INITIAL EVALUATION

PERSONAL DATA

Client Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Date of Birth _____

Occupation _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Education Level Completed _____ Other Training _____

_____

Insurance _____ Plan _____ Member ID # _____

MARRIAGE & FAMILY INFORMATION

Spouse Name _____ Address _____

Phone _____ Occupation _____

Is your spouse willing to come in to counseling? ☐ Yes ☐ No ☐ Not sure

Have you ever separated? ☐ Yes ☐ No Dates of Separation _____

Have either you filed for divorce? ☐ Yes ☐ No Date of Divorce _____

Date of Marriage _____ Any Prior Marriages? ☐ Yes ☐ No Dates of Prior Marriage _____

List Children and Ages _____

EMERGENCY CONTACT

Contact Name _____ Relationship _____ Phone _____

RELIGIOUS BACKGROUND

Is faith an important part of your life _____ Are you interested in christian counseling services _____

HEALTH HISTORY

List all important present or past illnesses, injuries or handicaps _____

_____

Family Physcian Name & Address _____

Phone _____

Date of Last Medical Exam _____ Known Allergies _____

CURRENT MEDICATIONS

CONDITION	MEDICATION	DOSE (mg)	FREQUENCY	DURATION	COMPLIANT	START DATE	EFFECTIVE
					☐YES ☐NO		☐YES ☐NO

PREVIOUS TREATMENT EXPERIENCE

Level of Care: In - Patient / Out - Patient / Day Program / Intensive Outpatient

DATE	PROVIDER	LEVEL OF CARE	DURATION	CONDITION (MH/SA)	OUTCOME

FAMILY HISTORY

Is there any history of mental health or substanmce abuse diagnoses in your family? ☐ **Yes** ☐ **No** ☐ **Unknown**

(If yes, place an X in the appropriate box below and specify mental health diagnoses, if known, e.g. depression, anxiety etc.)

DIAGNOSES	MOTHER	FATHER	SIBLINGS	CHILDREN	SPOUSE / SO	OTHER
Mental Health						
Substance Abuse						

ADULT SCREENING

Name _____ Age _____ Date _____

PLEASE CHECK THE APPROPIATE RESPONSE AS FELT DURING THE LAST TWO TO THREE WEEKS

FEELINGS	NEVER OR RARE 0	SOMETIMES 1	OFTEN 2	ALMOST ALWAYS 3
I feel sad				
I feel like a failure				
I have lost interest in my work				
I do not look forward to the future				
I feel guilty				
I have lost interest in my hobbies				
I feel that others do not like me				
I am unhappy with myself				
I doubt my own judgment				
I am easily frustrated				
I wish I were dead				
I feel lonely				
I avoid being around people				
My eating patterns have changed ie overeating or loss of appetite				
I have suicidal thoughts				
I deserve to be punished				
I have difficulty making decisions				
I feel emotionally shut down				
I feel worn out				
I feel worthless				
I am not interested in sex				
I feel hopeless				
I blame myself for other peoples problems				
I feel spiritually dead				
I have difficulty paying attention				
TOTAL SCORES ▶				

Sum Total of Scores _____

INFORMATION AND CONSENT FOR COUNSELING

I. Client Agreement/Contract

I Geannine LeBude desire to work with clients who have the capacity to resolve their own challenges with my assistance. Some clients need only a few counseling sessions to achieve these goals, while others may require months or years of counseling. As a client, you have the right to end our counseling relationship at any point. If counseling is successful, you should feel that you are able to face your immediate challenges.

I will keep confidential anything that you say with the following exceptions: (1) you direct me to tell someone else, (2) we determine that you are a danger to yourself or others, or (3) I am ordered by a court to disclose information. Also, (4) it is mandatory that I report child abuse.

Sessions are approximately 45 minutes in duration. Please note that it is impossible to guarantee any specific results regarding your counseling goals. I will help you identify your issues, but it is up to you to do the work. Together we will work to achieve the best possible results for you.

II. Legal Issues

If you are in the midst of any type of legal issue such as litigation, a dispute with your employer, separation or divorce, please inform me immediately. Please be aware that in custody cases, I typically need signed permission from both parents, and that medical records are frequently subpoenaed when litigation is involved. - PLEASE NOTE: I do not write any reports or asssesments for the courts or attorneys.

III. Payment Policy

I agree to provide counseling services for you in return for a fee. The fee for each session will be due at the time of service. Cash and personal checks are acceptable for payment. There is a $25.00 service charge for all returned checks. I will provide you with a receipt for all fees paid if you would like. Check with your insurance company to determine if your coverage honors outpatient counseling provided by me. Please note that many insurance companies require surveys that request information about symptoms, diagnosis, and treatment. By using insurance you are granting permission for me to communicate confidential information to your insurance company. Please remember that I have no control of, or responsibility for how information is handled once it is released to third parties. If you are using your insurance, and that insurance provider changes, or your copay changes, please let me know as soon as possible.

IV. Cancellation/Office Hours

In the event that you will not be able to keep an appointment, you must notify me 24 hours in advance. If I do not receive such advance notice, you will be responsible for paying a $50.00 cancellation fee (not covered by insurance).
My voice mail & email is available 24 hours a day in order for you to leave a message.

V. Emergencies

I cannot assume responsibility their client's day to day functioning, as some more intensive treatments are designed to do. It is the responsibility of the client to discuss expectations of after-hours care with the therapist upon intake so that, if necessary, an appropriate referral can be made. In the case of an emergency, when a client fears harm to him/herself or another, please dial 911 or go to your nearest emergency room, as this is not an emergency facility.

My signature below indicates that I grant consent for Geannine M. LeBude LCSW to provide counseling to myself and/or minor members of my family. I also acknowledge that I have received a copy of *Client Rights and Responsibilities*, and *Crisis / Emergency Procedures.*

Client / Guardian Signature _____ Date _____

Therapist _____ Date _____

VI. To Parents of Teenagers

I understand the need for confidentiality between my teenager and his/her therapist and that confidentiality will be maintained unless the therapist determines that my teenager is a danger to self or others.

Parent / Guardian Signature _____ Date _____

VII. Insurance Assignment

I, the undersigned, have insurance coverage with _____ and assign directly to Geannine M. LeBude, LCSW all medical benefits. If my insurance company does not cover for any reason, I agree that I am financially responsible for all charges. I also hereby authorize Geannine M. LeBude, LSCW to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that all services provided outside of my therapy session, which are not covered by insurance, will be billed separately.

Client / Guardian Signature _____ Date _____

INFORMED CONSENT ADDENDUM FOR TELEHEALTH

Online therapy or teletherapy is defined as the use of technology to have a therapy session. We will use thera-LINK, a HIPAA compliant platform that uses video and audio technology through a webcam on your device and my device to connect us securely.

thera-LINK uses encrypted data streams (AES-256) for our video sessions. Any data that is stored outside of our video session on the thera-LINK platform (such as documents, messages, or progress notes) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session.

Please list your main number and an alternate number here: _____

If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.

Consent to Treatment

I, voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Geannine LeBude LCSW to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Geannine LeBude LCSW at any time. I understand Geannine LeBude LCSW will determine on an on-going basis whether the condition being assessed and / or treated is appropriate for online therapy.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Patient / Client Signature _____ Date _____

Parent, Guardian or Legal Representative Signature _____ Date _____
(if minor or needed otherwise)

Health Insurance Portability and Accountability Act (HIPAA) - PRIVACY NOTICE

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.

In this Privacy Notice, "medical information" and "psychological information" mean the same as "health information."

Health information includes any information that relates to:

1) your past, present, or future physical or mental health or condition;

2) providing health care to you; or

3) the past, present, or future payment for your health care.

PROTECTING YOUR PRIVACY

Counselors must always manage psychological records with great concern for privacy and confidentiality. I am required by law to protect the privacy of your health information. This means that I will not use or disclose your health information without your authorization except in the ways I tell you in this notice. If I wish to use or disclose your health information in ways other than those stated in this notice, I will ask you for your written authorization. If you give such an authorization, you may revoke it at any time, but I will not be liable for uses or disclosures made before you revoked your authorization.

Although the security of psychological records has continuously been addressed by Counseling Codes of Ethics as well as by State and Federal laws, the rules have been considerably strengthened by the provisions of the Health Insurance Portability and Accountability Act (HIPAA).

The following information provides details about the provisions of HIPAA and your rights concerning privacy and your psychological records.

Who will observe these rules?

In my practice, the following individuals are required by HIPAA to comply with the privacy rules:

- Me and any practice staff such as office manager/scheduler, etc..
- Any billing agency or collection agency that handles information about you (name and address, diagnostic codes, treatment codes, and consultation dates...but not actual clinical records)

YOUR RIGHTS REGARDING PSYCHOLOGICAL INFORMATION ABOUT YOU

1. The Right to Inspect and Obtain a Copy of Your Psychological Record

Professional records constitute an important part of the therapy process and help with the continuity of care over time. According to the rules of HIPAA, your consultations are documented in two ways: 1) The Clinical Record (required), which includes the date of your consultations, your reasons for seeking therapy, your diagnosis, therapeutic goals, treatment plan, progress, medical and social history, treatment history, functional status, any past records from other providers, and any reports to your insurance carrier; and 2) Psychotherapy Notes (optional), which consist of specific content or analyses of therapy conversations (some of which may include sensitive information you have revealed that is not required to be included in your Clinical Record) and therapist's notes that may assist in treatment. Psychotherapy Notes, if created, are never disclosed to third parties, HMOs, insurance companies, billing agencies, patients, or anyone else. If your case manager or insurance company requests to see the psychotherapy notes, you have a choice about consenting (signing a Release of Information form) or denying access to them. If you refuse, it will not affect your coverage or reimbursement in any way, and your insurance company or HMO is obliged to provide payment, as usual.

2. The Right to Request a Correction or Add an Addendum to Your Psychological Record Correction

3. The Right to an Accounting of Disclosures of Your Psychological Information to Third Parties

4. The Right to Request Restrictions on How Your Information is Used

5. The Right to Request Confidential Communications

6. The Right to a Copy of This Notice upon Request

7. The Right to Withdraw Permission to Disclose Health Information

8. The Right to File a Complaint

You have the right to file a complaint if you believe your privacy rights have been violated. Complaints must be filed in writing, and may be addressed directly to your therapist, or to the Secretary of the Department of Health and Human Services (address: Office for Civil Rights, 200 Independence Ave., S.W. Washington, DC 20201). If you have any questions or concerns about this notice or your health information privacy, please do not hesitate to address them during session or contact my office by telephone.

9. The Right to be Notified if There is a Breach of Your Unsecured PHI

You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

10. The Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket -

You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for services.

_____ _____

My signature above represents that I have read and understand my rights under HIPAA. Date

MAGELLAN HEALTH SERVICES
MEMBER'S RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

MEMBERS HAVE THE RIGHT TO:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand, and free of charge.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- If asked, Magellan will act on the member's behalf as an advocate.*
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.
- Receive information about Magellan's staff qualifications and any organization Magellan has contracted with to provide services.*
- Decline participation or withdraw from programs and services.*
- Know which staff members are responsible for managing their services and from whom to request a change in services.*

Statement of Members' Responsibilities

MEMBERS HAVE THE RESPONSIBILITY TO:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let Magellan and their provider know if they decide to withdraw from the program.*

* This standard is required for our Condition Care Management (CCM) products.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Member Signature _____ Date _____

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Provider Signature _____ Date _____

PATIENT CARE COMMUNICATION FORM

Physician's Name _____ Telephone Number _____

Address _____

Dear Doctor _____

Your Patient _____ was recently referred by _____

We hope that the following information will be helpful in coordinating this patient's care.

Date of Initial Consultation _____ Date of Next Appointment: _____

Diagnoses and / or Presenting Problems _____

_____

_____

Treatment Recommendations _____

_____

_____

Medications _____

_____

Please call if further information would be helpful.

Geannine M. LeBude LCSW
1930 East Marlton Pike Suite M-69
Cherry Hill, NJ 08003
Telephone Number: 856-874-9200

Sincerely,

_____

Clinician Signature

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 24 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate orprosecute any alcohol or drug abuse patient.

AUTHORIZATION

I, _____ hereby authorize Geannine M. LeBude LCSW

Print Patient's Name — Treating Clinician

To release any applicable mental health information to my primary care physician

Please Check One

- ☐ (PCP) named above.
- ☐ To release any applicable substance abuse information to my PCP named above.
- ☐ To release only medical information to my PCP named above.
- ☐ Not to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that the action has been taken in reliance upon it.
If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

Print Name of Patient or Guardian _____ ID No. _____ Date of Birth _____

Signature of Patient or Guardian _____ Date _____

CRISIS EMERGENCY PROCEDURE

Your counselor is dedicated to assisting you through difficult life transitions. To serve you in this capacity, your counselor offer individual, group, martial and family therapy facilitated by a masters level therapist. However, your counselor has limits in their ability to assist you. In particular cases, your counselor does not offer crisis services, such as 24-hour hotline or emergency sessions after regular hours. This means your counselor is typically unable to provide immediate responses to calls that come in after business hours.

PLEASE TAKE THE FOLLOWING STEPS IF YOU FIND YOURSELF IN A CRISIS SITUATION OR STRUGGLING IN SUCH A WAY THAT REQUIRES IMMEDIATE ATTENTION.

- If it is a medical emergency please call 911 first.
- Call the 24-hour crisis hotline in the country /city in which you reside.
- You can call 1-800-SUICIDE (784-2433) from anywhere in the U.S. toll free.

NEW JERSEY

Atlantic County 24 hours	609-344-1118
Burlington County	609-835-6180
Mercer County	800-273-8255
Camden County	855-654-6734
Camden County - Cherry Hill	856-428-4357
Gloucester County	856-845-9100