Dependent Information Sheet

Name of Client____**Date**________________________

Address______________________________________**City**____________________**State**_____**Zip**___________

Phone(   )_____________________**Cell(   )**___________________**Soc. Sec#**___________________________

Date of Birth_______________**School**_______________________________________**Grade Level**___________

Favorite Activity__________________________**Referred to this office by:**_______________________________

Emergency Contact:_______________________**Relationship:**_____________**Phone(   )**__________________

Primary Physician:____________________________**Medications:**_____________________________________

Physical Illnesses:_________________________________**Allergies:**___________________________________

Parent/Guardian and/or person(s) providing insurance information

Mother's Name:____**Soc Sec#**___________________________
Address: (If different from above)____

Home(   )____________________**Cell(   )**______________________**Work(   )**_________________**Ext**______

Date of Birth:______________**Employer**_________________________**Occupation:**______________________

Fathers's Name:____**Soc Sec#**___________________________
Address: (If different from above)____

Home(   )_____________________**Cell(   )**_____________________**Work(   )**_________________**Ext**______

Date of Birth:______________**Employer**________________________**Occupation:**_________________________

Guardian Name______________________________**Relation**________________**Soc Sec#**__________________
Address: (If different from above)____

Home(   )_____________________**Cell(   )**______________________**Work(   )**________________**Ext**______

Date of Birth:______________**Employer**___________________________**Occupation:**_____________________

Siblings:
Name:__________________________**Age:**______**DOB**________________**SEX: M or F**
Name:__________________________**Age:**______**DOB**________________**SEX: M or F**

Insurance Information

Primary Company's Name:
____

Secondary Company's Name:
____

Subscriber(Parent)Name:_______________________
Subscriber#____________________________________

Subscriber(Parent)Name:_______________________
Subscriber#____________________________________

Hearthstone Counseling Associates, P.L.C
950 Office Park Road Suite 321
West Des Moines, IA 50265
(515)279-2834 phone (515) 279-4168 fax

Notice of Privacy Practices and Confidentiality (Effective April 14. 2003)

At Hearthstone Counseling Associates, we are committed to providing a safe, confidential and private setting for you. This notice describes how we make use of information about you, how it may be disclosed to others, how you can have access to this information, and your rights regarding this information. Please review carefully. A more detailed version is available upon your request.

Your Protected Health Information (PHI) is defined by the Health Information Portability and Accountability Act (HIPPA). Examples of PHI are: your name, address, phone number(s), health information, health insurance information, payment/billing information, etc. PHI **does not** include the therapists's psychotherapy session notes.

How we use and may disclose your PHI for treatment, payment and health care operations.

1. We may use and disclose PHI about you in order to provide health care treatment to you.
2. We may use and disclose PHI about you to obtain payment for services.
3. We may use and disclose your PHI for health care operations.
4. We may use and disclose PHI under other circumstances defined by law without your authorization.
5. We may contact you at phone numbers and addresses that you give us.
6. We may contact you with information about treatment and services.

Your rights with regards to you PHI:

1. You have the right to review and received a copy of you PHI.
2. You have the right to request limits on uses and disclosures of your PHI.
3. You have the right to request alternative ways to communicate with you.
4. You have the right to received a list of the disclosures made by the office.
5. You have the right to request an amendment to your PHI.
6. You have the right to a copy of this notice.
7. You have the right to file a complaint about our privacy practices with our privacy officer.

CONSENT/ACKNOWLEDGMENT OF RELEASE OF PATIENT INFORMATION TREATMENT/PAYMENT AGREEMENT

RELEASE OF INFORMATION: *I hereby authorize Hearthstone Counseling Associates, PLC (hereinafter referred to as "Provider") to disclose by telephone, facsimile, electronic data interchange, or by document delivery by carrier or postal service all or any part of my record for payment purposes, including but not limited to, any governmental agencies, insurance carrier, or companies, workers' compensation carrier, welfare funds or my employer, all information needed to substantiate payment for such hospitalization and medical care, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.*

Provider may also disclose by telephone, facsimile, electronic data interchange, or by document delivery by carrier or postal service all or any part of my medical record for treatment purposes, including but not limited to, any physician documented within the medical record, partners of treating physicians, on-call physicians, consultants utilized by any physicians of record, pharmacist and pharmacy staff, those employed by Provider, or to any health care facility that I am transferred to for continuance of care, including the ambulance service which transfers me.

PROVIDER'S NOTICE OF PRIVACY PRACTICES: *I understand that I have the right to review the Provider's Notice of Privacy Practices prior to signing this consent. I acknowledge that I have been referred to a copy of the Provider's Notice of Privacy Practices which summarizes the way my medical record may be used or disclosed by the Provider and states my rights with respect to my medical information. I understand that Provider has the right to revise its information practices and to amend the Notice. I understand that in the event Provider revises its Notice of Privacy Practices, a revised Notice will be posted in the office, and I may obtain a current Notice at any time from the provider.*

RIGHT TO RESTRICT DISCLOSURE: *I understand that I have the right to restrict how the Provider uses and discloses all or any part of my medical record for treatment, payment, or health care operations. I further understand that the Provider does not have to agree to such restrictions. If the Provider agrees to the restriction in writing, it is binding.*

RIGHT TO REVOKE AT ANY TIME: *I understand that I have the right to revoke this consent at any time in writing. I understand that any revocation by me of this consent will only apply to future uses and disclosures and such revocation must be in writing.*

TREATMENT/PAYMENT AGREEMENT: *I give permission to Provider to perform diagnostic and/or treatment services. I authorize payment directly to Provider from my insurance company. I also accept responsibility for payment of services I request or which are required for my treatment which may not be covered by my insurance. I am responsible for contacting my insurance company for initial authorization and verifying my mental health benefits. I am responsible for all fees applied to my account for treatment and services.*

____ ___________________________

Signature of Patient/Guardian/Legal Representative ***Date***

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Relationship to Patient

CANCELLATION/MISSED APPOINTMENT CHARGE

Please note there will be a $65.00 charge assessed to your account for any cancelled appointment (without a 24 hour notice), or for any missed appointment. THIS FEE IS NOT COVERED BY YOUR INSURANCE COMPANY.

INITIALS__________