heart soul Counseling, LCSW, PC
Counseling • Education • Training
Community Services

Phone: 631.321.7011 • Fax: 631.669.8532
Email: HeartSoul@att.net
Web: HeartAndSoulCenter.com
17 Fordham Road, / Sunrise Highway
W. Babylon, NY 11704

Welcome to Heart & Soul Community Counseling, Inc. Thank you for choosing us to assist you with your mental health needs.

Your initial appointment is scheduled for _____.

Please fill out the attached paperwork and bring your insurance card to the front desk along with your copayment. Your appointment will run approximately 45 minutes to an hour.

When you arrive, please have a seat in our waiting area and someone will be with you shortly. If you are unable to keep your initial appointment, please provide us with a minimum of 24 hours cancellation notice so that other clients waiting for an appointment can be contacted. **If we do not receive the minimum 24 hours cancellation notice, you will be charged a $90 fee for the initial session.** You will then have to wait until the next available opening to reschedule.

CLIENT INFORMATION

Name: _____ Date of birth: _____ Age: ____

Address: _____

Phone Number: (_____)_____ Marital Status: ☐S ☐M ☐D ☐W ☐Sep

Spouse/Significant Other Name: _____

Emergency Contact Name: _____ Relationship:_____

Emergency Contact Phone: (_____)_____

Referred By: _____

For Minors

Parent/Guardian Name: _____

Address: _____

Phone Number: (_____)_____

The mission of Heart & Soul Counseling, LCSW, PC is to educate, empower and care for those individuals, groups and communities who have suffered dependency, illness and oppression.

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CONSENT TO LEAVE VOICE MAIL ON HOME/MOBILE PHONE

Phone Number: (_____)_____ Client Signature: _____

MEDICAL INFORMATION

Insurance Company: _____ Member ID: _____

Phone Number for Providers: (_____)_____

Primary Care Physician: _____

Phone: (_____)_____ Fax: (_____)_____
Address: _____

Medical Problems (if applicable):

_____

_____

_____

Pharmacy Name: _____ Pharmacy Phone: (_____)_____

Allergies: _____

Current Reason for Seeking Treatment: _____

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CURRENT MEDICATIONS

Name and Dosage: _____

_____

_____

_____

CURRENT OR PAST MENTAL HEALTH PROVIDERS

Provider Name: _____ Phone: (_____)_____

Address: _____

HOSPITALIZATIONS, PROCEDURES, INJURIES, SURGERIES, ETC.

Date:_____ Procedure: _____ Outcome: _____

Date:_____ Procedure: _____ Outcome: _____

Date:_____ Procedure: _____ Outcome: _____

Date:_____ Procedure: _____ Outcome: _____

Females Only (indicate what is applicable):

Are you pregnant? ☐**Y** ☐**N** Are you considering pregnancy? ☐**Y** ☐**N** Are you nursing? ☐**Y** ☐**N**

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FAMILY HISTORY OF MENTAL ILLNESS

Indicate whether you or a family member have the following conditions

I = Self M = Mother F = Father S = Sibling C = Child G = Grandparent

Depression _____ Anxiety_____ Bi-Polar_____ OCD_____ Alcohol Abuse_____

Opioid Abuse_____ Cannabis Abuse_____ Cocaine Abuse_____

Suicide Attempts_____ Any Other Illnesses_____

LIFESTYLE/HEALTH HABITS

Tobacco use? ☐Y ☐N Cigarettes per day:_____ Past Smoker?☐Y ☐N

Recreational Drugs – current or past IV drug use?☐Y☐N How often?_____

Alcohol – Wine? ☐Y ☐N Glasses per day/week_____

Beer? ☐Y☐N Glasses per day/week_____

Liquor? ☐Y ☐N Glasses per day/week?_____

Caffeine – Coffee? ☐Y ☐N 6 oz. cups per day_____

Tea? ☐Y ☐N 6 oz. cups per day_____

Soda? ☐Y ☐N Cans per day_____

How many glasses of water do you drink per day?_____

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Please "x" if you or your child have experienced any of these symptoms

☐ Anxiety Attacks	☐ Hitting others	☐ Panic Attacks
☐ Being hit	☐ Oversleeping	☐ Overspending
☐ Not sleeping enough	☐ Underspending	☐ Under-eating
☐ Compulsive sex	☐ Overeating	☐ Low sex drive
☐ Angry outbursts	☐ Threatening others	☐ Being afraid to go out
☐ Being threatened	☐ Hearing voices	☐ Drinking/drugging too much
☐ Can't control emotions	☐ Can't feel emotions	☐ Feeling emotionally numb
☐ Cut yourself	☐ Suicidal thoughts	☐ Wanting to harm others

Briefly describe

As a child, how did your mother feel about you?_____

_____

As a child, how did you feel about your mother?_____

_____

As a child, how did your father feel about you?_____

_____

As a child, how did you feel about your father?_____

_____

As a child, how did your sibling(s) feel about you?_____

_____

As a child, how did you feel about your sibling(s)?_____

_____

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CONSENT TO TREATMENT

I consent to any psychotherapy, medication assessment and management, laboratory or other medical procedures or examinations rendered me under the general and specific instructions of Heart & Soul Community Counseling, Inc.

Client Name:_____ Signature:_____

Date: _____

PRIVACY POLICY

Recognizing that certain services provided are of confidential nature, Heart & Soul Community Counseling, Inc. has formally adopted a policy to protect your privacy. This policy states that the information you provide will be kept confidential and will not be distributed or shared with other persons or organizations without your written approval. However, there are situations where Heart & Soul Community Counseling, Inc. has a responsibility to release information, regardless of whether the client agrees. These exceptions include:

1. Cases of suspected child abuse or neglect are required to be reported in the State of New York to the Department of Children and Families;
2. Cases of suspected abuse or neglect of the elderly and mentally challenged adults are required to be reported in the State of New York;
3. The courts have a right to order Heart & Soul Community Counseling, Inc. to release client information;
4. Heart & Soul Community Counseling, Inc. is required to make a reasonable effort to inform the police at any reason directly threatened by a client, of the clients direct threat to harm that other person;

It is Heart & Soul Community Counseling, Inc.'s policy to keep your information confidential and to protect your privacy. However, the enactment of the HIPAA privacy rule, section 164.505 (b) requires that a client's right to have his or her health information kept private and secure has become more than just an ethical obligation of health care professionals; it is also the law. As a result, we have established this formal in-house privacy policy. As always, we strive to provide you with the best services, along with keeping your personal information confidential.

Signature: _____ Date: _____

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RELEASE OF INFORMATION AND CONFIDENTIALITY OF RECORDS

I authorize release of information to my Primary Care Physician, other healthcare providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation, and professional communication. If I am an insured client, I further authorize release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

Client Initials:_____ Date:_____

PAYMENT AND INSURANCE REIMBURSEMENT

If your services are covered by insurance, you are responsible for obtaining a referral from your Primary Care Physician if your insurance requires one. Heart & Soul Community Counseling, Inc. will bill your insurance, however, you are responsible for copayment amounts and deductibles as set by your benefit plan. Clients are expected to pay any fees due at the beginning of each session. I agree to alert Heart & Soul Community Counseling, Inc. immediately should my insurance change at any time while I am enrolled. If I am currently not insured or become uninsured, I agree to pay all of the charges incurred by me for services received.

Client Initials:_____ Date:_____

CANCELLATION POLICY

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours cancellation notice is required for rescheduling or cancelling an appointment. **MISSED APPOINTMENTS ARE NOT COVERED BY YOUR INSURANCE. THEREFORE, THE CHARGES ASSOCIATED WITH THEM ARE YOUR RESPONSIBILITY.** If 24 hours cancellation notice has not been given, there will be a $90 charge. This fee must be paid prior to making another appointment. This policy is necessary in order to make the time available to other clients.

Client Initials:_____ Date:_____

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MEDICATION MANAGEMENT / REFILL REQUESTS / CHANGES IN MEDICATION

When treatment involves medications, you will be provided with enough prescription refills to last you until your next scheduled appointment. If you need to cancel that appointment, you will need to reschedule before your medication runs out. Medication changes will not be made over the phone as a proper face-to-face evaluation will be necessary to determine a change in the course of care. If you have any questions about your care, please write them down to be sure they get addressed at your next meeting. If an emergency occurs between visits, please call 911 or go the nearest emergency room for an evaluation. Patient expectations for safe and effective medication management require that the client:

1. Inform Heart & Soul Community Counseling, Inc. when any new medical problems or medication that is prescribed by other health care professionals, and of any over-the-counter medications or supplements that you are using;

2. Inform me of any side effects or suspected side effects of medication at every visit;

3. Agree not to make changes in medication dosing, including stopping medications without consulting with me, for medications prescribed by me. **NOTE: IT MAY BE DANGEROUS TO ABRUPTLY STOP MEDICATIONS OR CHANGE DOSING WITHOUT CONSULTATION WITH A MEDICAL PROFESSIONAL.**

4. Attend all scheduled appointments as agreed upon in order to provide proper continuity of care and to properly assess efficacy of treatment.

5. Complete all requested laboratory testing in a timely manner. Some medications cannot be safely prescribed without periodic blood work.

Client Initials:_____ Date:_____

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OFFICE USE ONLY

FOR HEART & SOUL COMMUNITY COUNSELING, INC. TO COMPLETE

Client Name:_____ DOB:_____

Age:_____ Date of Assessment:_____

Diagnosis With ICD-10 Code:_____

Treatment/Plan of Care:_____

_____

_____

PLEASE READ AND SIGN BELOW

I authorize Heart & Soul Community Counseling, Inc. to release a copy of this form to the health care provider named above. I further give permission to my Primary Care Provider Heart & Soul Community Counseling, Inc. to correspond with each other for the purpose of continuity and coordination of my care. I may revoke this authorization at any time, by submitting written notification. In the event that I revoke this permission, I must understand that Heart & Soul Community Counseling, Inc. may discharge me from this practice.

Client Signature:_____ Date:_____

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HIPAA Authorization to Release and/or Exchange Information

Client Name:_____ DOB:_____

Address:_____

I authorize the use or disclosure of my health information as described below:

1. Description of health information that may be used or disclosed

   _____Complete Medical Records _____Admission/Discharge
   _____Summaries _____Plan of Care _____Treatment Notes
   _____Other (specify)_____

2. Name of person/organization that may use/disclose information to/from Heart & Soul Community Counseling, Inc.

   Name:_____

   Address:_____

   Phone: (_____)_____ Fax: (_____)_____

3. The purpose for which the information will be used or disclosed: (the purpose may be stated as "at the request of the individual" if the individual initiates this authorization and does not provide a statement of purpose)

   _____
   _____
   _____

I understand that I may revoke this authorization at any time, except to the extent the person/organization obtaining the authorization has already taken action in reliance on it by Heart & Soul Community Counseling, Inc. in writing to express such revocation

By signing below, I acknowledge that I have read and understood this authorization and that it will continue for the duration of my treatment with Heart & Soul Community Counseling, Inc.

Signature:_____ Date:_____

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I, _____, hereby grant Heart & Soul Community Counseling, Inc. permission to speak with the following individuals regarding healthcare information that is necessary for my care and/or follow-up care. The information shared with the individual(s) identified below will be limited to only the information that is relevant to that individual's involvement in my care.

1. Name:_____ Relationship:_____

   Phone Number: (_____)_____

2. Name:_____ Relationship:_____

   Phone Number: (_____)_____

3. Name:_____ Relationship:_____

   Phone Number: (_____)_____

Client Signature: _____ Date: _____

Attention Heart & Soul Clients

Please be aware that Heart & Soul Community Counseling, Inc. has a cancellation/missed appointment policy. ***If you fail to cancel your appointment with at least 24 hours' notice or fail to show up to your scheduled appointment, your credit card will be charged a fee of $90.*** This fee will be waived **only** if you can prove that you could not make your appointment due to an emergency.

Please provide your credit card information below:

Card Number: _____

Expiration Date: _____

CVV (3-digit code on the back of the card): _____

Zip Code: _____

By signing this form, I grant Heart & Soul Community Counseling, Inc. permission to charge my credit card if I fail to cancel my appointment with at least 24 hours' notice or if I fail to show up to my scheduled appointment.

Name: _____ Date: _____

Signature: _____