Andrea Wilhelm, LCMHC

77 Church Street Asheville, NC 28801. Phone 828.808.1078

Name:_____

Address:_____ City_____ State_____ Zip Code _____

Phone: (_____) _____ - _____ Birthday: ____/____/_____ Social Security #: _____-_____-_____

Emergency Contact: _____ Phone: (_____) _____ - _____

Employer/School: _____

Email:_____

Referred By:_____

Insurance

Insurance Company: _____

Policy Holder: _____Relationship to Insured: _____

Policy #: _____ Group #: _____

Mental Health Phone (on back of card) (_____) _____- _____

Financial Responsibilities (Please initial)

~Co -payments are due at the time of service. Cash or checks are the preferred methods of payment. All major credit cards are accepted with a 3% processing fee. There is no processing fee for payments made in cash or check. _____

~I hereby assign payment of insurance benefits directly to Andrea Wilhelm, LCMHC to bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay. It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied, I will be responsible for all charges. _____

~If your portion of the bill is not paid within 30 days from the last date it was incurred, a letter will be sent, giving 14 days to pay your account or to arrange for a payment plan. If no payment plan has been arranged the credit card on file will be charged for your portion of the bill_____

~You will be charged **$50** for missing an appointment: no show/ not giving at least 24 hours prior notice to cancel an appointment. The credit card on file will be charged the day of your missed appointment plus a 3% processing fee _____

~I HAVE received the disclosure statement I understand and agree to abide by my financial responsibilities. I understand that information will be released to my insurance company, if necessary, and any charges_____

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Please briefly describe why you are seeking counseling:

_____

_____

_____

_____

_____

_____

Symptoms: (Please circle all that apply)

Anxiety	Depression	Current/ Past Trauma	Visual or Auditory Hallucinations
Racing Thoughts	Feeling Sad/ Crying	Marital/ Relationship/ Family Problems	Talking or acting without thinking
Low self confidence/ Body Image Concerns	Hopelessness	Difficulty with life transition	Nightmares
Irrational fears	Argumentative/Anger	Intrusive Thoughts	Self Harm/ Cutting
Panic Attacks	Physical pain without known physical cause	Compulsive behaviors/ Obsessive thoughts	Lack of desired spiritual connection
Difficulty trusting others	Change in appetite	Feelings of unreality	Difficulty with goal setting/ achievements
Upset by minor changes	Change in sleep/ Difficulty with sleep	Difficulty Trusting	Substance use/ abuse issues

Other symptoms: _____

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Name of your Primary Care Physician: _____Phone: (_____) _____- _____

Are you working with a Psychiatrist Y / N

If yes, Name _____Phone (_____) _____- _____

Have you ever had suicidal thoughts? Y / N Have you ever attempted suicide? Y / N

If yes, what contributed to these feelings/thoughts?

_____

_____

Have you ever had homicidal thoughts? Y / N Have you ever tried to kill someone? Y / N

If yes, what contributed to these feelings/thoughts?

_____

_____

Prior outpatient therapy (please include previous therapists, approximate dates of treatment, treatment interventions, response to treatment and/or previous medications):

_____

_____

_____

_____

Please describe any family history of mental health concerns (including suicide and substance abuse)

_____

_____

List all current health concerns, diagnoses, and medications

_____

_____

If using alcohol or other mood altering substances describe use. (Include frequency and type of substances)

_____

_____

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Are you in a relationship? Married ____ Divorced____ Living together ____Separated____ Single____ Other___

Please describe the quality of your relationship:

_____

_____

What do you do for fun, relaxation, to recharge?

_____

_____

Please describe your support system(s) (friends, family, pets, spiritual community, etc.):

_____

_____

Please describe your typical diet and exercise routines:

_____

_____

Is there anything else that you feel is important for me to know?

_____

_____

_____

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Credit Card Authorization Form

A credit card on file is required for all services. Your card will NOT be charged without your permission, except in the following situations:

~Late cancelation/No show for appointment. Your credit card will be charged $50 plus a 3% processing fee the day of the missed appointment.

~If you portion of the bill is 30 days past due, you will receive a letter giving you 14 days from the date of the letter to make a payment or arrange a payment plan. If you fail to respond, your credit card will be charged for the outstanding balance on your account.

Credit Card Information:

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____ 3 Digit Security Code: _____ Zip Code: _____

I authorize Andrea Wilhelm. LCMHC to charge the above card in the designated manner. My signature also indicates that I will inform Andrea Wilhelm, LCMHC of any changes to this billing information over the course of our work together.

Signature _____Date_____/_____/_____

HIPAA Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health of condition and related health care services. Uses and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your counselor, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the counselor's practice, and any other uses as required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a managed care company that provides insurance coverage for your treatment here. Your protected health information may also be provided to a physician, to whom you have been referred, to ensure that the physician has the necessary information to properly diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for continued treatment or a hospital stay might require that your relevant protected health information be disclosed to the health plan to obtain approval for more sessions or hospital admission. Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of mental health professionals, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protective health information to interns or students that see patients in office. In addition, we may call you by name in the waiting room when your counselor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situation without your authorization. The situations include, as required by law: public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, research, criminal activity, military activity, national security, worker's compensation, inmates, required uses and

disclosures under the law. We must make disclosures to you and when required by the Secretary for the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your counselor or this counseling practice has an action taken in reliance on the use or disclosure indicated in the authorization.

The following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information: Under Federal Law, however, you may not inspect or copy the following records: counseling notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. We ask that this request be provided in writing. Your mental health professional is NOT required to agree to a restriction that you may request. If a mental health professional believes it is in your best interest to permit use and disclosure of your protected health information, then your protected health information will not be restricted. You always have the right to use another health care professional. You have the right to receive confidential communications by other means at an alternative location. You have the right to obtain a paper copy of this notice from us. You MAY have the right to have your mental health professional amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints: You may issue complaints with us, or with the Secretary of Health and Human Services if you believe your right to privacy has been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This noticed was published and went into effect on 4/14/2003.

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VERIFICATION OF RECEIPT OF HIPAA NOTICY OF PRIVACY PRACTICES

The Notice of Privacy Practices just given to you describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted and/or required by law.

It also describes you rights to access and control your protected health information. Protected health information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. Please be sure to read this information.

Your signature below attests ONLY to the fact that you were given the HIPAA Notice of Privacy Practices

Signature _____Date_____/_____/_____