EMERGE
COUNSELING SERVICES

Dear EMERGE Client,

Thank you for entrusting EMERGE Counseling Services to assist with your concerns. Our team of clinical and administrative professionals desire to provide you with the highest quality Christian mental health services.

To help us best serve you, **please thoroughly review and complete the attached documents and be sure to note any questions you have about the contents. Thank you for completing these documents prior to scheduling your first appointment.**

PLEASE NOTE: For **Minor Clients** (under the age of 18), a Parent/Legal Guardian is required to accompany their child and remain onsite during the child's first appointment. Please check with the clinician for the need of your ongoing involvement in the therapeutic process in subsequent sessions.

Current Custody Documents are required if the client is a minor with divorced parents or if the client is under the care of a guardian or Children's Services. This helps us to appropriately determine consent for care and access to confidential information. Please submit the full document along with the below forms.

Form A - HISTORY FORM - Please print one for each individual seen at EMERGE. For minors, you will need to complete the Child/Adolescent version.

Form B - NOTICE OF PRIVACY PRACTICES -This brochure outlines important information regarding the privacy of your health information. Please review prior to your first appointment.

Form C - FINANCIAL RESPONSIBILITY FORM - This form outlines any payment arrangements that have been established.

Additional items that are very important to bring to your first appointment:

- **Insurance cards** for all health plans in which you participate if you plan to access your health insurance benefits.
- **Additional materials** you feel may be helpful to your clinician (e.g. reports, test results from schools, medical and/or mental health professionals, legal documents).
- **Your treatment goals.** How can we best serve you?
- **Your calendar/mobile device** for scheduling appointments.

Should you need to cancel your session, please contact EMERGE Counseling Services as soon as possible (330-867-5603, option 3) so that we may reschedule you. **A 24 hour notice avoids a late cancellation fee.**

Please know that we desire to be helpful to you and to make your experience at EMERGE Counseling Services as beneficial and pleasant as possible. We always welcome your feedback and look forward to a productive and successful relationship. May God richly bless you!

Client Registration Team
EMERGE Counseling Services
330-867-5603 ext 3
intake@emerge.org

HEALTH HISTORY QUESTIONNAIRE

Name: _____ SS # _____
Age: _____ Date: _____

MEDICATION ALLERGIES _____
OTHER ALLERGIES _____
REACTION TO ALLERGIES _____

Please check all conditions that currently or have previously applied.

- ☐ Problems with vision
- ☐ Wear glasses
- ☐ Headaches
- ☐ Problems with hearing
- ☐ Use of a hearing aid
- ☐ Lung problems
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Stomach problems
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Dizziness
- ☐ Heart disease
- ☐ Chest pain
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Other hormone problems
- ☐ Problems with sense of smell
- ☐ Problems swallowing
- ☐ Swelling in feet, ankles, legs
- ☐ Problems with sexual functioning
- ☐ Currently pregnant
- ☐ Abortions/Miscarriages
- ☐ Menstrual problems…Date of last menstrual period _____
- ☐ Joint pain
- ☐ Arthritis
- ☐ Urinary problems
- ☐ Seizures
- ☐ Weight gain Amount _____ In what period of time _____
- ☐ Weight loss Amount _____ In what period of time _____
- ☐ Problems with appetite
- ☐ Trouble sleeping

- ☐ Check if you drink alcohol
  Type _____
  How often _____
  How much _____
  Age first used _____
  Most recent use _____
- ☐ Check if you use tobacco
  Type _____
  How much _____
  How often _____
  How long _____
- ☐ Check if you use drugs other than prescribed for you
  Type _____
  How much _____
  How often _____
  First use _____
  Last use _____
- ☐ Check if you have a history of IV drug use or sharing needles

List any medical illness for which you are presently or have previously been treated _____

_____

Date of last physical exam _____ Where _____

List current prescribed medications, including dose and frequency, that you are taking _____

_____

_____

_____

_____

_____

CHILD AND ADOLESCENT HISTORY QUESTIONNAIRE

Please bring this completed form with you at the time of your first appointment at EMERGE Counseling Services. Thank you for your investment of time. This information will help us to give the best care possible.

Date you completed this form: _____
Person who completed this form: _____
Relationship to child: _____

It is preferable that both parents accompany the child to the first consultation, if possible.

Child's name _____ Birthdate _____ Age ____ Sex ____
last first middle

Home address _____
street city state zip

Home telephone number _____

Emergency Contact _____ Telephone _____

Child's school _____ Telephone _____
Name

_____ Grade _____
Address

Child's living situation (place check in appropriate box):

	Column A Adults with whom child is living	Column B Non-residential adults involved with child
Natural mother	☐ ___	☐ ___
Natural father	☐ ___	☐ ___
Stepmother	☐ ___	☐ ___
Stepfather	☐ ___	☐ ___
Adoptive mother	☐ ___	☐ ___
Adoptive father	☐ ___	☐ ___
Foster mother	☐ ___	☐ ___
Foster father	☐ ___	☐ ___
Other (specify) _____	___	_____ ___

Place the number 1 next to the child's primary residential caregiver (Column A above) and provide the following information:

1. Name _____ Occupation _____

   Business name _____ Business phone # _____

   Business Address _____

Client Name _____

Place the number 2 next to the child's secondary residential caregiver (Column A above) and provide the following information:

2. Name _____ Occupation _____

   Business name _____ Business phone # _____

   Business Address _____

Place the number 3 next to the person checked in Column B who is most involved with the child and provide the following information:

3. Name _____ Home phone # _____

   Home address _____

   Occupation _____Business name _____

   Business address _____ Business phone no. _____

If primary caregivers work outside the home, who cares for the child when caregivers are away?

_____

How many hours per week is this child in this child-care setting: _____

If child was adopted, how old when s/he was adopted? _____

If child is or was in foster care, describe number and quality of placements, along with length of time in each (please, use separate sheet of paper and attach).

Who referred you to EMERGE? Name _____

Address _____

_____ Phone no. _____

Pediatrician or family doctor _____

Address _____

Phone # _____ Date of last appointment _____

Reason for appointment _____

Why are you seeking counseling for this child now? (brief summary of the main problems, please include when the problems began and how long each lasted):

_____

_____

_____

_____

_____

Client Name _____

PREGNANCY

Duration of pregnancy _____ weeks

Complications:
❑ Excessive vomiting ❑ Hospitalization required

❑ Excessive staining or blood loss ❑ Threatened miscarriage

Infection(s) (specify) _____

❑ Toxemia ❑ Operation(s) (specify) _____

Other illness(es) (specify) _____

❑ Smoking during pregnancy Average number of cigarettes per day _____

❑ Alcohol consumption during pregnancy

Describe what and how often _____

❑ Drugs taken during pregnancy (please specify if prescriptions) _____

_____

❑ X-ray studies during pregnancy _____

DELIVERY

Mother's age at birth: _____ Father's age at birth: _____
Type of labor: ❑ Spontaneous ❑ Induced _____ Forceps: ❑ high ❑ mid ❑ low
Duration of labor: _____ hours Caesarean delivery ❑ Yes ❑ No

Complications:
❑ Cord around neck ❑ Cord presented first ❑ Hemorrhage ❑ Infant injured during delivery
Other (specify) _____

Birth weight _____
❑ Appropriate for gestational age (AGA) ❑ Small for gestational age (SGA)

Mother's condition at birth _____

Child's condition at birth _____

POST-DELIVERY PERIOD (while in the hospital)

Respiration: ❑ immediate ❑ delayed (if so, how long) _____

Cry: ❑ immediate ❑ delayed (is so, how long) _____

❑ Mucus accumulation ❑ Apgar score (if known) _____ ❑ Jaundice

Rh factor _____ ❑ transfusion ❑ Cyanosis (turned blue)
❑ Incubator care Number of days _____ Oxygen given? _____ How long? _____
Suck: ❑ strong ❑ weak

Infection (specify) _____
❑ Vomiting ❑ Diarrhea

Client Name _____

Birth defects (specify) _____

Total number of days baby was in the hospital after the delivery _____

INFANCY-TODDLER PERIOD

Were any of the following present to a significant degree during the first few years of life? If so, describe.

- ❑ Did not enjoy cuddling
- ❑ Was not calmed by being held and/or stroked
- ❑ Colic
- ❑ Excessive restlessness
- ❑ Diminished sleep because of restlessness and easy arousal
- ❑ Frequent headbanging
- ❑ Constantly into everything
- ❑ Excessive number of accidents compared to other children

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall, check item at right.

	Age	I cannot recall exactly, but to the best of my recollection it occurred early	at the normal time	late
Smiled				
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Spoke first words besides "ma-ma" and "da-da"				
Said phrases				
Said sentences				
Bowel trained, day				
Bowel trained, night				
Bladder trained, day				
Bladder trained, night				
Rode tricycle				
Rode bicycle (without training wheels)				
Buttoned clothing				
Tied shoelaces				
Named colors				
Named coins				
Said alphabet in order				
Began to read				

COORDINATION

Rate your child on the following skills:	Good	Average	Poor
Walking	❑	❑	❑
Running	❑	❑	❑
Throwing	❑	❑	❑
Catching	❑	❑	❑
Shoelace tying	❑	❑	❑
Buttoning	❑	❑	❑
Writing	❑	❑	❑
Athletic abilities	❑	❑	❑

Client Name _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? _____ If not, why not? _____

_____

How would you rate your child's overall level of intelligence compared to other children?
❑ below average ❑ average ❑ above average

SCHOOL

Rate your child's school experiences related to academic learning.

	Good	Average	Poor
Nursery school	❑	❑	❑
Kindergarten	❑	❑	❑
Current grade	❑	❑	❑

To the best of your knowledge, at what grade level is your child functioning:
Reading _____ Spelling _____ Arithmetic _____

Has your child ever had to repeat a grade? If so, when? _____

Present class placement: ❑ regular class ❑ special class (if so, specify) _____

_____

Kinds of special therapy or remedial work your child is currently receiving at school:

_____

_____

Describe briefly any academic school problems _____

_____

_____

Do you have concerns about the quality of your child's school or teacher? _____

_____

_____

Rate your child's school experience related to behavior:

	Good	Average	Poor
Nursery school	❑	❑	❑
Kindergarten	❑	❑	❑
Current grade	❑	❑	❑

Does your child's teacher describe any of the following as significant classroom problems?

- ❑ Doesn't sit still in his or her seat
- ❑ Frequently gets up and walks around the classroom
- ❑ Shouts out. Doesn't wait to be called upon.
- ❑ Won't wait his or her turn.
- ❑ Does not cooperate well in group activities
- ❑ Typically does better in a one-to-one relationship
- ❑ Doesn't respect the rights of others
- ❑ Doesn't pay attention during storytelling

Describe briefly any other classroom behavioral problems _____

_____

_____

Client Name _____

PEER RELATIONSHIPS

- ☐ My child seeks friendships with peers.
- ☐ My child is sought by peers for friendship.
- ☐ My child plays primarily with children his or her own age.
- ☐ My child plays primarily with younger children.
- ☐ My child plays primarily with older children.

Describe briefly any problems your child may have with peers. _____

_____

_____

HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

- ☐ Hyperactivity (high activity level)
- ☐ Poor attention span
- ☐ Impulsivity (poor self-control)
- ☐ Low frustration tolerance
- ☐ Temper outbursts
- ☐ Sloppy table manners
- ☐ Interrupts frequently
- ☐ Doesn't listen when being spoken to
- ☐ Sudden outbursts of physical abuse of other children
- ☐ Acts like he or she is driven by a motor
- ☐ Wears out shoes more frequently than siblings
- ☐ Heedless to danger
- ☐ Excessive number of accidents
- ☐ Doesn't learn from experience
- ☐ Poor memory
- ☐ More active than siblings or peers

Most children exhibit, at one time or another, one or more of the symptoms listed below. Place a P next to those that your child has exhibited in the PAST and an N next to those that your child exhibits NOW. Only mark those symptoms that have been or are present to a significant degree over a period of time. Only check as problems behavior that you suspect is unusual or atypical when compared to what you consider to be the normal for your child's age. Then, on pages 8-9, list the symptoms checked off on pages 6-8 and write a brief description including age or onset, duration, and any other pertinent information.

___ Thumb sucking

___ Baby talk

___ Overly dependent for age

___ Frequent temper tantrums

___ Excessive silliness and clowning

___ Excessive demands for attention

___ Cries easily and frequently

___ Generally immature

___ Eats non-edible substances

___ Overeating with overweight

___ Eating binges with overweight

___ Undereating with overweight

___ Long periods of dieting and food abstinence with underweight

___ Preoccupied with food—what to eat and what not to eat

___ Preoccupation with bowel movements

___ Constipation

___ Encopresis (soiling)

___ Insomnia (difficulty sleeping)

___ Enuresis (bed wetting)

___ Frequent nightmares

Client Name _____

___ Night terrors (terrifying night-time outbursts)
___ Sleepwalking
___ Excessive sexual interest and preoccupation
___ Frequent sex play with other children
___ Excessive masturbation
___ Frequently likes to wear clothing of the opposite sex
___ Exhibits gestures and intonations of the opposite sex
___ Frequent headaches
___ Frequent stomach cramps
___ Frequent nausea and vomiting
___ Often complains of bodily aches and pains
___ Worries over bodily illness
___ Poor motivation
___ Apathy
___ Takes path of least resistance
___ Tries to avoid responsibility
___ Poor follow-through
___ Low curiosity
___ Open defiance of authority
___ Blatantly uncooperative
___ Persistent lying
___ Frequent use of profanity to parents, teachers, and other authorities
___ Truancy from school
___ Runs away from home
___ Violent outbursts of rage
___ Stealing
___ Cruelty to animals, children, or others

___ Destruction of property
___ Criminal and/or dangerous acts
___ Trouble with the police
___ Violent assault
___ Fire setting
___ Little, if any, guilt over behavior that causes others pain and discomfort
___ Little, if any, response to punishment for anti-social behavior
___ Few, if any, friends
___ Doesn't seek friendships
___ Rarely sought by peers
___ Not accepted by peer group
___ Selfish
___ Doesn't respect the rights of others
___ Wants things own way with exaggerated reaction if thwarted
___ Trouble putting self in other person's position
___ Egocentric (self-centered)
___ Frequently hits other children
___ Argumentative
___ Excessively critical of others
___ Excessively taunts other children
___ Complains often
___ Is often picked on and easily bullied by other children
___ Suspicious, distrustful
___ Aloof
___ "Wise-guy" or smart aleck attitude
___ Brags or boasts

___ Bribes other children
___ Excessively competitive
___ Often cheats when playing games
___ "Sore loser"
___ "Doesn't know when to stop"
___ Poor common sense in social situations
___ Often feels cheated or treated unfairly
___ Feels others are persecuting him/her when there is no evidence for such
___ Typically wants her or his own way
___ Very stubborn
___ Obstructionistic
___ Negativistic (does just the opposite of what is requested)
___ Quietly or silently defiant of authority
___ Feigns or verbalizes compliance or cooperation but doesn't comply with requests
___ Drug use
___ Alcohol use
___ Very tense
___ Nail biting
___ Chews on clothes, blankets, etc.
___ Head banging
___ Hair pulling
___ Picks on skin
___ Speaks rapidly and under pressure
___ Irritable, easily "flies off the handle"
___ Anxiety attacks with palpitations (heart pounding), shortness of breath, sweating, etc.

Client Name _____

FEARS

___ dark
___ new situations
___ strangers
___ being alone
___ death
___ separation from parent
___ school
___ visiting other children's homes
___ going away to camp
___ animals
___ other fears (name) _____

___ Disorganized
___ Tics such as eye-blinking, grimacing, or other spasmodic repetitious movements
___ Involuntary grunts, vocalizations (understandable or not)
___ Stuttering
___ Depression
___ Frequent crying spells
___ Excessive worrying over minor things
___ Suicidal preoccupation, gestures, or attempts
___ Excessive desire to please authority
___ "Too good"
___ Often appears insincere and/or artificial
___ Too mature, frequently acts older than actual age
___ Excessive guilt over minor indiscretions
___ Asks to be punished
___ Low self-esteem
___ Excessive self-criticism
___ Very poor tolerance of criticism
___ Feelings easily hurt
___ Dissatisfaction with appearance or body part(s)
___ Excessive modesty over bodily exposure
___ Perfectionistic, rarely satisfied with performance
___ Frequently blames others as a cover-up for own shortcomings
___ Little concern for personal appearance or hygiene
___ Little concern for or pride in personal property
___ "Gets hooked" on certain ideas and remains preoccupied
___ Compulsive repetition of seemingly meaningless physical acts
___ Shy
___ Inhibited self-expression in dancing, singing, laughing, etc.
___ Recoils from affectionate physical contact
___ Withdrawn
___ Fears asserting self
___ Inhibits open expression of anger
___ Allows self to be easily taken advantage of
___ Frequently pouts and/or sulks
___ Mute (refuses to speak) but can
___ Gullible and/or naïve
___ Passive and easily led
___ Excessive fantasizing, "lives in her/his own world"
___ Flat emotional tone
___ Speech noncommunicative or poorly communicative
___ Hears voices
___ Sees visions

As requested, please first list below symptoms from list above marked with the letter P (for past) and next to each symptom give descriptive information such as when symptom began, how long it lasted, and other important data. Then list symptoms marked with an N (for now) and provide similar information.

P or N	Symptom	Brief Description
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____

Client Name _____

P or N	Symptom	Brief Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY SPIRITUAL HISTORY

Attend church? ❑ Yes ❑ No
If yes, denomination _____
Level of involvement of parents _____
Level of involvement of child _____
Attitude of client toward God _____
Attitude of client toward church _____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? _____
_____

What are your child's areas of greatest accomplishment? _____
_____

What does your child enjoy doing most? _____
_____

What does your child dislike doing most? _____
_____

What are your child's greatest strengths? _____
_____

What are your child's weaknesses? _____
_____

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe any complications) _____
_____
_____

Client Name _____

Operations _____

_____

Hospitalizations for illness(es) other than operations _____

_____

Head injuries _____

_____ with unconsciousness _____ without unconsciousness

Convulsions _____

_____ with fever _____ without fever

Coma _____

Meningitis or encephalitis _____

Immunization reactions _____

Persistent high fevers _____ Highest temperature ever recorded _____

Eye problems _____

Ear problems _____

Poisoning _____

PRESENT MEDICAL STATUS

Present height _____ Present weight _____

Present illness(es) for which child is being treated _____

_____

Medications child is taking on an ongoing basis _____

_____

Allergies to medication: _____

_____

Allergies to food: _____

_____

Other allergies: _____

FAMILY HISTORY—MOTHER

Age _____ Age at time of pregnancy with client _____

Number of previous pregnancies ____ Number of spontaneous abortions (miscarriages) ____

Number of induced abortions ____

Fertility problems (specify) _____

School: Highest grade completed _____

Learning problems (specify) _____ grade repeat _____

Behavior problems (specify) _____

Medical problems (specify) _____

Client Name _____

Have you or any of your blood relatives (not including client and siblings) ever had problems similar to those your child has? If so, describe. _____

_____

FAMILY HISTORY—FATHER

Age _____ Age at time of client's conception _____

Fertility problems (specify) _____

School: Highest grade completed _____
Learning problems (specify) _____ grade repeat _____
Behavior problems (specify) _____

Medical problems (specify) _____

Have you or any of your blood relatives (not including client and siblings) ever had problems similar to those your child has? If so, describe. _____

_____

SIBLINGS

	Name	Age	Medical, social, or academic problem
1.			
2.			
3.			
4.			
5.			

FAMILY EMOTIONAL/PSYCHOLOGICAL HISTORY (Include extended family members, such as aunts, uncles, cousins, grandparents, etc.):

Has the child had previous outpatient psychotherapy? ❑ Yes ❑ No
If yes, by whom and for how long? _____
Name Telephone

_____
Address

Length and frequency of treatment: _____

What was the diagnosis and outcome? _____

_____

Has any family member had outpatient psychotherapy? ❑ Yes ❑ No

If yes, what is relationship to child and why did this person seek treatment? (list all):

_____

_____

Has the child had previous inpatient treatment? ❑ Yes ❑ No

If yes, how many times? _____ How long was the longest stay? _____

_____
Name of facility Telephone

_____
Address

Client Name _____

What was the diagnosis and outcome? _____

_____

Has any family member had inpatient treatment for psychological, emotional, or substance abuse problem? ❑ Yes ❑ No

If yes, what is their relationship to the child and why did they seek treatment? _____

_____

Do any family members take medications for psychological problems? ❑ Yes ❑ No

If yes, what is their relationship to the child and what problem does the medicine treat? (list all):

_____

_____

Please describe what current stress the family is experiencing:

Inadequate housing? _____
Financial problems? _____
Divorce? _____
Recent death in family? _____
Other: _____

Do you think any of the above will interfere with treatment? _____

_____

LIST NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ANY OTHER PROFESSIONALS CONSULTED (e.g., neurologists, speech therapists, etc.):

1. _____
2. _____
3. _____
4. _____

ADDITIONAL REMARKS

Please use the remainder of this page to write any additional comments you wish to make regarding your child's difficulties.

EMERGE
COUNSELING SERVICES

Notice of Privacy

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.

Summary

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. **PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.**

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. A new notice will be available to you at our office or on request and will be effective for PHI that we maintain from that time forward.

1. Uses and Disclosures of PHI

Uses and Disclosures of PHI Based Upon Your Written Consent

You will be asked by your clinician to sign a Consent form. Once you have signed the form, your PHI may be used and disclosed by your clinician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services o you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the clinician's practice. Please note that EMERGE's policy is to not disclose your information without your written authorization, except as noted in this Privacy Notice. Following are examples of the types of uses and disclosures of your PHI that the clinician's office is permitted to make once you have signed our Consent form – these examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support our internal health care operations.

We may also call you by name in the waiting room when your clinician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may share your PHI with third party "business associates" that perform various activities (including billing) for our internal practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms to protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services.

Uses and Disclosures of PHI Based Upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written Authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your clinician or the clinician's practice has taken an action if reliance on the use or disclosure indicated in the Authorization.

EMERGE
COUNSELING SERVICES

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your PHI in the following instance. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be provided.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, your clinician shall try to obtain your Consent as soon as reasonably practicable after the delivery of treatment. If your clinician or another clinician in the practice is required by law to treat you and the clinician has attempted to obtain your Consent but is unable to obtain your Consent, he or she may still use or disclose your PHI to treat you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your Consent or Authorization. These situations include:

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease injury, or disability.

> Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a government health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect.

In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information, consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery requests or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: Your PHI may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your clinician created or received your PHI in the course of providing care for you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500et. Seq.

2. Your Rights

You have the right to inspect and copy your PHI. You may inspect and obtain a copy of your PHI that is contained in a designated record set from April 2003 forward, for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your clinician and the practice use for making decisions about you. This includes your medical and billing records but does not include information gathered or prepared for a civil, criminal, or administrative proceeding. Depending on the circumstances, a decision to deny access may be reviewable. To inspect and copy PHI, please contact our Privacy Official. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor and supplies used in meeting your request.

You have the right to request a restriction of your PHI. You may request in writing that we restrict and/or not use or disclose your PHI for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to adhere to it.

It is the policy at EMERGE to disclose your PHI only with your written authorizations except as described in this Privacy Notice.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our front desk.

You may have the right to have your clinician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment with us we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in the Notice of Privacy Practices. It may exclude disclosures we may have made to you, to family member or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

3. Complaints or Questions

You may contact our Privacy Official at 330-867-5603 for further information about the complaint process or other information in this Notice of Privacy.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Official of your complaint. We will not retaliate against you for filing a complaint.

In compliance with the HIPAA regulations per the US Government, this notice was published and became effective on April 14, 2003. It was most recently revised on July 31, 2015.

EMERGE COUNSELING SERVICES, INC.
900 Mull Avenue • Akron, OH 44313 • (800) 621-5207

Financial Responsibility Form

Agreement for Payment of Services

(Please print)

Client's Name: _____
Last **First** **MI**

Client's SS#: _____ **Client's DOB:** _____

Responsible Party: _____
Last **First** **MI**

Responsible Party SS#: _____ **Responsible Party DOB:** _____

Please initial in box if insurance is provided:

☐ I agree to pay 100% of charges not covered by insurance, Medicaid, or special contract agreements.

Please initial the correct box if insurance is not provided:

☐ I do not have insurance. I agree to pay $100% of the non-insured rate of $150 for the initial visit and a maximum of $110 for each following session, depending on the length of the session. Group sessions are $30.

☐ I submitted the proper documentation and qualify for a fee reduction. I agree to pay $_____ for each session.

Responsible Party must initial both boxes:

☐ I understand I may be charged per the below fee schedule.

- Client Late Arrival Additional Fee (10-20 Minutes Late) $ 20
- Client Late Arrival Additional Fee (21+ Minutes Late) $ 40
- No Show/Late Cancellation fee (Less than 24 hours) $ 75

☐ I understand that if I fail to pay the balance on my account this may result in EMERGE Counseling Service, Inc. pursuing any collection means possible. If I don't pay my bill, my services may be terminated.

Self Pay Responsibilities: You are responsible for all charges. I understand that my insurance policy is a contract between me, my employer, and/or the insurance company. EMERGE Counseling Services is not bound by such contracts unless otherwise specified. EMERGE Counseling Services reserves the right to amend this agreement if necessary.

_____ _____
Responsible Party Signature Date

For office use only

Your claim may be denied for the following reason:

Date: _____