LAYH AND ASSOCIATES, INC.

FILE INFORMATION (ADULT FORM)

Today's Date_____

Client Name_____

Social Security #_____DOB_____Age_____

Street Address_____City: _____State:___Zip: _____

Primary Ph _____ (home/cell/work) Alt Ph _____ (home/cell/work)

Email Address _____

Place of Employment_____Occupation_____

Marital/Relationship Status_____Name of Spouse/Partner_____

Names and Ages of Children_____

Reason for Visit _____

Referred by_____Phone_____

Address_____

Family Doctor_____Phone_____

Address_____

Emergency Contact_____Phone _____Relationship _____

Primary Insurance Company_____ID Number_____

Policy Holder's Name_____ Relationship _____

Secondary Insurance Company_____ID Number_____

Policy Holder's Name_____ Relationship _____

This section for office use only

Dx:

LAYH AND ASSOCIATES, INC.
MEDICAL INFORMATION FORM

Name:_____ Date of birth:_____ Age:_____

Family physician's name and address/phone number:_____

Current medications, including birth control pills and over-the-counter medications (please include dosage/frequency and dates of initial prescriptions, if known):_____

_____

Medication allergies or side effects:_____

Daily caffeine intake:_____ Smoker _____no_____yes—packs per day_____

Physical Concerns (please check all that apply to you)

General
_____concentration/memory problems
_____fatigue
_____sleep difficulties/nightmares
_____depression/weepiness
_____weight gain/loss
_____hallucinations
_____high energy
_____flushes/chills/hot flashes
_____skin rashes/hives
_____anxiety/panic
_____fears/phobias
_____rituals

Cardiovascular
_____blood pressure
_____heat disease
_____chest pains
_____palpitations

Hearing and Sight
_____blindness
_____glaucoma
_____blurred vision
_____watery eyes
_____color blindness
_____other visual disturbances
_____
_____dizziness
_____ringing in ears
_____frequent ear infections
_____deafness
_____other hearing problems
_____

Cancer
_____specify year of discovery/type
_____

Kidney
_____specify type of disease
_____

Gastrointestinal
_____diarrhea
_____constipation
_____overeating/undereating
_____vomiting/nausea
_____ulcers

Neuromuscular
_____headaches/migraines
_____back problems
_____tingling/numbness
_____tremors/tics/twitches
_____seizures
_____dizziness/lightheadedness
_____loss of consciousness
_____difficulty in walking

Respiratory
_____asthma
_____emphysema
_____shortness of breath
_____TB

Endocrine
_____thyroid
_____diabetes
_____hypoglycemia

Genito-Urinary
_____prostate
_____erection/ejaculation difficulties
_____low sexual desire
_____urination problems

Gynecological
_____PMS
_____painful periods
_____irregular periods
_____painful sex
_____menopause

Other
_____

Ongoing Medical Conditions
_____

Family history of mental health or medical problems:_____
Surgical history (year and type):_____
_____
_____
Describe any accidents or serious injuries:_____
_____

_____ _____
Client or Guardian Signature Date

LAYH AND ASSOCIATES, INC.

POLICY INFORMATION -- PLEASE READ CAREFULLY

Welcome to Our Practice!

The best psychological care can only be provided on the basis of mutual understanding. This information is provided to answer the most frequently asked questions; however, you are encouraged to discuss any additional questions you may have with your therapist.

Services: Layh and Associates, Inc. offers a variety of services, including psychotherapy with adults, adolescents, children, and families, group therapy, psychological assessment and testing, and consultation services.

Fees: The charge for the first appointment is $145.00. The charge for ongoing psychological services is $125.00 per hour, unless otherwise indicated. Each therapy session will usually last about 45-55 minutes, unless otherwise specified (Nursing Home visits may be briefer), to allow time for progress notes and other record keeping. Fees for testing, assessment and other services may vary and should be discussed in advance with your provider. Court appearance and testimony is billed at the rate of $150.00 per hour for time involved. We are often asked to provide special services such as completing forms for employers, communicating with attorneys, extended phone calls, or sending letters at your request. While we are happy to assist, these do involve time and are not typically covered by insurance. **When you request these services, you will be billed at the rate of $125 per hour for the time involved.**

Insurance: Most insurance policies pay something toward outpatient psychotherapy; however, policies widely vary. Some may require you to pay a deductible; some may reimburse at 50%, some at 80%, and so forth. You should check with your employer or insurance provider for details. Your insurance policy is a contract between you and your insurance company, and it is important that you understand the plan's provisions. **We cannot guarantee payment of your claim by your insurance company.** If you are considering changing insurance, you may wish to discuss this with us in advance. It may impact your mental health coverage. If you provide us with a copy of the front and back of your insurance card, we will be happy to bill your insurance company for you at no extra charge. **Fees for treatment, however, are your obligation to us, not your insurance company's. Any unpaid balances may be turned over to a collection agency. At that time, interest will be added to the balance.** By signing below, you authorize benefits/claims to be billed on your behalf to your insurance company, including the release of relevant clinical data as requested and payment to be made to your doctor for any service rendered.

Co-payment: The amount owed after insurance payment is your copayment. Unless other arrangements are made with your therapist in advance, **we ask that you make your copayment in full at the time of service.** After we have been reimbursed by your insurance company (usually within 6 to 8 weeks), we will bill you for the remainder, or promptly refund any overpayment. We expect to receive any balance due from you within thirty (30) days. A processing fee may be added monthly to any monies/balances over thirty (30) days past due. Please contact your therapist or the office to discuss other arrangements. We will send monthly statements to keep you updated on your account.

Cancellation: If you find that you cannot keep your scheduled appointment, please let the office know **at least 24 hours in advance.** While emergencies do happen, "no-shows" or repeated last-minute cancellations may be billed to you. Please note that these charges are **not covered by your insurance company** and are **your responsibility**. _____ **(Client Initials)**

Emergency Services: In case of an emergency, you may need to call 911 or go to the emergency room.

Notice of Privacy Practices (Short Version): 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 CAREFULLY.

Our Commitment to Your Privacy: Our practice is dedicated to maintaining the privacy of your personal health information. We are now required also by law to do this. These laws are complicated, and they require us to provide you with the following information. This is a shorter version of the full, legally required NPP (Notice of Privacy Practices) which you may review at your request. We can't anticipate all possible situations so please talk to your therapist or our Privacy Officer (see the end of this form) about any questions or concerns. We will use the information about your health which we get from you or others mainly to provide you with treatment, to arrange payment for our services, or for some other business activities which are called, in law, health care operations. After you have read this NPP, we will ask you to sign to indicate your understanding and consent. If we or you want to use or disclose (send, share, release) information for any other purposes, we will discuss this with you and ask you to sign an authorization to allow for this. Of course, we will keep your health information private, but there are times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Worker's Compensation and similar benefit programs.
5. The psychologist, psychiatrist, or counselor is working as the agent of another, such as in the case of a court-ordered evaluation.
6. Suspicion of child abuse or neglect.
7. Non-custodial parents have rights to information about the treatment of their children.

There are other situations like these but which don't happen very often. They are described in the longer version of the NPP. If you have any concerns about the limits of confidentiality in your situation, please feel free to discuss these with your therapist.

Physician Contact: Medicare, United Behavioral Health, and some other insurance companies require that a therapist consult with the patient's primary care physician in accordance with acceptable professional standards. Unless you indicate otherwise, your signature below authorizes us to meet that obligation to coordinate with your physician.

SIGNATURE LINE ON SECOND PAGE

Supervision and Consultation: Supervision of psychology professionals and trainees, as required by law in the State of Ohio, is provided by licensed staff of this practice. For supervision and consultation purposes, clients should understand that the rules of confidentiality extend to all staff associated with this practice. Case information may be shared with associated staff for supervision and consultation purposes without specific authorization from clients. Supervision between a supervisor and supervisee will take place on a regular basis as required by Ohio State Law. A supervisor can be made available to meet at the client's request. Service provided by therapists and trainees will be billed under the name of the supervising licensed psychologist or psychiatrist, who is ultimately responsible for the services provided.

Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health-related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact your therapist or our Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice, and we have offered you a copy. If we change this NPP, we will post it in our waiting room and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Other Client Rights and Responsibilities:

Clients' Rights

1. Clients have the right to be treated with dignity and respect.
2. Clients have the right to fair treatment regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
3. Clients have the right to have their treatment and other client information kept private.
4. Only in an emergency, or if required by law, can records be released without client permission.
5. Clients have the right to information from staff/providers in a language they can understand.
6. Clients have the right to have an easy-to-understand explanation of their condition and treatment.
7. Clients have the right to know all about their treatment choices. This would mean no matter of cost or if they are covered or not.
8. Clients have the right to get information about their insurance company's services and role in the treatment process.
9. Clients have the right to information about providers.
10. Clients have the right to know the clinical guidelines used in providing and/or managing their care.
11. Clients have the right to provide input on policies and services.
12. Clients have the right to know about the complaint, grievance, and appeal process.
13. Clients have the right to know about State and Federal laws that relate to their rights and responsibilities.
14. Clients have the right to know of their rights and responsibilities in the treatment process.
15. Clients have the right to share in the formation of their plan of care.

Clients' Responsibilities:

1. Clients have the responsibility to give providers information they need. This is so that they can deliver the best possible care.
2. Clients have the responsibility to let their provider know when the treatment plan no longer works for them.
3. Clients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
4. Clients have the responsibility to treat those giving them care with dignity and respect.
5. Clients should not take actions that could harm the lives of employees, providers, or other clients.
6. Clients have the responsibility to keep their appointments and to call their provider as soon as possible if they need to cancel visits.
7. Clients have the responsibility to ask their providers questions about their care to understand their care and their role in that care.
8. Clients have the responsibility to let their provider know about problems with paying fees.
9. Clients have the responsibility to follow the plans and instructions for their care, as agreed upon by the client and provider.

If you have questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, Dr. John P. Layh, who can be reached at (937) 767-9171. The effective date of this notice is April 14, 2003. I have read and understand the information in this document. Questions have been answered to my satisfaction. I consent to be treated with these understandings.

Client or Guardian (PRINT NAME)	Client or Guardian (SIGNATURE)	Date

Name: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤