**JENNELLE HINES COUNSELING, PLLC**
5400 Holiday Terrace, Suite 200A Kalamazoo, MI 49009
Phone (269) 520-0035 Fax (269) 520-0051
jennelle@jhinescounseling.com

Today's Date:_____

## PERSONAL INFORMATION

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

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

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

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

**Alternate Phone:** _____

**If we need to reach you, may we leave/send you a message?**
Primary Phone: □ Yes □ No
Alternate Phone: □ Yes □ No
Email: □ Yes □ No
**Any specific instructions:** _____
_____

**Employment Status:**
□ Employed □ Unemployed □ Disabled
□ Retired □ Student

## EMERGENCY CONTACT

Relative or friend to contact in case of an emergency:
_____

Relationship to Client: _____
Phone: _____

## REFERRAL INFORMATION

Whom may we thank for referring you:

□ Self-Referred □ Primary Care Physician □ School
□ Psychiatrist □ Friend □ Relative
□ Web/Social Media
□ Other: _____

## INSURANCE/PAYMENT

**Primary Insurance**
**Policy Holder's Name:** _____
**Relationship to Client:** _____
**Policy Holder's DOB:** _____
**Policy Holder's Gender:** _____
**Policy Holder's Home Address (if different):**
_____
**Insurance Company:** _____
**Insurance Company Phone:** _____
**Policy Holder's ID#:** _____
**Group #:** _____
**Employer Name:** _____

**Secondary Insurance (if applicable)**
**Policy Holder's Name:** _____
**Relationship to Client:** _____
**Policy Holder's DOB:** _____
**Policy Holder's Home Address (if different):**
_____
**Insurance Company:** _____
**Insurance Company Phone:** _____
**Policy Holder's ID#:** _____
**Group #:** _____
**Employer Name:** _____

□ **EAP Services**:_____

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

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

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

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

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

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

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

3. **CANCELLATIONS**: If an appointment needs to be rescheduled or canceled, a 24-hour notice is required. If such notice is not provided a fee of $75/missed and $50/late cancellation will be applied to your account. Payment of this fee is due prior to any further services rendered. Insurance companies do not reimburse for missed appointments, and you will be directly responsible for the cancellation/missed appointment fee.

_____***By initialing you authorize Jennelle Hines Counseling, PLLC to charge your credit/debit card the fee as indicated above for any cancellations/missed appointments.***

4. **EMERGENCY PROCEDURES**: If you are experiencing a mental health emergency please contact Gryphon Place by calling (269) 381-HELP (4357). You may also contact 911 or go to your local emergency room.

5. **CONFIDENTIALITY**: Confidentiality is of the utmost importance in clinical care. All information regarding your treatment, including documentation such as clinical notes, evaluation reports, and process notes will be held in a locked and secured file within the premises. You may request in writing that this information be shared with any source you deem necessary. Please also be aware that your information may be used for consultation between the JHCPLLC clinical staff. Additionally, for case outcome purposes, some de-identified data may be used for research purposes. You have the option to opt out of such data usage.

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

____Yes ____No I authorize benefits to be paid directly to my treatment provider.
____Yes ____No I consent to the use of electronic account usage and communications (email etc.).
____Yes ____No I have received a copy of the HIPAA Privacy Notice.
____Yes ____No I authorize the release of any medical information necessary to process my insurance claims.
____Yes ____No I consent to the exchange of treatment information between JHCPLLC and primary care physician.
____Yes ____No I authorize cross clinician communication for the purposes of consultation/supervision.

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

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

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

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## MEDICAL INFORMATION

Primary Care Physician (PCP): _____

PCP Location: _____

PCP Phone Number: _____

List any current health concerns: _____
_____
_____

Current Medications (Including Vitamins/Supplements): ____
_____
_____
_____

List any prior surgeries or major injuries: _____
_____
_____

Any family history of:
□ Thyroid Problems □ Diabetes □ Pituitary Problems

## MENTAL HEALTH INFORMATION

**What brings you in for services now?**
_____
_____
_____
_____

List any prior counseling/psychological services:

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

Providers and Approximate Dates Seen:
_____
_____
_____
_____

How would you describe your current concerns?
□ Mild □ Moderate □ Severe □ A Crisis

## CURRENT CONCERNS (Please Mark All That Apply

□ Excessive crying
□ Unable to have fun
□ Decreased energy
□ Feelings easily hurt
□ Lacking confidence
□ Feeling overwhelmed
□ Difficulty making decisions
□ Constipation
□ Diarrhea
□ Feeling panicky
□ Feeling grouchy
□ Excessive worrying
□ Skin picking, hair pulling, or nail biting

□ Feeling worthless
□ Poor appetite
□ Overeating or binging/purging
□ Feeling sad
□ Feeling tense or on edge
□ Feeling angry
□ Difficulty concentrating
□ Trouble sleeping
□ Can't sit still or antsy
□ Acts without thinking
□ Problems handling money
□ Nightmares
□ Flashbacks
□ Mood swings

□ Unmotivated, procrastinating
□ Avoiding things
□ Parenting concerns
□ Sexual concerns
□ Threatens or bullies others
□ Fast heartbeat
□ Struggles to make/keep friends
□ Avoiding going places
□ Problems with parents
□ Problems with partner
□ Fighting and quarreling
□ Family conflict
□ Relationship issues

Are there any past mental health concerns that you are no longer experiencing? If so, what concerns, approximately when did you experience them, and for how long? _____

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# FAMILY INFORMATION

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

| NAME | GENDER | AGE | EDUCATION/OCCUPATION |
|---|---|---|---|
| CLIENT (S) | | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| SPOUSE/PARTNER | | | |
| | ☐ M ☐ F | | |
| PARENTS | | | |
| _____ □ Biological □ Adoptive □ Step Parent | ☐ M ☐ F | | |
| _____ □ Biological □ Adoptive □ Step Parent | ☐ M ☐ F | | |
| _____ □ Biological □ Adoptive □ Step Parent | ☐ M ☐ F | | |
| _____ □ Biological □ Adoptive □ Step Parent | ☐ M ☐ F | | |
| CHILDREN IN THE HOME | | | |
| _____ □ Biological □ Adopted □ Step Child | ☐ M ☐ F | | |
| _____ □ Biological □ Adopted □ Step Child | ☐ M ☐ F | | |
| _____ □ Biological □ Adopted □ Step Child | ☐ M ☐ F | | |
| _____ □ Biological □ Adopted □ Step Child | ☐ M ☐ F | | |
| _____ □ Biological □ Adopted □ Step Child | ☐ M ☐ F | | |
| _____ □ Biological □ Adopted □ Step Child | ☐ M ☐ F | | |

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# TELEHEALTH/TELETHERAPY CONSENT

Telehealth/teletherapy offered at Jennelle Hines Counseling, PLLC is a secure way to receiving counseling services through the use of video or phone call from the comfort of your own home. The terms telehealth and teletherapy are considered synonymous and are used interchangeably to describe the use of electronic information and telecommunications technologies to support clinical mental health care.

The telethealth system utilized doxy.me.com meets HIPPA standards of encryption and privacy protection however, privacy cannot be fully guaranteed due to limitations involving telehealth. Risks and limitations involving telehealth include but are not limited to; discomfort in utilizing virtual sessions in lieu of in-person, disruptions or delays in counseling sessions due to technology issues, and breach of confidentiality out of clinician's control. These risks and limitations can be further discussed with Jennelle Hines. The doxy.me link to connect to telehealth sessions with Jennelle Hines is: https://doxy.me/jhines

Copay and deductible amounts/requirements based on your individual insurance policy will still apply. Please direct any questions regarding billing/statements to your insurance company or  directly to Jennelle Hines.

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

## Emergency Contacts

| | |
|---|---|
| _____ | _____ |
| Family member & Relationship | Telephone Number |
| _____ | _____ |
| Friend | Telephone Number |
| _____ | _____ |
| Physician/Psychiatrist | Telephone Number |
| _____ | _____ |
| Crisis Hotline and Name | Telephone Number |

**I acknowledge that I have read and understand all of the foregoing statements related to Telehealth/Teletherapy and that my signature below indicates that I agree to receive Telehealth/Teletherapy session with Jennelle Hines.**

Client/Responsible Party Printed Name:_____

Client/Responsible Party Signature:_____

Date:_____

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A. **ELECTRONIC ACCOUNT**: You may access your account, update your information, schedule an appointment, send a secure message to your clinician, view monthly statements, and pay your bill online. Please visit www.therapyappointment.com. Click "Find your Therapist." Search for your clinician's name (Jennelle Hines). Enter your username and password. Please indicate here what you would like your username and temporary password to be:

LOGIN NAME (please print clearly – case sensitive):

|___|___|___|___|___|___|___|___|___|___|___|___|___|___| (max 15 characters, letters and/or numbers only – NO symbols)

TEMPORARY PASSWORD (you will be prompted to change this upon first log-in):

| _ **P** _ | _ **a** _ | _ **s** _ | _ **s** _ | _ **w** _ | _ **o** _ | _ **r** _ | _ **d** _ | _ **1** _ |

**If you do not provide a login, you will be assigned:** LOGIN NAME (case sensitive): LastnameFirstinitial

B. **PAYMENT INFORMATION**: Our fee schedule is as follows —

Initial Appointment (90791) - $230
60 Minute Session (90837) - $200
45 Minute Session (90834) - $175
45 Minute Family/Couples Counseling (90847) - $200

Participation in Legal/Court Proceedings (Including preparation, travel, and court time) - $300/hour
Medical Records Request/Written Correspondence: $50 per document
Missed Appointment/Late Cancellation: $75/$50

Fees for any services including and beyond the above mentioned can be discussed with Jennelle Hines.

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

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

UNDERSTANDING THE TYPE OF INFORMATION WE HAVE: We obtain information about you when you receive services through Jennelle Hines Counseling, PLLC (JHCPLLC). It includes your date of birth, gender of record, Social Security Number and other personal information.

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

*Treatment/Services: We may disclose information about you with your written consent to coordinate your services. For example, we may give information to your other healthcare providers.
*Payment: We may also use and disclose information so the care you get can be properly billed and paid for. For example, we will submit bills to your insurance company or other entities.
*Business Operations: We may need to use and disclose information for our business operations. For example, we may use information to review the quality of the services you receive.
*Exceptions: For certain kinds of records, your permission may be needed even for release for treatment, payment, and business operations.
*As Required By Law: We will release information when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, workers' compensation claims, medical examiner or funeral director if an individual dies, subpoenas or other court orders, communicable disease reporting, review of our activities by government agencies, to avert a serious threat to health or safety, reporting suspected abuse, neglect, or domestic violence, or in other kinds of emergencies. *With Your Permission: If you give permission in writing, we may use and disclose your personal information. If you give permission, you have the right to change your mind and revoke it. This must be in writing also. We cannot take back any uses or disclosures already made with your permission.

YOUR PRIVACY RIGHTS: You have the following rights regarding the health information that we have about you. Your requests must be made in writing to the Privacy Officer at JHCPLLC.
*Your Right to Inspect and Copy: In most cases, you have the right to look at or get copies of your paper or electronic health records. We will provide a copy or a summary of your health information, usually within 30 days of your request. You may be charged a fee for the cost of copying records.
*Your Right to Amend: You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we will give you a written reason for our denial within 60 days.
*Your Right to a List of Disclosures: You have the right to ask for a list of disclosures or your health information for six years prior to the date you ask, who we shared it with and why. This list will not include the times that information was disclosed for treatment, payment, or business operations. This list will not include information provided directly to you or your family, or information that was sent with your authorization.
*Your Right to Request Restrictions on Our Use or Disclosure of Information: You have the right to ask for limits on how your information is used or disclosed. We are not required to agree to your request if it would affect your care. If you pay for your services out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer unless a law requires us to share that information.
*Your Right to Request Confidential Communications: You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You do not have to explain the basis for your request.

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

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