PRIVACY PRACTICES ACKNOWLEDGEMENT

MARRIAGE AND FAMILY COUNSELING CENTER
JANET M. EGGIMAN RN, MS, LMFT
614 W. Berry, Ste. C
FORT WAYNE, IN. 46802

I have received the Notice of Privacy Practices provided to me from Janet M. Eggiman and Marriage and Family Counseling Center on this date as required by HIPPA (Health Insurance Portability & Accountability Act.) I understand it is my responsibility to read it. I also understand if I have any questions, I may ask Janet Eggiman or the privacy officer about it.

NAME_____

SIGNATURE_____

DATE_____

Marriage & Family Counseling Center

PATIENT INFORMATION

DATE_____

NAME_____ SSN#_____ DOB_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
HOME PHONE_____ CELLPHONE_____ WORK_____
EMPLOYER_____ POSITION_____ FULL/PT
MARITUL STATUS MARRIED SINGLE DIVORCED OTHER
SPOUSE'S NAME_____ EMPLOYER_____
REASON FOR VISIT_____
NAME OF INSURED_____ DOB_____
INSURANCE ID #_____ or SSN_____
FAMILY PHYSICIAN_____ PHONE #_____
IN CASE OF EMERGNCY, WHO SHOULD WE NOTIFY?_____
(May we notify emergency contact? YES or NO) HOME PHONE_____
CELL PHONE_____
WHO MAY WE THANK FOR REFERRING YOU?_____

I hereby give permission to the therapist to release any information requested by my insurance company acquired in the course of my examination and treatment.
I hereby authorize and direct my insurance benefits to be paid directly to the therapist. I am financially responsible for non-covered services. If full payment of your account is made at the time of service, we will send payments directly to you or credit your account.
I hereby give permission to the therapist in the diagnosis and/or treatment of my consition as she deems necessary.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS.

SIGNATURE_____ DATE_____
(PATIENT/LEGAL GUARDIAN)

Marriage & Family Counseling Center

614 West Berry Street, Suite C
Fort Wayne, Indiana 46802
260-444-5034
jmeggi@yahoo.com

TREATMENT AGREEMENT

I, _____, hereby request evaluation and treatment from Marriage & Family Counseling Center.

I understand that medicine is not an exact science and that no guarantee can be made as to the success of treatment. I will insist on fully understanding the proposed treatment with its risks, benefits, and alternatives. I will unhesitatingly ask for a second opinion if I am in need of reassurance regarding the proposed plan of treatment. Once I agree to a plan of treatment, I will follow it to the best of my ability, and I will promptly notify from Marriage & Family Counseling Center of any unexpected effects.

I have received the Marriage & Family Counseling Center Notice of Privacy Practices. I understand that the minimum necessary medical information about me will be disclosed by from Marriage & Family Counseling Center for treatment, payment, and health care operations. I further understand that the from Marriage & Family Counseling Center Notice of Privacy Practices may change, and that I may request a new copy of the Notice of Privacy Practices from Marriage & Family Counseling Center at any time.

I have received a schedule of professional fees from Marriage & Family Counseling Center, and in consideration of the services to be rendered to me by Marriage & Family Counseling Center, I agree to be responsible for prompt, full payment of all fees regardless of third party liability. I am responsible for interest on my account balance at the maximum statutory rate and any applicable service fee. I further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made at the time of service, or within 30 days of service, to pay reasonable collection fees incurred or any attorney fees and court costs if this account is placed in the hands of an attorney for collection, including collection costs.

If from Marriage & Family Counseling Center does not accept my insurance, I understand that fees are due as stated and are payable at the beginning of the assessment or evaluation session (this allows Marriage & Family Counseling Center to focus entirely on my problems, needs and concerns during the session). If Marriage & Family Counseling Center does accept my insurance, I understand that I am responsible for paying my co-pay/co-insurance/deductible amount at the time the service is rendered.

I agree to accept financial responsibility for any missed appointment/"no-show" and my insurance company will not be billed for nor reimburse me for missed appointments. To avoid paying the full fee for assessment, 24 hours advance notice is required to cancel or reschedule an appointment without incurring this full fee charge to my credit/debit card.

Accounts which are not settled within a 45-day billing period will be charged a monthly service charge of 10%

Marriage & Family Counseling Center is hereby authorized to release any necessary confidential medical information to my insurance company for the purpose of obtaining reimbursement for services provided, and my insurance company is authorized to pay Marriage & Family Counseling Center directly for said services.

I agree that my failure to fulfill my obligations under this contract will immediately relieve Marriage & Family Counseling Center, its employees, officers, directors, and shareholders, of further obligations to me.

_____

Signature Date

_____

Witness Date

Marriage & Family Counseling Center
Janet M. Eggiman, RN, MS, LMFT
614 W. Berry Street, Ste. C
Fort Wayne, IN. 46802
Phone & Fax: 260-444-5034

Authorization for Release or Exchange of Information

Patient Name:_____DOB:_____
Information to Be Released By Or Exhanged With:

Name: _____

Address: _____

Phone: _____ Fax: _____
Information To Be Released By Or Exhanged:

___History and Physical ___Progress Notes
___Discharge Summary ___Diagnosis
___Psychiatric Evaluation ___Educational Tests
___Psychological Testing ___Lab Results
___Court/Agency Documents ___Treatment Plan
___Other_____
_____

The purpose of the use of this information is: _____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: _____
I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____
I understand that this authorization will expire on __ __/__ __/__ __ __ __ Initials: _____
I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials: _____

Signature of patient or patient's representative: _____Date: _____

Printed name of patient's representative:_____

Relationship to the patient:_____

Witness: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Marriage & Family Counseling Center

Name:

D.A.S.S.

INSTRUCTIONS: Please read each statement and choose the number which indicates how much the statement applies to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement. The rating scale is as follows:

0 = Does not apply to me at all
1 = Applied to me in some degree, or some of the time
2 = Applied to me to a considerable degree, or a good part of the time
3 = Applied to me very much or most of the time

Check the number that applies

Statements	0	1	2	3
1. I found myself getting upset by trivial things				
2. I was aware of dryness of my mouth				
3. I don't experience many positive feelings at all				
4. I experience breathing difficulty (excessively rapid breathing, breathlessness in the absence of exercise)				
5. I just can't seem to get going				
6. I tended to over-react to situations				
7. I have a feeling of shakiness (legs going to give way)				
8. I found myself in situations that made me so anxious I am most relieved when they end				
9. I have nothing to look forward to				
10. It is very difficult to relax				
11. I get upset rather easily				
12. I use a lot of nervous energy				
13. I feel sad and depressed				
14. I get impatient when I am delayed in any way (elevator, traffic lights, waiting)				
15. I had a feeling of faintness				
16. I felt that I had lost interest in just about everything				
17. I feel worthless as a person				
18. I am really touchy				
19. I perspired noticeably in the absence of high temperatures or exercise				
20. I felt scared without any good reason				
21. I feel or have felt that life was not worthwhile				
22. I found it hard to wind down				
23. I have had difficulty swallowing				
24. I don't get any enjoyment out of the things that I used to				
25. I can feel my heart beating hard in the absence of exercise (heart racing, missing a beat)				
26. I felt down-hearted and blue				
27. I feel very irritable				
28. I felt I was close to panic				
29. I found it hard to calm down after something upset me				
30. I feared that I would be "thrown" by some trivial but unfamiliar task				
31. I find it hard to become enthusiastic about anything				
32. I found it difficult to tolerate interruptions to what I was doing				
33. I am in a constant state of nervous tension				
34. I feel guilty about things often				
35. People tell me I have a quick temper				
36. I have felt terrified				
37. I could see nothing in the future to be hopeful about				
38. I felt life was meaningless				
39. I can't stop pacing or moving				
40. I worry people are thinking that I am weird or odd somehow				
41. I experienced trembling (in my hands)				
42. I found it difficult to work up the energy or motivation to do things				
TOTAL SCORE				

AUDIT Questionnaire

Questions	0	1	2	3	4	Enter Score
1. How often do you have a drink containing alcohol	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
If score to 1st question is zero, stop screening here.						
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
If the total score for Questions 1-3 is 5 points or higher for Men or 4 points or higher for Women, then continue						
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of ' your drinking?	Never	Less than monthly	Monthly.	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
10. Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
TOTAL SCORE						

The Alcohol Use DIsorders Identification Test (AUDIT) IS used by permrssion from the World Health Organization,

Scores of 8 or more for men (up to age 60) or 4 or more for women, adolescents, and men over the age of 60 are considered positive results.