Nancy Schornack, LMHC
CONFIDENTIAL QUESTIONNAIRE

PERSONAL INFORMATION

Name: ______________________________________ Home phone: _________________________

Address: ____________________________________ Cell phone: ___________________________

____________________________________ Date of Birth: _________________________

Occupation: ____

Education (last year completed): _____________________________

Marital status: ____________ Years married: ________ Spouse (if applicable): ____________________

May we leave you a message at home? _____ Yes _____ No

Names and ages of children: ____

____

In case of emergency, please contact the following: ____

Relationships: _______________________________ Phone: ___________________________________

Referred to Family Legacy by: ______________________________________

HEALTH INFORMATION

Rate your overall health: _____Very good _____Good _____Average _____Declining _____Poor

Are you sleeping through the night? ________Yes ________No

Have you had a weight change recently? _____Yes _____No If Yes, loss or gain? ______

Are you sleeping through the night? _____Yes _____No Lacking energy? _____Yes ______No

Who is your physician? _____________________________ Phone: ___________________

Are you currently taking any medication? _____Yes _____No If Yes, please list all medications that you are taking and their purpose: ____

____

OTHER INFORMATION

Have you recently suffered a significant loss (social, business, or family relationship)?
_____Yes ____No If Yes, please explain____
____
____

Have you ever participated in any counseling before? ______Yes ______No
If Yes, please list the date, the name of the therapist, and the reason for counseling:
____
____
____
____

Briefly describe your belief about God, and if/how you see your faith being part of the change process in your counseling: ____
____
____
____
____

What has brought you here today, and what would you like the counseling process to accomplish?
____
____
____
____

Please circle the areas you may wish to discuss during the counseling process:

Abortion	childhood hurts	marital issues	sexual issues
Abuse	communication	occupation	spirituality
Anger	depression	parenting	stress
Anxiety	finances	parents/in-laws	substance abuse
Appearance	grief/loss	relational conflicts	suicidal thoughts

<u>FAMILY LEGACY COUNSELING</u>
<u>NOTICE OF PRIVACY PRACTICES</u>

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted to ensure the privacy and security of a consumer's Protected Health Information ("PHI"). PHI is individually identifiable health information that is transmitted or maintained in any form or medium. Some examples of PHI include an individual's name, social security number, address, and date of birth.

Family Legacy Counseling (counselors and office manager, heretofore referred to as "we") is required by law to protect the privacy of your mental health information. We are also required to send you this notice which explains how we may use information about you and when we can give out or "disclose" that information to others.

The terms "information" or "health information" in this notice include any personal information that is created or received by a mental health care provider that relates to your mental health and/or that of your child(ren), the provision of mental health care to you, or the payment of such care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our Family Legacy Counseling website, www.familylegacycounseling.com.

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you ;
- Where required by law.

We have the right to use and disclose health information to operate our business. For example, we may use your health information:

- For collection of payment of grossly overdue or delinquent accounts; account information may be disclosed to a billing collection agency.

We may use or disclose your health information for the following purposes under limited circumstances:

- <u>For appointment reminders</u>. We may use health information to contact you for appointment reminders using phone numbers provided by you.
- <u>To persons involved with you care:</u> We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency or when permitted by law.
- <u>For reporting victims of abuse, neglect or domestic violence</u> to government authorities, including a social service or protective service agency.
- <u>For judicial or administrative proceedings</u> such as in response to a court order, search warrant or subpoena.
- <u>For law enforcement purposes</u> such as providing limited information to locate a missing person.
- <u>To avoid a serious threat to health or safety</u> by, for example, disclosing information to public health agencies.

If none of the above reasons applies, **then we must get your written authorization to use or disclose your and/or your child's health information.** The dated Release of Information specifies what information may be disclosed, to whom, and during what period of time. Your written authorization to disclose your health information would apply in the following situations:

- <u>For payment</u> of fees due us (whether by insurance or other third party payees such as churches) and to process claims for mental health care services.
- <u>For treatment</u> information from other family members, referring physicians, other mental health counselors, or physicians to whom we may refer you. This information may be shared via phone consultation, in person, by fax or direct mail.
- <u>For specialized government functions</u> such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law.

To protect your health information records:

- Information requested by referring or referred physicians or other mental health counselors may be shared in summary form rather than in case note form when possible.
- Appointment reminders will only be left with phone/fax numbers that are provided by you and with your permission.
- Mental health records are stored in color-coded folders applicable solely to your or your child's counselor.
- Mental health records are stored in locked file cabinets when not in use.
- After five years of appointment inactivity, health information records are shredded or burned.

HIGHLY CONFIDENTIAL INFORMATION

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

WHAT ARE YOUR RIGHTS

The following are your rights with respect to your health information.

- **You have the right to ask to restrict uses or disclosures** of your information for treatment, payment or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health
  care or payment of your health care. We may also have policies on dependent access that may authorize certain restrictions. *Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.*
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address).
- **You have the right to see and obtain a summary copy** of health information that may be used to make decisions about you such as claims.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time.

EXERCISING YOUR RIGHTS

If you have any questions about this notice or want to exercise any of your rights, please call Family Legacy Counseling at (515) 727-1338.

NANCY SCHORNACK, M.A., LMHC
INFORMED CONSENT

Professional Information: I have a Bachelor of Arts degree in Psychology and a Master of Arts degree in biblical Counseling, both from regionally accredited institutions. I am a Licensed Mental Health Counselor in the State of Iowa. I have 20 years of experience in counseling and social work, working with children, families, couples, and adults with a variety of concerns. I use an eclectic approach to counseling, which takes into account spiritual, psychological, social, and biological dimensions of the client.

Counseling Relationship: I believe counseling is a process whereby a client seeks to resolve interpersonal, emotional, and /or spiritual difficulties with the assistance of aNother caring individual. As your counselor I will bring to the sessions my professional kNowledge and experience, but the ultimate responsibility for growth and change rests with you, the client. Therapy can last from a few weeks to several months. We will be in ongoing dialogue about your needs, progress, and recommended duration of therapy. You are invited at any time to ask questions about my methods or the direction of your counseling. If for any reason you are dissatisfied with my services, please let me kNow and I will try to resolve your concerns. If we are unable to resolve your concerns, I will be available to assist you in finding qualified help elsewhere. Occasionally, I may elect to discontinue therapy. This usually happens when I feel No substantial progress is being made or other factors are interfering with my ability to help you.

Confidentiality: Under Normal circumstances everything you discuss with me will be held in strict confidence. However, you should be aware that there are some situations in which I may be required to report information to the proper authorities and/or an appropriate family member without your permission. **(Disclosure for Mandatory Abuse reporting is required by State Law, Code Section 232 & 235, for suspected incidents of child and/or dependent adult abuse).** I may also be required to disclose information in response to a subpoena issued by a court of law, or with some particular insurance programs where clients are utilizing third party payment. I will discuss these circumstances with you if they arise, and I will only disclose essential information when required. You should be made aware that I consult regularly with other professionals regarding clients with whom I am working. This allows me to gain other perspectives and ideas as how to best help you reach your goals. Such consultations are obtained in a way that complete confidentiality is maintained.

Sessions, Fee, and Cancellations: Counseling sessions Normally last 50 minutes, the fee for your first session is $150.00 and all session thereafter are $110.00. It is expected that you pay the fee at each session, if your account shows a balance of $220.00 services will be suspended until the balance is brought up to date. **Please initial ______** If you have Wellmark BlueCross/BlueShield insurance you will be responsible for paying your co-pay at each visit. A processing fee of $10.00 will be added to those accounts that require a statement to be sent for unpaid balances. By maintaining a zero balance on your account for co-pays, private pay, testing or other fees you will be able to avoid the processing fee. This excludes billed insurance balances. **Please initial ______**
If you need to cancel an appointment, you must give 24 hours Notice. Please contact me at 515-727-1338 to leave a message regarding your cancellation. Failure to give 24 hour Notice will result in you being charged half the appointment fee, or $55.00. **Please initial** _____________

Appointments & Emergencies: Appointments can be made following each session, or you may call Family Legacy 515-727-1338 to schedule. Voice mail is confidential and is checked daily. If you have an emergency and it is after hours please listen to the instructions on voice mail or contact your local police department, emergency room or shelter.

Notice of Privacy Rights: I have read and understand my privacy rights at Family Legacy.

Your signature indicates that you understand and agree to the above information and policies, and that any questions you have about this information has been answered to your satisfaction.

Client Signature____Date__________

Client Signature____Date__________