Kelly O'Donnell Counseling, LLC

(314) 643-8224
Kelly@KellyOdonnellCounseling.com
456 New Ballas Rd.
Creve Coeur, MO 63141

Client Information Form

Today's date: ____________

Note: If you have been a client here before, please fill in only the information that has changed.

A. Identification

Your name: ______________________________________ Date of birth: _______________ Age: ___

Social Security #: ____________________

Home street address: ____ Apt.: ____________

City: ____ State: ____ Zip: __________

phone: __________________________ e-mail: ____

Calls or e-mail will be discreet, but please indicate any restrictions: _________________________________

B. Referral: Who gave you my name to call?

Name: ____Phone:_____________________

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

C. Religious and racial/ethnic identification

Do you have a religious affiliation ❑ Yes❑ No (if yes, please specify): _____________________________

Ethnicity/national origin: __________________________ Race: _____________________

D. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: ____________________________ Phone: _________________ Relationship:_____________

Address: ____

E. Health habits

1. What kinds of physical exercise do you get? ____
2. Tell me about your diet. ____
3. How much caffeine do you consume daily (soda, coffee, tea, energy drinks, pills)?_____________________________

4. Do you try to restrict your eating in any way? How? Why? ____

5. Do you have problems getting enough sleep? ____

6. What is your height?_________________ Your weight?______________________

F. Is there any other information you think I should know about your health? (use the back of this sheet if necessary)

G. Please describe the main difficulty that has brought you to see me: (use the back of this sheet if necessary)

H. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
❑ No ❑ Yes If yes, please indicate:
When? From whom? For what? Diagnosis? With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:
When? From whom? Which medications? For what? With what results?____

I. Chemical use

1. How much tobacco do you smoke each week? ____

2. Do you drink alcohol? ❑ No ❑ Yes

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. How much beer, wine, or hard liquor do you consume each week on the average? ______________________________

7. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ No ❑ Yes

8. Have you ever used illegal drugs? ❑ No ❑ Yes If yes, which and when?

____

6. Are you involved in any legal matters? ____

J. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written

about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited.

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Payment Form

I truly appreciate your choosing to come to me for services.
As part of providing high-quality services, I need to be clear about our financial arrangements.

Client's name: ____________________________ Birthdate: _______ Soc. Sec. #: _________________

Address: ____Phone #: ___________________

Email address: ____

OR

Person responsible for payment: _____________________ Birthdate_______ Soc.Sec.#______________

Address: ____ Home phone: _____________

Email address:____

1. I understand that Kelly O'Donnell Counseling, LLC does not take any form of insurance. I am expected to pay for services in the full amount agreed in the form of personal check, cash, or credit card.
2. The standard fee for one individual session is $100. I agree to make payment by the end of each session. The fee for check or credit card payments that do not clear is $35. Please make checks out to **Kelly O'Donnell Counseling, LLC**.
3. I agree to give 24-hour notice of the need to cancel or reschedule an appointment. Exceptions may be made in extreme emergencies. Leaving a message on my office voice mail is sufficient notice, as well as email.
   (314)643-8224 or Kelly@KellyOdonnellCounseling.com
4. I agree to keep a credit card on file. This credit card will be charged a full session fee if I do not give my therapist 24-hours notice of the need for a cancellation or rescheduled appointment. The full rate will also be charged if there is no call or email (a "no-show") for my appointment. Previously scheduled appointments will be cancelled until all outstanding balances are paid.

Credit Card Information (VISA, MasterCard, American Express, Discover):

Type of Card: ____________________________________
Name on Card: __________________________________
Billing Address:_________________________________ zip code ___________
Credit Card # ___________________________________
Expiration Date: ____/____/____
CVV (3 digit # on back of MC and V or 4 digit # on front of AMEX) __________

Signature ____

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Notice of Privacy Practices

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.

My commitment to your privacy: My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of
privacy practices. Please talk to me about any questions or problems. **How I may use and disclose your protected health information with your consent:** I will use the information I collect about you mainly to provide you with **treatment**, to arrange **payment** for my services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice I will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and your parents if you are a minor and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent: There are some times when the laws require me to use or share your information. For example: 1) When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat. 2) When I am required to do so by lawsuits and other legal or court proceedings. 3) If a law enforcement official requires me to do so. 4) For workers' compensation and similar benefit programs. **Your rights regarding your health information**

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.
2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but I may charge you for the time and expense to make the copies.
4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You have to make this request in writing to me. You must also tell me the reasons you want to make the changes.
5. You have the right to a copy of this notice. If I change this notice, I will post the new version in my waiting area, and you can always get a copy of it from me.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me or with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the

same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or these health information privacy policies, please contact me.

The effective date of this notice is 12/5/15

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Consent to Use and Disclose Your Health Information

This form is an agreement between you and me. When I use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: ________________________________

When/if I diagnose, treat, or refer you, I will be collecting what the law calls "protected health information"(PHI) about you. I need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard this notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information. (see Handout titled *Notice of Privacy Practices*) **If you do not sign this form agreeing to our privacy practices, I cannot treat you.** In the future, I may change how I use and share your information, and so I may change our notice of privacy practices. If I do change it, you will get a copy. If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it in writing to me. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

________________________________ ______________

Signature of client or his or her personal representative Date

________________________________ ________________________________

Printed name of client or personal representative Relationship to the client

____

Signature of Therapist

❑ Copy of "Notice of Privacy Practices" and this "Consent to Disclose Health Information" was given to the client/parent/personal representative. Effective 12/5/2015

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When/if I diagnose, treat, or refer you, I will be collecting what the law calls "protected health information"(PHI) about you. I need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard this notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information. (see Handout titled *Notice of Privacy Practices*) **If you do not sign this form agreeing to our privacy practices, I cannot treat you.** In the future, I may change how I use and share your information, and so I may change our notice of privacy practices. If I do change it, you will get a copy. If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it in writing to me. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

____ ____________________

Signature of client or his or her personal representative Date

____ ____

Printed name of client or personal representative Relationship to the client

____

Signature of Therapist

Effective 12/5/2015 ❑ Copy given to the client/parent/personal representative.

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Release of Information Consent Form

Name of client: ____________________ Date of birth: ________Social Security #: ___________

I understand that the purpose of this release is to assist with my/this client's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the client's life. To further this goal, **I authorize Kelly O'Donnell, LCSW to obtain and/or release** the below-specified information regarding me/the client to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below, and any items not to be released have a line drawn through them:

❑ Admission/discharge information ❑ Treatment plan ❑ Progress notes

❑ Compliance with treatment ❑ Treatment summary ❑ Psychological evaluation

❑ Medications ❑ Other: _______________

This information is to be obtained and/or released among these persons:
1. Name: __________________________ Relationship to client: _________________
Office Phone: _________________ Fax: ____________________
Address: ____
Email address;____

2. Name: __________________________ Relationship to client: _________________
Office Phone: _________________ Fax: ____________________
Address: ____
Email address;____

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire ❑ one year from this date, ❑ upon my discharge from treatment by this agency or by the person specified above, or ❑ under these circumstances:
____.

___________ _________________ _____________

Signature of client Printed name Date

_________________________ ______________________

Kelly O'Donnell, LCSW Date