Darren W. Love, M.Ed.
Licensed Professional Supervising Clinical Counselor
darrenwlove.com | 419.215.4567

Larry E Hamme, Ph.D. & Associates

Counseling Service Agreement: Your Rights and My Policies

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign the Client Information & Consent for Treatment Form, it will represent that you understand your rights and agree with my policies.

COUNSELING SERVICES

Counseling is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Counseling is not like a visit to your family doctor. Instead, it calls for a very active effort on your part. In order for the counseling to be most successful, you will have to work on things we talk about both during our sessions and at home.

Counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an assessment of your needs. By the end of the assessment, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with counseling. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Counseling involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

SESSIONS

During the time of initial assessment, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If counseling is begun, I will schedule one appointment hour of 50 minutes duration at a frequency and time we agree on, although some sessions may be longer, or frequency may change. Once an appointment hour is scheduled, you will be expected to attend unless you provide 24 hours advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control. You will be expected to pay half the fee if you cancel less than 24 hours in advance and the full fee if you provide no notice of cancellation since insurance providers do not pay for missed sessions. It is my ethical responsibility to end the counseling relationship when it becomes reasonably clear you are not benefiting from treatment.

PROFESSIONAL FEES

My fee for the initial assessment is $185.00 and the hourly fee for individual counseling is $135.00. In addition to individual counseling appointments, I charge an hourly fee of $60.00 for other consultation services (includes report writing, phone conversations over 10 minutes, attendance at meetings you request me to attend, or other services you may request), though I will break down the hourly cost in 15-minute blocks for periods of less than one hour. As an established client, you may

also take advantage of online support services as outlined on my website, darrenwlove.com. If you become involved in legal proceedings and require my participation, you will be expected to pay for my professional time. Because of the difficulty of

legal involvement, I charge $175.00 per hour for preparation and attendance at any legal proceeding. The payment schedule for additional services is included in the intake packet.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held unless you have insurance coverage. If you have insurance coverage, I will accept the insurance reimbursement for covered services and will only expect co-pay fees, if any, to be paid at the time of service unless we agree otherwise. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installment plan. However, if more than 90 days have passed without payment and there have been no attempts to make arrangements to the pay the bill, or I have been unable to reach you to discuss your bill during that timefrme, I reserve the right to seek payment through formal collection services.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his or her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. For example, certain insurance providers may not allow some services and you will be expected to pay for all services not covered by your insurance plan. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

CONTACTING ME

I am sometimes not immediately available by telephone. I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail that I continually monitor. I will return your call on the same day. If you are difficult to reach, please inform me of several times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or call Rescue Mental Health Services at 419.255.2801. If it is an emergency, call 911 or go to the nearest emergency room and ask for the psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. These records are considered Protected Health Information. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because

these are professional records, they can be misinterpreted or may be upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Additional information regarding your Protected Health Information is included in the intake packet. Clients will be charged an appropriate fee for any time spent in preparing information requests.

CONFIDENTIALITY

In general, the law protects the privacy of all communications between a client and a counselor, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment unless you use your state of mental health as a defense. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I am required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to an identifiable person or persons, including an identifiable structure, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for a client. If a client threatens to harm himself or herself, I am obligated to seek hospitalization for him or her; or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

At times, I will be under supervision with Larry E. Hamme, Ph.D. or his designee because of insurance purposes as required by Ohio law. You have the right to ask for an appointment with the supervisor at any time. I may occasionally find it helpful to consult other professionals about a case. During such a consultation, I make every effort to avoid revealing the identity of my client. Any consultant or supervisor is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations or supervision sessions unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

CHILD AND ADOLESCENT CONFIDENTALITY

Before treatment, it's important for you to understand my approach to child and adolescent counseling and agree to some rules about your child's confidentiality while in treatment. One risk of child counseling involves disagreements among parents or disagreements between parents and the counselor regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain mine. We can either resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether counseling will continue. If either of you decides that counseling should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Counseling is most effective when a trusting relationship exists between the counselor and the client. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" so that they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence.

However, it's my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide

you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he or she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming himself or herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision.

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Larry E Hamme, Ph.D. & Associates
Client Information and Consent for Treatment Form

Client Name: _____

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

Home Phone: _____ Cell: _____ Work: _____

Client SSN: _____ Client Date of Birth: _____

Martial Status: Married **[ ]** Single **[ ]** Spouse's Name: _____

Gender: Male **[ ]** Female **[ ]** Spouse's Work Phone: _____

Client's Employer: _____

Who is Financially Responsible for this Bill?

Name: _____

Address: _____
If different from clients (Street) (City) (State & Zip Code)

Home Phone: _____ Cell: _____ Work: _____

Insured SSN: _____ Insured Date of Birth: _____

Insured's Employer _____

Insurance Carrier: _____

Primary Care Physician: _____

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

Current Medications: _____

Past Mental Health Outpatient Treatment: _____

Past Substance Abuse Outpatient Treatment: _____

Past Mental Health / Substance Abuse Inpatient Treatment: _____

Current Medical Conditions: _____

Emergency Contact Person: _____

Referral Source: _____

Copy of Insurance Card(s) Attached: Yes **[ ]** No **[ ]**

I hereby give permission to Darren W. Love, M.Ed., LPCC-S or designee to provide counseling for me on an outpatient basis and by signing this form, I am acknowledging the following:

1. I have a right to an explanation of the risks and benefits for each proposed counseling service, of alternative treatments, and of no treatment.

2. I have the right to refuse treatment.

3. Darren W. Love, M.Ed., LPCC-S, or Larry E. Hamme, Ph.D. or designee will be responsible for making efforts to develop alternative approaches to ensure that needed services are received.

4. Darren W. Love, M.Ed., LPCC-S, or Larry E. Hamme, Ph.D. or designee will be responsible for explaining the implications and potential consequences of refusing or withdrawing consent for counseling.

5. I am in receipt of an explanation of my rights and the policies of the Counseling Service Agreement, Fee Schedule, and HIPAA Notice of Privacy Practices by Darren W. Love, M.Ed., LPCC-S, Larry E. Hamme, Ph.D. or designee.

Ohio law requires that insurance reimbursable mental health services be provided by, or under supervision of, a licensed physician, psychologist, professional clinical counselor, professional counselor, or clinical nurse specialist whose nursing specialty is mental health (ORC 3923.28). In order to comply with the above law, when Larry E. Hamme, Ph.D. or designee is the only approved provider for your insurance company, he or his designee will be responsible for said supervision and his/her name will appear on your insurance forms and bills. And, when Darren W. Love, M.Ed., LPCC-S is an approved provider for your insurance company, he will be responsible for said supervision and his name will appear on your insurance forms and bills.

I authorize insurance claims to be filed for me and also that information regarding counseling services rendered be furnished to the insurance company at their request.

I authorize payment of benefits to the undersigned supplier for services rendered.

My signature below indicates that I have read the client information and policy statements in the Counseling Service Agreement and agree to abide by its terms during our professional relationship.

I understand that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. Payment for service is due at the time of its delivery. Appointments not cancelled within 24 hours of the appointment will be charged a no-call fee. You may contact Mr. Love at **419.215.4567** and he will contact you the same day or use the office's 24-hour phone service at **419.472.7330** where messages can be left at any time.

Client Signature _____ Date_____

Parent Signature (if applicable) _____ Date_____

Witness Signature _____ Date_____

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Larry E Hamme, Ph.D. & Associates

Client Fee Schedule

Initial Diagnostic Assessment Session *(including medical record review and writing initial report)*	$185 this typically last 60+ minutes
Individual Counseling Session	$135 for 50-minute session
Individual Counseling Session *(including assessment instruments and their interpretation)*	$175 this typically last 60+ minutes
Couple Counseling Session *(typically, not covered by insurance companies)*	$135 for 50-minute session
Family Counseling Session *(including additional preparation and notation for multiple participants)*	$165 for 60+ minutes
Group Counseling Sessions *(typically, not covered by insurance companies)*	$50 per person for each session
Attendance at Any legal Proceeding *(including preparation, travel to and from court, and time spent at the legal proceeding)*	$175 per hour for 60 minutes
Consultation *(including report writing)*	$60 per hour
Case Management & Phone Consultation *(including by over 10 minutes, attendance at meetings you request me to attend, or other services you may request not covered by insurance)*	$60 per hour

All fees and co-pays are due upon delivery of services

Clients will be expected to pay, at the time of the next session, half of the initial fee for an appointment not cancelled within 24 hours of the scheduled appointment and the full fee for an appointment for which you don't call to cancel and for which you don't show up.

Clients are responsible for reimbursement of all fees. We have no way of knowing for certain if your insurance policy will reimburse services, but we will gladly file the insurance form for reimbursement.

I understand That I will pay the full fee for missed appointments not canceled 24 hours prior to the appointment time. Insurance companies cannot be billed for missed appointments. I also understand that I am responsible for all services not covered by insurance.

I have read the above terms and agree to them.

Signature: _____ Date: _____

Witness (facilitator): _____ Date: _____

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Telecounseling & eCounseling Service Agreement: Your Rights and My Policies

What You Can Expect

During the COVID-19 outbreak Federal, State, County, and many Local Municipalities have all declared a State of Emergency. This has been accompanied with a wide rage of regulatory changes which will permit telecounseling that would not be permitted under normal circumstances. **Due to this event, no treatment sessions will not be conducted face-to-face in the office until further notice.**

I will be conducting all services via telecounseling which, under normal circumstances, I would not do. Rather, I usually only provide a supportive service via eCounseling. Typically, eCounseling services are reserved for clients who reside in the State of Ohio and find it hard to come in for sessions (I do require the first session to be in person). I use a secure computer, but you are solely responsible for the privacy and security of your system. eCounseling is a supportive service and is not intended to replace in-person treatment sessions.

As a result, at this time, eCounseling services are suspended, and I am only providing telecounseling services until further notice.

You may choose to communicate through the use of Wi-Fi and Internet Service Providers. This may include sending or receiving email, texting, the use of live instant messaging chat services, or live video chat services. You may also choose to communicate through wireless device such as a cell phone, laptop computer, tablet, or smart phone.

Your Obligations

- When using Internet and wireless communications for treatment, use Web-based e-mail and chat systems that are encrypted. This allows for additional privacy and may help reduce unauthorized access to your e-mail or chat by users sharing your computer.
- You're encouraged to consider getting a separate account just for this service that can't be easily identified with you. This allows for additional privacy and may help reduce unauthorized access to your e-mail or chat by users sharing your computer.
- If you must use a shared computer, always close the browser when you have finished your session.
- Do not access therapy Internet and wireless communications at work. Ideally, counseling using Internet and wireless communications should occur on a private device that is not shared with other users.
- Do not share your Internet and wireless communications passwords with others.
- You will have an agreed upon password which will be given to me in person or over the phone that is used in all our Internet and wireless communications treatment services to ensure it is you with whom I am communicating.

Risks of Telecounseling and eCounseling

- Emergency situations should be handled by calling 911, Rescue Crisis (419) 255-9585, or by going to the nearest emergency room and asking to speak to the Psychiatrist on-call.
- I do make every effort to respond to your online requests within 24 hours, but please, do not take this goal as an implied guarantee.
- Your privacy, confidentiality and security could be compromised on a cell phone, or other wireless device, using computers, or just accessing the Internet.
- Finally, concerning email, I may not be able to give a response to your email within 24 hours. And I may misunderstand your message due to the limitations of written exchange.

Payment

- Due to the COVID-19 event, insurance providers are making attempts to reimburse licensed mental health professionals for telecounseling services. Please review your options with me prior to engaging in services.

- eCounseling is not a covered service for most insurance providers. Please know that these services are not a necessary part of your office visits that are covered by insurance. And if you choose not to use eCounseling, it won't decrease the effectiveness of your current counseling sessions or those sessions you've had with me in the past.

- The benefit of eCounseling is to give you additional options for contacting me for treatment.

- Now I do reserve the right to not use Telecounseling (or eCounseling) service to address an issue you share if I believe that issue needs to be addressed with you in person.

- **I will make every attempt to be reimbursed for Telecounseling services thorough your insurance provider.** For eCounseling services, all fees for these services are paid in advance by credit card in my office or by PayPal on my website. Any unused funds will be returned to you when you have decided to either end treatment or decided to discontinue using eCounseling services.

Hold harmless clause:

I agree to indemnify and hold harmless the counselor, the therapy practice, its officers, website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet, Email, or wireless devices to communicate with the counselor or the use of his websites or blogs, any arraignments I make based on information obtained by the counselor's websites or blogs, any products or services obtained through the counselor's websites or blogs, and any breach by me of these restrictions and conditions. The counselor does not warrant that the functions contained in any materials provided will be uninterrupted or error-free, that defects will be corrected, or that the counselor's websites, blogs, or servers that make such sites available is free of viruses or other harmful components.

Termination of Telecounseling & eCounseling services:

The counselor shall have the right to immediately terminate Telecounseling (or eCounseling services), and refer to (or offer) face-to-face counseling, with the client if the counselor determines, in his or her sole discretion, that the client has violated the terms and conditions set forth above or otherwise breached this agreement, or has engaged in conduct which the counselor determines, in his or her sole discretion, to be unacceptable. eCounseling services will terminate in the event that the counselor, in his sole discretion, no longer wishes to utilize eCounseling and the client will be offered face-to-face sessions or, if the client lives too far away to travel to Toledo, will be referred to another counselor in their area.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the counselor and acknowledge that I have read and fully understand this consent form. I understand the risks associated with Internet, Email, Instant Messaging, Video Chat, and wireless device communications between the counselor and myself, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the counselor may impose to communicate with clients via Internet, Email, Instant Messaging, Video Chat, or wireless devices. Any questions I may have had were answered.

Client Signature _____ Date_____

Witness Signature _____ Date_____

Darren W. Love, M.Ed.
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Larry E Hamme, Ph.D. & Associates
HIPPA Notice of Privacy Practices

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.

This notice of privacy practices describes how we may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment, health care operations, and other purposes permitted or required by law and your rights to access and control your PHI. PHI is identifiable information, including demographics, about your past, present or future health or condition, the provision of health care to you, or payment for health care.

We have a legal duty to protect your health information. We are required by law to maintain the privacy of your PHI.

Uses and Disclosures of Protected Health Information:
Your PHI may be used and disclosed by your counselor, our office staff, and others outside of our office that are involved in your case and treatment for the purpose of providing mental health care services to you, to pay your behavioral health care bills, to support the operation of the counselor's practice, and any other use required by law.

For Treatment:
We will use and disclose your PHI to internal and external health care providers to provide, coordinate, or manage your care and any related services. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

To Obtain Payment for Treatment:
Your PHI will be used, as needed, to obtain payment for your healthcare services. for example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may disclose, as needed, your PHI in order to support business activities of your counselor's practice. these activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students/counselor trainees or clinical residents, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students/counseling students or residents that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your counselor. We may also call you by name in the waiting room when your counselor is ready to see you. We may disclose your PHI, as necessary, to contact you to remind you of your appointment. Examples: We may review your progress notes, treatment plans, and diagnostic assessment to evaluate the quality of services tht you received or to review the performance of the professionals who provide services to you; and we may provide information about you to our accounts, attorneys, consultants, and others in order to make sure we are complying with the laws. We may use and disclose your PHI in the following situations without your authorization. These situations include: As Required by Law, Public Health Issues as Required by Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, and Required Uses and Disclosures Under the Law. 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 164.500.

Other Permitted and Required Uses and Disclosures:
Will be made only with your consent, authorization, or opportunity to object unless required by law.

You May Revoke This Authorization:
At any time, in writing, except to the extent that your service provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your PHI:

You have the right to inspect and get copies of your PHI:

Under federal law, however, you my not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You Have the right to request a restriction of your PHI:
This means you may ask us not to disclose any part of your Protected health Information for the purposes of treatment, payment, or behavioral healthcare operations. You may also request that any part of your Protected Health Information not be disclosed to family members or friends who may be involved in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction apply.

Your counselor is not required to agree to a restriction that you may request. If the counselor believes it is in your best interest to permit use and disclosure your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You Have the right to request to receive confidential information from us by alternative means at an alternative location. You have the right to a paper copy of this notice from us. Upon request, even after you have agreed to accept this notice by alternative means (i.e. electronically).

You have the right to receive an accounting of certain disclosures we have made, if any, of your PH.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may revoke your consent or authorization for you counselor to use and disclose PHI. You must submit your revocation in writing to myself or the Privacy Officer of Larry E. Hamme, Ph. D. & Associates. Your counselor is permitted to use and disclose your PHI based on your consent until your revocation is received. If you revoke your consent, your counselor reserves the right to refuse to provide further treatment to you, on the basis of your refusal to allow us to share information for the purpoases of treatment, payment, and healthcare operations.

Complaints:
You may complain to us if you believe your privacy rights have violated by us. You may file a complaint with us by notifying myself, or our privacy contact, Melanie Hanus, of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **April 14, 2003**, and revised November 25, 2012.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with myself or the Larry E Hamme, Ph.D. & Associates HIPAA Compliance Officer in person or by phone at our main phone number at 419. 472.7330.

Signature below in only acknowledgement that you have received this notice of our privacy practices.

Print Name _____

Client Signature _____ Date_____

Darren W. Love, M.Ed.
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Larry E Hamme, Ph.D. & Associates
General Health and Mental Health Information

Date _____

Client Name _____ Age _____

Date of Birth _____ Gender Male [ ] Female [ ]

Children (please list ages) _____

_____

Date of last physical exam _____

List medical problems for which you are being treated _____

_____

_____

_____

Medications you are currently taking _____

_____

_____

Allergies to medication _____

_____

_____

Other allergies _____

_____

Any major medical events (including pregnancies and surgeries) _____

_____

_____

_____

Illnesses that run in your family (check all that apply):

	You	Blood Relative		You	Blood Relative
Anemia			Suicide Attempts		
High Blood Pressure			Stroke		
Seizures			Kidney Disease		
Tuberculosis			Bleeding / Tendency		
Sickle Cell Disease			Cancer		
Diabetes			Mental Illness		
Heart trouble			Alcohol / Drug Abuse		

Please Check

Do you have:

	Yes	No
Frequent headaches		
Blurred Vision		
Constipation		
Diarrhea		
Excessive thirst		
Frequent Urination		
Weight Changes in Past 3 Months (if so list how much)		
Chest Pain		
Shortness Of Breath		
Frequent Stomach Aches		
Do You Smoke (if so list number of pack per day)		
Other:		

Special Diet? Yes [ ] No [ ]

If yes, explain _____

_____

Physical Limitations Yes [ ] No [ ]

If yes, explain _____

Do you have concerns about your sexual functioning? _____

_____

Do you get regular exercise? _____

Do you eat a balanced diet? _____

Do you have sleep problems? _____

Do you drink alcohol? If yes, how much per week? _____

Do you drugs not prescribed to you? Yes [ ] No [ ]

Are you considered to be at risk for Hepatitis / HIV/AIDS? Yes [ ] No [ ]

Do you have concerns about your health now? Yes [ ] No [ ]

Additional Information

1. Are you currently employed? Yes [ ] No [ ]

If yes, what is your current employment situation: _____

Do you enjoy your work? Is there anything stressful about your current work?

2. Do your consider yourself to be spiritual or religious? Yes [ ] No [ ]

If yes, describe your faith or belief: _____

3. What do you consider to be your strengths? _____

4. What do you consider to be your weaknesses? _____

5. What would you like to accomplish out of your time in counseling? _____

Client Signature _____ Date _____

Assessor Signature _____ Date _____

PROBLEM CHECKLIST

The following information will help us learn about issues that are problematic for you. Please take the time to mark each of the following items with either a "0", "1", "2", "3", or "4" indicating the degree to which that issue is a problem for you at the present time. This list is not exhaustive, but covers many of the common problem areas seen by Counseling Services. Thank you!

0	1	2	3	4
Not a Problem (or not applicable)	Slight Problem	Moderate Problem	Serious Problem	Severe Problem

1. _____ Academic concerns; school work and grades
2. _____ Time management, procrastination, getting motivated
3. _____ Overly high academic standards for self
4. _____ Pressures from family for success
5. _____ Decision about selecting major and/or career
6. _____ Homesickness
7. _____ Relationship with roommate
8. _____ Relationship with friends and/or making friends
9. _____ Relationship with romantic partner
10. _____ Concern regarding break-up
11. _____ Conflict/argument with parents or family member
12. _____ Shy or ill at ease around others
13. _____ Self-confidence or self-esteem; feeling inferior Body
14. _____ image concerns
15. _____ Anxiety, fears, worries
16. _____ Feeling overwhelmed by a number of things; hard to sort things out
17. _____ Problems adjusting to the college
18. _____ Generally unhappy and dissatisfied
19. _____ Confusion over personal beliefs or religious beliefs and values Concerns
20. _____ related to being a member of a minority
21. _____ Issues related to gay/lesbian identity Grief
22. _____ over death or loss Depression
23. _____ Depression
24. _____ Thoughts of ending your life Feelings
25. _____ of hopelessness
26. _____ Eating problems (not eating, overeating, or excessive dieting) Self
27. _____ – injurious behaviors
28. _____ Alcohol and/or other drug problem
29. _____ Alcohol/drug problem in family
30. _____ Sexually abused or assaulted, as child or adult Physically
31. _____ or emotionally abused, as child or adult
32. _____ Physical stress (headaches, stomach pains, muscle tension, etc)
33. _____ Sleep problems (can't sleep, sleep too much, nightmares) Sexual
34. _____ matters
35. _____ Irritable, angry hostile feelings; difficulty expressing anger appropriately Fear
36. _____ of loss of contact with reality
37. _____ Violent thoughts, feelings, or behaviors
38. _____ Have been considering dropping out or leaving school
39. _____ Feel that someone is stalking or harassing me (by phone, letter, or email)