The Columbus Wellness Center
124 Hyatts Rd ~ Delaware, OH 43035 ~ (833) 336-7543
A Subsidiary of Recovery For Life
www.thecolumbuswellnesscenter.com

Clinical Intake Paperwork

SUPERVISING CLINICIAN:

Virginia Clagg PhD ABD, MBA, MSW, LISW-S, LICDC
Clinical Hypnotherapist
VC NPI: 166 991 1749
Recovery For Life NPI: 168 933 2470
(614) 352-6807
Claggv@gmail.com

☐ **Copy of insurance card is included front and back**

☐ **Copy of State ID/ Driver License is included**

☐ **Copy of CC is included front and back**

Primary Insured Information:

Name: _____

Address: _____ City/State: _____ Zip: _____

DOB: _____ SS#: _____

E-mail: _____

Phone: _____

Insurance Co: _____

Employer: _____

Member ID: _____

Group ID: _____

☐ Emergency Contact same as above:

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Emergency Contact Name: _____

Emergency Contact preferred method: ☐ Text ☐ Phone ☐ Email

Phone: _____e-mail: _____

**Patient authorizes The Wellness Center and it's associates and affiliates to contact my emergency person including emergency services in cases of crises situations involving suicidal ideation, homicidal ideation and/or if I cannot be reached within 48 hours by other reasonable means.*

Patient Demographics:

☐ **Same as Above** ☐ **Patient is a minor**

Patient Name: _____

DOB: _____ SS# : _____

☐ Address same as Primary Insured

Address: _____ City/ State: _____ Zip: _____

Preferred means of contact:

☐ Home Phone: _____
☐ Can leave a message on Voice Mail (VM) ☐ Cannot leave a message on VM

☐ Cell Phone: _____
☐ Can leave a message on(VM) ☐ Cannot leave a message on VM

☐ Email: _____

☐ Text: _____

I understand that Text communication through cell service is not HIPAA compliant and agree that this is the most efficient method of communication. I agree to text with The Wellness Center, its associate and its affiliates. I have been given information about other protected means of communication and understand that texting does not protect my privacy rights. By my signature below I agree to text messages.

Signature: _____ *Date:* _____

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Credit Card Authorization Form:

I hereby authorize The Columbus Wellness Center and associates to charge my credit card for fees incurred which include fees for appointments, appointments missed or not canceled with 24-hr notice, copays or coinsurance, or fees for completion of paperwork requested or not part of a regular appointment, including extended phone contact, per office policy.

Name: _____

Card Address: _____

Card City/ State _____ **Zip**_____

Credit Card: ☐ Mastercard. ☐ Visa ☐ Discover ☐ Amex

Card Number: _____

CVC: _____ Exp Date: _____ Zip Code: _____

Card Holder Signature: _____ Date: _____

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Notice of Privacy Policy:

This notice is being sent to you, to inform you that we are H.I.P.A.A. compliant, and to describe to you an "overview" of your privacy rights.

The H.I.P.A.A. law was created for companies who now transfer your personal and medical information electronically (via the Internet, email, etc.) As stated previously, we do not transfer any personal and/or medical documents electronically without your consent at this time and are not foreseeing doing this in the future.

Our Statement to You: We acknowledge your right to your privacy and will abide by both the H.I.P.A.A. and Privacy Act laws and regulations, we understand the meaning of the word "confidential" and we respect your rights to your privacy.

If you have any questions or you would like to exercise any of your rights described in this brochure, you must submit your request in writing to our H.I.P.A.A. manager; or you may call and leave a detailed message and our H.I.P.A.A. manager will get back to you as soon as possible.

A full copy of the H.I.P.A.A. Law and regulations is located at our place of business for your review, or you can visit these Government web sites for further information:
www.CMS.hhs.gov/hipaa
www.hhs.gov/ocr/hipaa
www.hhs.gov/ocr/hipaa/privacy.html

Notice:
Our office does not transfer "Personal Health Information" electronically; we are however H.I.P.A.A. compliant and we are regulated by the Federal Privacy Act.

Our Responsibility:
The confidentiality of your personal health information is very important to us. All information kept in your file is confidential and will not be released unless we obtain written consent to do so and/or it is stated by the law that we may release this information without your consent.

What we are allowed to do without your Consent:
Under federal and Ohio law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. [However, the American Psychiatric Association's Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal health information.] [If relevant: Participants in this organized health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.]

Examples of these are:
Asking a nurse to assist with taking your temperature and to document the results. Supplying your insurance company with a diagnosis or other related health information that will assist payment for services rendered. Supplying the billing department with demographic and diagnostic information, etc.
Under Federal and Ohio State law, we are permitted to use and disclose personal health information without authorization, for treatment, payment, and health care operations. Note: If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to

determine what is in your best interest regarding any such disclosure. Instances where your consent is not needed. *(examples)*

- **Abuse, Neglect, or Domestic Violence**
- **Appointment reminders and other health related services (this would include leaving messages on**
- **Answering machines, unless directed not to)**
- **Business Associates such as a Billing Company**

- **Communicable Disease Control**
- **Communications with family, only if they are the responsible party for your care and/or payment**

- **Coroners, Medical Examiners, and Funeral Directors**
- **Disaster relief or to assist in disaster relief efforts**
- **Food and Drug Administration (FDA)**
- **Judicial or Administrative Proceedings**
- **Law Enforcement**

There are other instances where your PMI (Personal Medical Information) may be given out. But our office policy is to always try to get permission from you first before we disclose any such information.

In general our practice will only release actual medical information, such as a diagnosis, medications you have been prescribed. Length of treatment, etc.

Session notes that document diagnoses, medications prescribed and the content of our sessions will only be released upon your signing of a specific release of information allowing me to share that information with those you designate. This is mostly done via fax. Please advise if this is not acceptable.

Your Health Information Rights:
Under the law, you have certain rights regarding the health information that we collect and maintain about you.

This includes the right to: *(examples)*

- **Request that we restrict certain uses and disclosures of your health information. We are not, however, required to agree to a requested restriction.**
- **Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in the reason for the denial and your right, if any, to request a review of the decision.**
- **Request that we amend or update the health information about you that is maintained in our files. This does not include therapy notes however.**
- **Request a list of whom we sent your health information to.**

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge and understand The Columbus Wellness Center and affiliates is abiding by the H.I.P.A.A., Ohio state and federal privacy act law(s) and regulations; and I hereby acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices

Patient Name: _____

Patient Signature: _____ Date: _____

Responsible party Name: _____

Relationship: _____

Responsible Party Signature: _____ _____

Date: _____

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Practice Policies

The Wellness Center & Affiliates: Therapists working in the clinic enjoy a collegial and educational professional relationship with several therapeutic disciplines within The Columbus Wellness Center network. In your particular situation, your therapist works as an independently credentialed clinician through the Clinic and its affiliation Recovery For Life. Services will be billed to your insurance company via that relationship.

Your Therapist: Sessions with therapists are by appointment only. The best way to contact your therapist is by calling their direct phone number or sending an e-mail to the email provided by him or her. Voice mail will be checked throughout the day and at least once in the evenings and on the weekends. Practitioners strive to respond to VM within 48 hours. In the event of an emergency, please contact Riverside Hospital Behavioral Health Emergency Services at (614) 566-5056, NetCare Access at (614) 276-CARE, 911 or 988.

Appointments: Appointments are typically 50-60 minutes long. Missed appointments are not covered by insurance and may be paid out of pocket. There is a $60 no show fee if there is not 24 hours notice of a cancellation.

Payments & Insurance: Co-payments are due at the time of the appointment. Payments can be given to the therapist. We do not accept checks. If you are unsure about your balance or have any questions regarding billing, please contact Supervising practitioner Virginia Clagg at claggv@gmail.com.

Confidentiality: Everything that takes place in psychotherapy is confidential and may not be released without your expressed written permission. There are two exceptions to this: if you or your child becomes a danger to self or others; and if you or your child is involved in child abuse. In these situations, we are legally bound to break confidentiality in order to protect all involved. Confidentiality for children and adolescents in situations other than those listed above will be discussed with you during the evaluation phase of treatment.

By signing this document, I understand and agree with the policies described above. I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. If my account is more than 90 days in arrears, I authorize that pertinent billing information can be released to a professional service for purposes of collection of the outstanding balances.

Patient Name: _____ ☐ I am patients Guardian

Patient Signature: _____ Date: _____

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Consent for Treatment

I give my consent to receive treatment and related services from (Practitioner name) _____. I understand that this consent is for the duration of the services provided.

Client Name (please print): _____

Client Signature: _____

Date: _____

****

Minor Consent to Treat

I give my consent as parent of guardian for the following individual to receive treatment and related services from (Practitioner name) _____.

I understand that this consent is for the duration of the services provided.

Client Name (please print): _____

Parent or Guardian Name (please print): _____

Parent or Guardian Signature: _____

Date: _____

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Release of Information

I hereby authorize (Name of practitioner): _____ to exchange my protected personal Information with (organization):

_____

(Name of patient or client): _____

(Date of birth): _____

☐ Information to be exchanged:
☐ Evaluation
☐ progress/therapy notes
☐ Summary of treatment. This may contain information that includes alcohol and drug use
☐ Other (Listed, if applicable): _____

The above information is for the following purpose:

☐ For coordination of care

☐ Other (Listed, if applicable): _____

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to your therapist/The Columbus Wellness Center & Affiliates. I understand that your therapist/The Columbus Wellness Center & Affiliates may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

Signature: _____ ☐ **Guardian**

Witness: _____ **Date:** _____

PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE SUBJECT TO PROSECUTION UNDER FEDERAL LAW. THE FEDERAL RULES RESTRICT ANY USE OF THIS INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT [52 FR 2 1809, June 9, 1987; 52 FR 4 1997, Nov. 2, 1987]