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.

We will not disclose your protected health information to third parties without your written authorization or other authority under the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (the Privacy Regulations). We are required by law to maintain the privacy of protected health information. Your written authorization and specific provisions of the Privacy Regulations govern disclosure of your protected health information. Disclosures not described in this and the next paragraph may be made only with your written authorization, which you may revoke in writing as provided in the Privacy Regulations. We are permitted under the Privacy Regulations to use and disclose protected health information for treatment, payment and health care operations. For example, protected health information may be disclosed from one staff member to another for consultation.

Subject to requirements of the Privacy Regulations, we may use and disclose protected health information for purposed of complying with legal requirements, public health activities, reporting abuse, neglect, and domestic violence, cooperation with health oversight by government agencies and as required by the Secretary of Health and Human Services for compliance with the Privacy Regulations: for judicial and administrative procedures: for law enforcement; with respect to decedents; with respect to serious threats to health or safety: specialized government functions; and incident to use or disclosure otherwise permitted or required by the Privacy Regulations. We may also disclose protected health information, pursuant to your agreement, to persons indicated by you for involvement in your health care and for notification purposes, which includes Health Insurance Carrier that is used for payment of treatment.

Missouri state laws with respect to genetic information and human immunodeficiency virus infection status are more stringent than the Privacy Regulations and protected health and information regarding these matters will be disclosed only in accordance with the governing Missouri statutes.

You have certain rights regarding the handling of your protected health information, as provided in the Privacy Regulations. These are as follows. You may request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a requested restriction. You may receive confidential communications of protected health information as provide by the Privacy Regulations, you may inspect and copy your protected health information, upon written request, subject to certain restrictions in the Privacy Regulations, such as a restriction on access to psychotherapy notes. You have the right to appeal a denial of access to your records. You may request an amendment of protected health and demographic information, upon written request, subject to certain limitations in the Privacy Regulations. You have the right to contest a denial of an amendment. You may receive an accounting of certain disclosures of protected health information. You may obtain a paper copy of this notice upon request.

You may complain to us and the Secretary of health and Human Services if you believe your privacy rights have been violated. If you wish to contact us for further information or to complain, please contact Sheilan Cook-Cornman, MA, LPC at 573-205-9662. We will not take any action against you for filing a complaint or for exercising your rights under the Privacy Regulations.

I_____, hereby acknowledge receipt from Diversified Therapy Services,
(please print)
LLC of the above Notice of Privacy Practices.

_____ _____
(signature) (date)

SHEILAN COOK-CORNMNA, MA, LPC
DIVERSIFIED THERAPY SERVICES, LLC

Appointments

Clients are seen by appointment only. Being on time for your appointment is appreciated, as is letting us know when you cannot keep an appointment. It is the counselor's option to charge for a missed appointment without 24 hours' notice of cancellation.

***Please provide a credit card number: _____

Expiration date: _____CVC: _____ Mailing address zip code related to this

card_____

This card is used if appointment has been missed without a 24-hour notice, and there is no prior contact of cancellation within the 24 hours. Any cancellation on the same day as the appointment, will be charged the session fee, unless therapist finds justifications for the absence. This card is also billed for any unpaid balances, unless prior payment arrangements have been made. Note: As a courtesy, every effort will be made to send a text message reminder the day before the client's appointment but, it is the clients responsibility to remember the appointment and contact their therapist if they are unable to keep the appointment as scheduled.

Payment for Services

Payment for counseling sessions is expected in full at the time of your session. If you are unable to make prompt payment, please discuss the matter with your counselor. Should your counselor be required to send you a billing statement due to your failure to pay at the time of your session, you will be charged $3.00 per statement sent to you. Checks returned due to insufficient funds will incur a $20.00 penalty. Should you default in payment and collection/legal action is required you will be responsible for any and all fees incurred. You are ultimately responsible for all charges incurred. Payment for services may be made via, cash, credit card, or money orders (personal checks are accepted with prior authorization). **Health Records or letter for proof of services will be charged at a fee of $50 per request. (Note: all request must have patient sign a release form).**

Court Appearances

Occasionally a client will request that Sheilan Cook-Cornman, MA, LPC testify on his/her behalf in court. Please note that it is Sheilan Cook-Cornman's policy to ***not*** make such appearances. If she is subpoenaed, your fee will be $150.00 per hour, with a minimum fee of $225.00, to be paid in advance of the court date. Should the court date be cancelled you will still be responsible for the payment of $225.00. **There are no exceptions to this policy**. **Depositions require a fee of $125.00; all written reports require a $50.00 fee.**

Emergencies/Call Backs

An emergency refers to a serious and urgent situation. Contacting your counselor should be reserved for emergencies. Every effort will be made to meet your needs, but you may also want to consider going to the nearest hospital for immediate assistance. Call backs are made throughout the day; from 10 am to 8 pm.

By my signature, I am agreeing to the above information.

_____ _____

Client Signature (or guardian) Date

CLIENT INFORMATION

Date_____SSN#_____Birthdate_____

Client Name_____
(First) (M.I.) (Last)

Address_____
(street, apt#, city, state, zip code)

_____

Gender: M F, Your Age:____:

(Please Circle One)
Marital Status: Married Widowed Single Divorced Separated

Occupation_____Employer/School_____

What is the highest grade you completed? _____

Spouse's Name_____Spouse's Birthday_____

Spouse's Employer_____

Name of Client's Physician and Telephone #_____

Whom may we thank for referring you?_____

Phone Numbers

Home_____cell_____email address_____

May Sheilan Cook, MA, LPC Text you? Y N Email you? Y N

Emergency Contact: Name_____Relationship_____

Home phone_____cell_____work_____

Medical and Family History

Date of last physical exam_____.

Has client ever been under the care of a…
( ) psychiatrist?
If yes when? _____where? _____
( ) psychologist
When? _____where? _____
( ) counselor?
When? _____where? _____

What were your symptoms? Diagnoses given?

Have you ever been hospitalized for a psychiatric condition? If yes when? Was there a diagnosis given?

Has there been any trauma in your life? If so, can you briefly explain? (who was involved? What age were you?)

Medications and Dosages, you are currently taking: **what is the purpose of this medication**? Please use the back if needed.

1._____

2._____

3._____

4._____

5._____

6._____

Are there any medical conditions? (diabetes, asthma, thyroid conditions etc.)

Is there any substance or alcohol abuse with you are your family? If so, who and how long?

How May I Help You?

1. Briefly state the situation that brought you to counseling at this time. How long has this been going on? How often do you have these symptoms?

2. What goals would you like to accomplish through counseling?

3. What strengths or positive assets (personal, family, spiritual, or community) do you bring to your situation?

PLEASE CIRCLE THE ANSWERS TO THE FOLLOWING QUESTIONS

- Are you experiencing physical problems for which you are not being treated? Y N
- Do you use tobacco? Y N
- Have you ever received treatment for alcohol or drug abuse? Y N
- Do you have more than two alcoholic drinks per day? Y N
- Do you currently participate in drug activity? Y N
- Are you currently taking any medication for emotional problems? Y N
- Do you exercise at least three times per week? Y N

If yes to any of the above questions, please explain.

PLEASE CIRCLE ALL ANSWERS THAT APPLY TO THE FOLLOWING QUESTIONS

Was there any incidence of the following **with you or your family**?

- Verbal Abuse? How old were you when this started? _____

  Who was abused? _____

  Who was the abuser? _____

- Physical Abuse? How old were you when this started? _____

  Who was abused? _____

  Who was the abuser? _____

- Sexual Abuse? How old were you when this started? _____

  Who was abused? _____

  Who was the abuser? _____

- Alcohol or Drug Abuse? How old were you when this started? _____

  Who was abused? _____

  Who was the abuser? _____

- Suicide Attempt? How old were you when this happened? _____

  Who?_____When? (date/s)_____

  Who?_____When? (date/s)_____

Please list all arrest as well as convictions and if you are on probation (both juvenile and adult). Use the back side of form to add additional charges.

YEAR CITY/STATE CHARGE OUTCOME

1._____

2._____

3._____

Is your father living? Y N What is/was your relationship like with your father?

If passed…what year and how old were you?

Is your mother living? Y N What is/was your relationship like with your mother?

If passed…what year and how old were you?

Were your parents married throughout your childhood?

If they were never married, how old were you when they separated? _____

If never married, did they live together while you were growing up? _____

If they divorced, how old were you? _____

Stepmom living? Y N What is/was your relationship like with your stepmom?

Stepfather living? Y N What is/was your relationship like with your stepfather?

Do you have siblings? If so, what is your relationship like with them? (Please list first name and age of sibling)

Has there been any diagnosis of mental illness within your immediate family (ex. Bipolar, Depression, Schizophrenia, etc.)? If so, what was/were the diagnosis and whom?

Who lives in your household? (Name, age, relationship with client)

1._____

2._____

3._____

4._____

5._____

6._____

Your Children NOT living in your household? Age?

1._____

2._____

3._____

4._____