Ward:**	
List present or previous health problems: **Previous mental health counseling? Yes No**		**List any medications you are currently taking:**	

Marital Status: S M W SEP D ☐ **Spouse or** ☐ **Parent Information if under 18**			
First Name **Middle Initial**	**Last Name**	**Marriage Date:**	
Street Address (if different from client)	**City**	**State**	**Zip**
Birth Date:	**Preferred Phone:**	**Email Address:**	
List present or previous health problems:	**List any current medications:**		

Children's Information: (list all children)

Name	Birth Date	Lives with you?	Name	Birth Date	Lives with you?

Insurance Information (if filing) **Payment Arrangements:** ☐ **Client** ☐ **Ward** ☐ **Insurance**			
Insurance Company	**Policyholder**	**Policyholder's birth date**	**Applicant's relationship to policyholder** ☐ **Self,** ☐ **Spouse,** ☐ **Child,** ☐ **Other**

Other Information (CHECK ALL THAT APPLY)

History of grief/loss	___	**Substance abuse in family**	___	**Legal involvement**	___
Problems at work/school	___	**Sexual abuse**	___	**Mood symptoms**	___
Isolation issues or fears/phobias	___	**Traumatic events**	___	**Anxiety symptoms**	___
Compulsive behavior	___	**Focus or attention problems**	___	**Financial stress**	___
Behavioral problems/aggression	___	**Current/past substance abuse**	___	**Social skill deficits**	___
Marital conflict	___	**Mood swings irritability**	___	**Impulsive Behavior**	___

List 3 things you hope to change or accomplish through Counseling? (Use the back if more room is needed.)

1.

2.

3.

Signature	**Signature (spouse)**

Authorization for Release of Confidential Information

Client Name	Client Name

I understand that:
By signing this *General Authorization* I am authorizing *FINDING BALANCE* to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to *FINDING BALANCE*. My health information includes, without limitation, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that:
I may revoke this authorization at any time by sending a written notice of revocation to *FINDING BALANCE*. I understand that my revocation of this *General Authorization* will not affect a disclosure that *FINDING BALANCE* has already made under this authorization.

This authorization is only valid until _____ [fill in date], or until three months after my file is closed.

Name	Address	Client's Initials
Name	Address	Client's Initials
Name	Address	Client's Initials
Insurance (if filing)	Address	Client's Initials
Bishop	Ward	Client's Initials

Signatures			
Client's signature	Date	Client's signature	Date
Signature of parent or guardian (if client is under 18)	Date	Signature of parent or guardian (if client is under 18)	Date
Witness	Date	Witness	Date

DESCRIPTION OF SERVICES

GOALS AND OUTCOMES:
Generally, counseling is most useful in helping individuals help themselves or improve their relationships by changing feelings, thoughts, and/or behaviors. You determine the nature and amount of change you wish to make.

BENEFITS AND RISKS:
Most people experience improvement or resolution to the concerns that brought them to counseling, but of course, there are no guarantees; and there are some risks. For example, counseling could open new levels of awareness that may cause discomfort.

CONFIDENTIALITY:
I understand that the information you share in counseling can be very personal and that you may not want me to disclose this information to others without your authorization you do this by signing this *Description of Services* and the *Notice of Privacy Practices* included in this packet. This document describes your rights and my obligations regarding the use and disclosure of any information, unless such release is otherwise authorized or required by law. For example, the law may require us to disclose confidential information if there is reason to believe that a child has been abused or neglected, or that you may be in danger of harming yourself or others.

PAYMENT FOR SERVICES:
The fee for a 50-minute counseling session is $90, the fee for the initial session is $125. Self-pay clients and clients who are getting re-reimbursed through their Insurance company are responsible for payment of services at the time of the session. Payments are made to Rebecca Tesimale and be made online, cash or check. After 3 missed payments client must pay the balance in full before services can continue. If a bishop has authorized payment for services through the ward I will send the bill to him for payment. Please call your insurance company in advance for information about your mental health coverage including if visits require pre- authorization.

CANCELLATION OF APPOINTMENT:
If you need to change or cancel an appointment, as a courtesy, please notify me at least *24 hours* in advance.

Please arrange for children to remain at home.

I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the counseling process at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.

It is my understanding that the payment arrangements are as follow (place amount by payer/s):

*CLIENT: $*_____ *INSURANCE: $*_____ *WARD PAY: $*_____

_____ _____
Signature Date

_____ _____
Signature Date

Please retain a copy of this document for yourself

NOTICE OF PRIVACY PRACTISES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us, in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we many use and disclose your health information.

For Treatment
I may use or disclose health information about you to facilitate counseling and other health treatment. For example, I might disclose information about you to another Licensed Practioner so that I can determine the most appropriate care for you.

For Payment
I may use and disclose health information about you so that I can be paid by you, an insurance company, or another party, including current or future bishops if they are paying any portion of the fee for the services I provide to you. For example, I may need to give your insurance company information about my services to you so the company will pay me for these services. You have the right to request that your health information from treatment not be shared with your health plan when you pay out-of-pocket.

Special Situations
I may use or disclose your health information without your permission for several reasons. These reasons include:

- Disclosing your health information when I believe that disclosure is necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- Disclosing your health information as required by federal, state, or local law.
- Disclosing your health information as required by law to prevent injury or suspected abuse or neglect.
- Disclosing your health information in response to a court order, subpoena, warrant, summons, or similar process.

Other Uses and Disclosures of Health Information
Except where otherwise required or authorized by law, I will not use or disclose your health information for any purpose without your written authorization. If you authorize me to use or disclose health information about you, you may revoke your authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose your health information for the reasons covered by your written authorization, but I cannot take back any uses or disclosures I have already made with your permission. I have a duty to inform you if your health information is used or disclosed in a way contrary to law.

Your Rights Regarding Your Health Information
You have the following rights with regard to your health information:

- You may inspect and copy your health information, with certain exceptions.
- If you believe that the health information I have about you is incorrect or incomplete, you may ask me to amend the information.
- You may obtain an accounting of my disclosures of your health information. This is a list of all of my disclosures of your health information for purposes other than treatment, payment, and health care operations.
- You have the right to request that I restrict or limit our use or disclosure of your health information to only treatment, payment, or health care operations. I am not required to comply with your request.
- You may request that I communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail.
- You have the right to receive a paper copy of this notice.

If you want to exercise any of these rights, please communicate to me in writing.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with me directly or with the Secretary of the U.S. Department of Health and Human Services. (You will not be penalized for filing a complaint.)

_____ _____
Client's Signature Date

_____ _____
Client's Signature Date

Please retain a copy of this document for yours