Kari O'Neill Counseling/IHCG PLLC

1301 4th Ave. NW
Suite 103
Issaquah, WA 98027
Phone: 425.677.8686 Fax: 425.961.0783

Please provide the following information for us. The information you provide here is protected and confidential. All intake paperwork must be signed and completed for treatment to begin. Kari O'Neill Counseling/ IHCG PLLC is the custodian of your patient records.

Legal Name: _____ Today's Date: _____

Preferred Name: _____

Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip Code)

Mobile Phone: ( )_____ May we send texts/leave a message? ☐ Yes ☐ No

Home Phone: ( )_____ May we leave a message? ☐ Yes ☐ No

Patient Email: _____ May we email you? ☐ Yes ☐ No

- Email, text, and phone messages are not HIPAA compliant.
- Messages left on Kari O'Neill Counseling's voicemail are heard by the office manager for coordination of care.

_____ **Please initial here to consent to Teletherapy treatment**. Teletherapy is the delivery of psychological treatment and consultation provided through interactive internet technologies where the patient/client and clinician are not in the same physical location.

Gender: _____ Gender Identity: _____ Sexual Orientation: _____

Education Level: _____

Relationship Status: ☐ Single ☐ Married ☐ Partnership ☐ Divorced ☐ Widow/Widower ☐ Other _____

Place of Employment: _____ Profession: _____

Emergency Contact: _____
Name Relationship to Patient Phone #

Emergency Contact: _____
Name Relationship to Patient Phone #

Please list immediate family members, their ages and relationship to you, and if they live in your household:

Name	Relationship	Age	Living in Household?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Who is your primary care physician? _____

Are they located at: ☐ Allegro ☐ Overlake ☐ Swedish ☐ UW ☐ Virginia Mason

☐ Other: _____

May we contact your Physician to coordinate treatment? ☐ Yes ☐ No

Please list past psychological treatment providers, both inpatient and outpatient, as well as any substance abuse treatment you have received:

Dates	Details

Please list any medications you are now taking:

Name	Dosage	How often every day?	How long have you been taking?

Do you have any health problems for which you currently receive treatment?	
Do you currently consume alcohol? If so, how much/how often?	
Do you currently use marijuana? Frequency?	
Has anything been helping you feel better, or maintain your mood?	
What is your educational background?	
Have you ever been in the military?	
Do you practice a religion?	

Please list any blood-related relatives you have with a mental health history:

ADD/ADHD	
Alcoholism	
Anxiety	
Bipolar Disorder	
Attempted/Completed Suicide	
Dementia	
Depression	
Drug Abuse/Dependence	
OCD	
Schizophrenia	
Other	

What are your current mental health concerns?

☐ Anxiety	☐ Job/School Conflicts	☐ Difficulty Falling Asleep	☐ Change in Appetite
☐ Panic Attacks	☐ Irritability	☐ Frequent Awakening	☐ Decreased Appetite
☐ Depression	☐ Anger Control Problems	☐ Body Image	☐ Anorexia/Disordered Eating
☐ Loss of Interest	☐ Rapid Mood Swings	☐ Sexuality	☐ Purging
☐ Low Energy	☐ Suicidal Ideas		

Please list what you are seeking support for at this time	
Please list some of your strengths	
Please list some of your challenges	

Patient Signature: _____ Date: _____

Financial Policy
Kari O'Neill Counseling/ IHCG PLLC

PRIVATE BILLING -Our office is out of network with all insurance companies. We do not bill insurance. The fee for the session is due at the time of the service. Patients will receive a receipt which they may submit to their insurance provider for potential reimbursement.

PATIENT/CLIENT FEE SCHEDULE

Psychiatric diagnostic intake, 60 minutes	**$325.00 - $400.00**
Individual Session, 50 minutes	**$225.00**
Couples Session, 50 minutes	**$275.00**
Family Session, 50 minutes	**$275.00 - $325.00**
Phone Session, 50 minutes	**$225.00**
Executive Coaching, 60 minutes	**$300.00-$400.00**
Add-on Session, 30 minutes	**$150.00**
Add-on Session, 50 minutes	**$225.00**
Emails/Calls/Forms/Letters outside of appointment	**$225.00/hour, billed in increments of 15 min.**
Calls and letters for attorneys/court	**$225.00/hour, billed in increments of 15 min.**
Clerical fee for searching/handling records, per WAC	**$25.00**
Pages 1-30 (copying fee), per WAC	**$1.17 per page**
Pages 31+ (copying fee), per WAC	**$0.88 per page**
Editing of confidential information, per WAC	**$175.00/hour**
Late cancel/no show for initial visit	**Full Session Fee**
Late cancel/no show fee for follow-up visits	**Full Session Fee**

We require notice of 48 HOURS, two business days (Monday through Friday) for canceled or rescheduled appointments. Any cancellations within 48 hours, two business days, will result in a late cancellation fee which is the full session rate. For example, if your appointment is scheduled for Monday at 10 a.m., you will need to cancel your appointment no later than 10 a.m. the Thursday before the appointment. We maintain the same policies for all patients/clients and there are no exceptions to our cancellation policy to provide equity in care.

Patient Signature or Parent/Guardian (if under 18 years of age) DATE

CREDIT CARD AND BILLING POLICY:

Kari O'Neill Counseling/IHCG PLLC is committed to making our billing process as simple and easy as possible. All patients are required to provide a credit card on file with our office. We will store your credit card number in a secure, compliant location in your medical record. For security reasons the information will only be visible to our office manager who will process payments for the office. Credit cards on file will be used to pay for session fees, missed appointment fees, late cancellation fees, and misc. fees such as emails, phone calls between sessions, and emergency care coordination.

Patients/clients may request a copy of their current statement anytime by contacting the office manager directly at (425) 677-8686.

Please complete the form below:

I authorize Kari O'Neill Counseling/ IHCG PLLC to charge my credit card the balance due on my account as needed for payment of my balance. Payment receipts will be sent to the mailing address on file.

Credit Card Information:

Type: MASTERCARD VISA DISCOVER AMEX HSA

Cardholder Name: _____

Account Number: _____

Exp. Date: _____

CVV Code: _____

I understand that this authorization form will remain in effect until I cancel it in writing. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company; so long as the transactions correspond to the terms indicated in this authorization form. I have read and understood the above information and have been provided with a copy at my request.

_____ _____

Patient Signature or Parent/Guardian (if under 18 years of age) DATE

_____

Patient Name

KARI O'NEILL COUNSELING/ IHCG PLLC
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This form when completed and signed authorizes the release of your protected health information

Patient Name: _____ Date of Birth: _____

I authorize Kari O'Neill Counseling/ IHCG PLLC to ☐ release ☐ request ☐ exchange my protected health information from or to the following:

Physician Name/Location: _____

Phone: _____ Fax: _____

Physician Name/Location: _____

Phone: _____ Fax: _____

Psychiatrist Name/Location: _____

Phone: _____ Fax: _____

Family Member(s): _____

☐ I authorize family members for scheduling and billing purposes only

_____

☐ I authorize family members for scheduling and billing purposes only

_____

☐ I authorize family members for scheduling and billing purposes only

Other: _____

The following information is to be disclosed **(please initial)**

_____All Protected Health Information (PHI), including diagnosis, treatment goals, therapy notes, medications, drug and/or alcohol use, assessment (testing) reports, labs.

I understand that I have the right to revoke this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. This authorization is to remain in place unless cancelled by patient. There are three ways to cancel this authorization:

1. Write, sign and date a letter cancelling your authorization.
2. Sign, date and write **CANCEL** on this original form
3. Sign and date a revocation form, available by the Kari O'Neill Counseling/ IHCG PLLC office.

Once this information is released, it is beyond our control. The recipient might re-disclose it, as HIPAA privacy laws may no longer protect it.

_____

Patient Signature Date

_____

Parent/Guardian Signature (If patient is under 13 years of age) Date

Kari O'Neill Counseling/ IHCG PLLC

NOTIFICATION OF PRIVACY PRACTICES / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA):

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES:

TREATMENT – Your health information may be used by our providers and staff members or may be disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

HEALTH CARE OPERATIONS – Your health information may be used as necessary to support the day-to-day activities and management of Kari O'Neill Counseling/IHCG. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality to ensure that our practice is meeting state and federal guidelines and laws designated to protect your health care information.

LAW ENFORCEMENT – Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting. For example, any known or reasonably suspected cases of child abuse or neglect, any known or suspected intentions of harming oneself, and/or any known or suspected intentions of harming others.

PUBLIC HEALTH REPORTING – Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases to the State of Washington Department of Health.

BUSINESS ASSOCIATES – The following companies may have access to your Protected Health Information for the purpose of carrying out Treatment, Payment, and/or Health Care Operations: TherapyNotes (medical records software company).

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION – Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a disclosure or use of your information, you may submit a written revocation of the authorization. However, your decision to revoke your authorization will not affect or undo any disclosure or use that occurred before you notified this practice of your decision.

ADDITIONAL USES OF INFORMATION:

APPOINTMENT REMINDERS – When applicable, your health information will be used by our staff to call / send you appointment reminders.

INFORMATION ABOUT TREATMENT – Your health information may be used to send you information on the treatment and management of your health condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

INDIVIDUAL RIGHTS - YOU HAVE CERTAIN RIGHTS UNDER THE FEDERAL PRIVACY STANDARDS. THESE INCLUDE:

The right to request restrictions on the disclosure and use of your protected health information; The right to receive confidential communications concerning your medical condition and treatment; The right to inspect and copy your protected health information; The right to request an amendment or to submit corrections to your protected health information; The right to receive an accounting of how and to whom your protected health information has been disclosed; The right to receive a printed copy of this notice.

PROVIDER / OFFICE DUTIES – We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES – As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. These revised policies and practices will be applied to all protected health information we maintain.

RIGHT TO INSPECT PROTECTED HEALTH INFORMATION – As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting your individual practitioner or the front office. If you request a copy of your records, the following fees will be assessed: $25 Clerical fee, $1.17 per page fee for the first 30 pages and then $0.88 per page for any pages 31 and over. This fee must be paid prior to the copies being released.

COMPLAINTS AND CONTACT PERSON – If you would like to submit a comment or complaint about our privacy practices or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

Kari O'Neill Counseling/ IHCG PLLC – Attention Office Manager, 1301 4th Ave. NW, Suite 103, Issaquah, WA 98027, or calling (425) 677-8686. OR YOU MAY ALSO CONTACT: Office for Civil Rights-U.S. Dept. of Health and Human Services, 200 Independence Avenue SW, Washington D.C., 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/.

Signature: _____ **Date:** _____

Printed Name: _____