CLIENT DEMOGRAPHIC FORM Date _____
Linda M. Hussey, MSN, CNS, LPCC

Last Name _____ First Name _____ Age _____

Marital: M S W D Gender M F

Client Social Security # _____ Client Date of Birth _____

Mailing Address _____ City: _____

State _____ Zip _____ Email: _____

Home Phone _____ Work Phone _____ Other / Cell _____

IN ORDER TO FOLLOW UP WITH YOU DURING AND AFTER SERVICES, CHECK EACH APPLICABLE BOX

HOME:	**WORK:**	**OTHER/ CELL:**
Permission to call you Y N	Permission to call you Y N	Permission to call you Y N
Permission to leave message Y N	Permission to leave message Y N	Permission to leave message Y N

Permission to use Mailing Address: Y N Special Instructions _____

Primary Insurance Information: Insurance Company _____

Insurance ID #: _____ Insurance Group #: _____ Co-pay Amount: $ _____

Have you called Insurance for pre-authorization? Yes No Authorization # if required: _____

Name of Benefit Holder _____ Benefit Holder Birth Date: _____

Benefit Holder's Relationship to Client _____ Benefit Holder's SS# _____

Secondary Insurance Information: Insurance Company _____

Insurance ID #: _____ Insurance Group #: _____ Co-pay Amount: $ _____

Have you called Insurance for pre-authorization? Yes No Authorization # if required: _____

Name of Benefit Holder _____ Benefit Holder Birth Date: _____

Benefit Holder's Relationship to Client _____ Benefit Holder's SS# _____

Who referred you to me? _____

For Office Use:

Copy of front and back of Insurance Card: _____

DSM Primary DX: _____

Linda Hussey MSN, CNS, LPCC
Mason Family Counseling
Financial Agreement / Consent

1. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that services are rendered. It is your responsibility to know any stipulations of your insurance such as co-pay amount, need for referral forms, deductibles, and need for treatment pre-authorization. For example, your insurance company may require that you have your sessions authorized prior to being seen for the first time. You will need to check for and obtain initial authorizations otherwise you will be responsible for the payment. In addition, you will need to keep track of the number of sessions allowed; if this amount is exceeded you will be responsible for the payment.
2. Please bring all paperwork including insurance authorizations to my attention at the beginning of your session. I prefer that all such work be done in your session so that you are fully aware of and can participate in what is written. If you give me the paperwork at the end of a session, I may not be able to complete it during the session, and I charge for paperwork that is done outside of sessions.
3. Please inform the Mason Family Counseling Office Manager immediately of any change in insurance coverage, employment, address, and phone numbers. Changes in insurance coverage could result in your sessions not being reimbursed by your insurance company, and then you would be responsible for the charges.
4. Co-payments, in the form of cash or check, are due at the beginning of each session. There is a $25 charge for a returned check.
5. Your appointment time is reserved for you; I do not double book appointments. Therefore, I have to charge you if you fail to show up for an appointment or if you cancel less than 24 hours before the appointment. You will be billed for the full cost of the session since this charge cannot be billed to your insurance company.
6. If you are paying out of pocket, an initial session (lasting 50 minutes) will cost $150, each 15 minute follow-up session will cost $100 and any extended follow-up sessions (40 minutes) will cost $125
7. Other expenses:
    a. For unpaid charges over 30 days old (from the date of the first billing), a service fee of 2% of the balance per month will be applied. A past due account may cause interruption of treatment and/or transfer of the outstanding balance to a collection agency.

    b. $25 for paperwork completed outside of a session

    c. $85 for a written report for any purpose (this fee must be paid before the report is released to you)

    d. $25 for a phone call lasting longer than 15 minutes

I have read the above information. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

_____ _____
Patient Date

_____ _____
Clinical Nurse Specialist Date

Linda Hussey MSN, CNS, LPCC

Payment Authorization Form

Patient: _____ Responsible Party*_____

Billing Address: _____ CC #: _____

_____ Expiration Date: _____

_____ Validation Code: _____ HSA (Y/N) _____

***Parent/Legal Guardian is responsible for Minors and non-minor Children. If parents are divorced, Mason Family Counseling will not act as a mediator in settling claim/payment issues. The parent that brings the child in for treatment is responsible for payment. Legally, we are not able to bill ex-spouses, regardless of divorce decree. If you leave us this payment authorization form or pre-pay the ESTIMATED amount you will be able to drop your child off for treatment. If you do not, you will be required to sign your Child in and pay the ESTIMATED due or they will not be seen. PLEASE do not put your child in a difficult situation!**

It is Mason Family Counseling (MFC) **obligation** and **responsibility** to the insurance companies that we are contracted with to collect all office fees for therapy visits at the time of service, which includes **co-pays and deductibles**. If your insurance company has given you other payment information, we will need this in writing.

Please be informed that if you have not met your deductible at the time of service, your insurance will not pay and will apply the fees to your responsibility until your deductible is met. Please complete the following Insurance information:

Your Deductible: $ _____ **Deductible Accumulation to Date**: $_____

Your Co-Pay/Co-Insurance: $_____ **Visit Limit**: _____ **Visit Accumulation**: _____

We check this information at each visit and we will let you know what we ESTIMATE your payment to be. This information is based on information we receive from your insurance company. Please note that it is ultimately your responsibility to review your insurance coverage and benefits prior to and during treatment. You may be responsible for amounts not indicated above if the Explanation of Benefits we receive from your insurance company indicates and additional amount that is your responsibility.

We will be utilizing your credit card within 24 hours of the day of each visit to collect the ESTIMATED amounts due including by not limited to:

- Co-pays, Co-Insurance and Deductibles due
- Any Self-Pay rates if not going through insurance
- Patient portions applied by insurance and not quoted above following any processed claim.
- Any No-Show/Last-Minute cancellations fees due in accordance with our 24-hour Cancellation Policy.

This will not compromise your ability to dispute charges or question your insurance company's determination of payment. For any questions about your statements, charges or if you believe you are due a refund, please do not hesitate to contact our billing department at 513-229-7900.

By signing below, I understand and agree that I am responsible for any collectible payments as due. I authorize MFC to apply estimated charges to the credit card as I accumulate charges from services rendered and as claims are processed. I understand the no prior contact will be made before these charges are made. I also understand that MFC will only send me a statement or detailed invoice of the charges made upon my request.

_____ _____ _____

Financially Responsible Party (Print) Signature of Financially Responsible Party Date

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To Be filled in at by our office at your first office Visit:

Unit your deductible is met; we have calculated your patient portion for every visit to be an ESTIMATED $_____.

After your deductible is met we have calculated your patient portion for every visit to be an ESTIMATED $_____.

If no deductible, we have calculated your Co-Pay/Co-Insurance to be an ESTIMATED: $_____

Initials: _____ Date: _____

Mason Family Counseling
Informed Consent / Consent to Treat

1. In addition to prescribing medication, I will provide you with information about your diagnosis, prognosis, and treatment including your medication. As the Responsible Party (the patient) you agree to engage the Clinical Nurse Specialist to provide services consistent with her education, license and specialty and hereby give permission to treat.

2. I will keep all information that you provide me confidential, and this obligation of mine will last indefinitely. The only times that I will reveal confidential information are if you sign a release of information, if you are in an emergency situation (for example you're being admitted to a hospital), if I am required by law, and if your insurance company requires it for reimbursement. You may choose not to authorize the release of information to your insurance company; however, this may prevent you from using your insurance benefits. Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use your benefits.

3. I provide 24-hour emergency call service for after hours and weekends. The answering service phone number is 721-0990. This service is provided for **true emergencies ONLY.** I do not carry a pager so it may take time for me to return your call. If you are experiencing severe side effects of a medication going to the nearest Emergency Room is always a safe option. Do not call this number to schedule an appointment or for medication refills; it would be appropriate to call the office at 513-229-7900 M-F between 9 am – 4:30 pm and speak with the front desk.

4. Initial sessions are 50 minutes, and follow-up medication evaluation appointments are 15 minutes.

5. Medication refill policy:

a. You are expected to attend all scheduled follow-up appointments which will minimize any need for refills between appointments (I will provide for enough medication to last you between scheduled appointments.) Professional Standards of Care dictate that if medication is prescribed for a patient both patient and medication need to be evaluated at intervals. If a Medication Evaluation appointment is missed, I may not refill medication.

b. I am at Mason Family counseling on Tuesday and Thursday. If you need a medication refill call the office M-F between 9 am – 4:30 pm and speak with the front desk. In your message the following information is necessary: your name, your birth date, name of medication, dosage, and pharmacy phone number. I will call in enough medication to last until your next appointment. You are responsible for keeping track of the amount of medication that you have.

c. Only under extenuating circumstances will I refill a prescription early (before you should be out of the medication.)

The terms of this agreement will begin on the date of this agreement and will remain in full force and effect until completion of the services. By executing this agreement, you are agreeing to pay for all services that are received.

I fully understand the above agreement and I freely agree to the above conditions:

_____ _____

Patient Date

_____ _____

Clinical Nurse Specialist Date

Behavioral Health/Primary Physician Patient Care Communication Form

Patient Name _____ Date of Birth _____

Behavioral Health Provider:	*Primary Physician*:
Name: Linda M. Hussey MSN, CNS, LPCC	Name:
Mason Family Counseling	Phone:
Address: 5134Cedar Village DR.	
Mason, Ohio 45040	Therapist:
Phone: 513-229-7900	Phone:
Fax: 513-229-0202	

___ *Patient does not have a primary physician*

Authorization to Disclose Information

I understand that records or information about my mental health including alcohol and drug abuse are confidential; they are protected by applicable state and federal laws, and cannot be disclosed without my written consent unless otherwise provided for in state and federal regulations. I also understand that any information about me concerning AIDS, HIV infection, and AIDS related conditions and any tests, counseling, and the treatment thereof cannot be released without my authorization. I understand that I may revoke this consent at any time.

___ I authorize any information on my care to be shared between providers listed above to facilitate my treatment. This authorization will continue during my entire course of treatment by Mason Family Counseling/Linda M. Hussey and may include information concerning psychiatric diagnosis and treatment; alcohol and drug use; and/or HIV testing, diagnosis or treatment of AIDS, and AIDS related conditions.
___ I do not wish to have information on my care to be shared between my physicians, names above, for the purpose of facilitating my treatment.

_____
Patient/Guardian Signature Date

To be Completed by Behavioral Health Provider:
Presenting Problem: _____
_____
Diagnosis: _____
_____
Treatment Plan (including medications prescribed): _____
_____
_____
Information Requested from Primary Physician: _____
_____

To be Completed by Primary Physician:
Please provide the information requested as well as any other information relevant to this patient's treatment (attach pages or forms from the patient's chart as needed): _____
_____
_____

CLIENT INFORMATION FORM

Completed by Client

Please Print Legibly – Information Remains Strictly Confidential

Emergency Contact_____

Phone_____ Relationship_____

WHAT CONCERERNS DO YOU CONTINUE TO HAVE ABOUT HOW YOU ARE FEELING? _____

_____

_____

Symptoms (please mark all that apply):

Emotional:

- □ Feeling of extreme happiness
- □ Feeling of extreme sadness
- □ Feeling stressed
- □ Feeling nervous or anxious
- □ Feeling fearful
- □ Excessive worry
- □ Indecisiveness
- □ Depression
- □ Easily irritated
- □ Paranoid thoughts
- □ Self-esteem problem
- □ Feeling guilty
- □ Sudden feelings of panic
- □ Perfectionism
- □ Change in sleeping habits
- □ Procrastination
- □ Crying spells
- □ Problems with anger
- □ Exaggerated startle response
- □ Lack of enjoyment of usual activities
- □ Increased use of alcohol / drugs
- □ Avoiding things
- □ Trouble performing your job
- □ Poor interpersonal skills
- □ Reckless behavior
- □ Trouble concentrating
- □ Not getting along with friends / family
- □ Hearing voices
- □ Fear of situations where escape is difficult
- □ Obsessions or compulsions
- □ Thoughts about hurting yourself
- □ Thoughts about hurting others
- □ Thoughts about killing yourself
- □ Thoughts about killing others
- □ Suicide attempts
- □ Acting violently
- □ Intrusive thoughts

Physical:

- □ Lack of energy
- □ Dry mouth
- □ Memory problems
- □ Chronic weakness
- □ Chronic pain
- □ Muscle tension / aches
- □ Numbness
- □ Sweating / clammy hands
- □ Nerve problems
- □ Trembling / twitching
- □ Hot flashes
- □ Dizziness
- □ Frequent urination
- □ Stomach or bowel problem
- □ Weight changes
- □ Change in eating habits
- □ Self-starvation
- □ Chest pain
- □ Shortness of breath
- □ Heart symptoms
- □ Trouble swallowing
- □ Change in sexual interest

HOW LONG HAVE YOU HAD THE SYMPTOMS CHECKED ABOVE? ***(APPROXIMATE DATE SYMPTOMS BEGAN)*** _____

_____

_____

ANY DETERIORATION IN JOB / SCHOOL PERFORMANCE DUE TO THE PROBLEM?

___Attendance ___Absences Mon/Fri.'s ___Tardiness ___Decrease in productivity
___Erratic Behavior ___Conflict with Supervisors ___Discipline ___None
___Conflicts with Fellow Employees

CONSEQUENCES OF DETERIORATING PERFORMANCE ON WORK OR SCHOOL: _____

_____

_____

On a Scale of 1-5, how would your rate your distress? (l is low, 5 is severe distress) _____

Medical Condition You Have: (If yes check)

___Diabetes	___ High Blood Pressure	___Heart Disease
___Blood Problems	___Bone/Joint Problems	___Brain Problems
___Skin/Hair/Nail Problems	___Liver Disease	___Respiratory Problems (Breathing)
___Genital	___Kidney/Bladder	___Cancer
___Allergies	___Eyes	___Autoimmune
___Chronic Pain	___Gastrointestinal	___Head Injury

Other health problems not listed above:_____

_____

Sleep Problems:_____

Appetite Problems: _____

Past Health Problems (include difficulties with developmental milestones under age 18) _____

_____

Medication currently using: If NONE, write your initials here_____

Medication	Dosage	Time Taken	Prescribing Doctor	Reason Prescribing

Medication Allergies: If **NONE**, initial here_____If yes what:_____

_____

PAST TREATMENT INTERVENTIONS:

Date	Medical & Surgical	Provider/Program/Hospital
Date	**Psychiatric**	**Provider/Program/Hospital**
Date	**Chemical Dependency**	**Provider/Program/Hospital**

Medical Conditions that Run in Your Family: (If yes check)

___Diabetes	___ High Blood Pressure	___Heart Disease
___Blood Problems	___Bone/Joint Problems	___Brain Problems
___Skin/Hair/Nail Problems	___Liver Disease	___Respiratory Problems (Breathing)
___Genital	___Kidney/Bladder	___Cancer
___Allergies	___Eyes	___Autoimmune
___Chronic Pain	___Gastrointestinal	

HEALTH HABITS INFORMATION:
For the following questions please base your answers on **the past month** (approximately).

Y N Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?
Y N Have you been dieting to lose weight?
Y N Have you smoked cigarettes on a daily basis?
Y N Have you experienced any increased feelings of sadness or hopelessness?
Y N Have you felt more anxious or worried than usual?

How often in the past month did you drink alcohol? (Circle your answer):

A) I do not drink at all
B) About once a month.
C) Two to three times a month.
D) One to three times a week.
E) Once a day or more.

For the **past month**, please fill in a number for each day of the week indicating the **typical number of alcohol drinks** you usually consume on that day.

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of drinks:							

Y N In the past **year** have you used any illicit or non-prescription drugs?
Y N During the past **month** have you participated in leisure/social/spiritual activities?

Have you ever had a DUI? _____No _____Yes: Details: _____

Y N "In the past year, have you ever drunk or used drugs more than you meant to?" Or "have you spent more time drinking or using than you intended to?"
Y N "Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?"
Y N "Have you felt you wanted or needed to ***cut down*** on your drinking or drug use in the last year?"
Y N "Has anyone objected to your drinking or drug use?"
Y N "Have you ever found yourself preoccupied with wanting to use alcohol or drugs?"
Y N "Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?"

FAMILY RELATIONSHIPS (Members of the family you are/were close to)

Name	**Relationship**	**Age (or Year**	**Quality of Relationship: Excellent, Good, Fair, Bad**	**Lives with you:**
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N

RELATIONSHIP HISTORY: (List all marriages & divorces and/or lived together relationships)

Partner's First Name	**Indicate:** Married (M) Live together (LT)	**Length of** Relationship	**Reason ended**

WORK HISTORY: (Start with most recent)

Place	**Position**	**From**	**To**	**Reason ended**

PERSONAL & FAMILY HISTORY:

Were you or any family member physically abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member sexually abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member emotionally abused? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member had a problem with drugs or alcohol? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member ever tried to commit suicide? YES NO (circle)

If yes: Self - family (circle one or both)

Is there any history of anxiety, depression or mental illness in your family? YES NO (circle)

If yes: Self - family (circle one or both)

COMMENTS: