



7407 Turkey Run, Fort Wayne, IN 46815

Mailing Address:

7400 East State Blvd., Fort Wayne, IN 46815

Phone (260) 493-0055 Fax (260) 493-2051

Information Sheet

Service Guidelines

Seeking the services of a therapist is not to be taken lightly, as the material that is dealt with is usually very delicate and uncomfortable. A therapist is dedicated to help a person work through these problems as directly and rapidly as possible. Successful counseling also requires that the client be dedicated to openness and honesty. Hiding or denying only delays resolution of the problem and prolongs the emotional pain – sometimes even increasing it. A therapist is dedicated to dealing with these painful thoughts and feelings in a kind and gently manner with open directness. Successful resolution of a problem depends upon the client's willingness to change attitudes and behaviors supporting the problem. Service providers will only provide such treatment within the scope of their licenses, certification, training, or within the scope of those directly supervising them.

We provide services by appointment between the hours of 9:00 a.m. and 8:00 p.m. A typical counseling session lasts approximately fifty minutes. You will need to call Family Care Center to schedule your appointments.

Emergencies

Family Care Center does not have an outpatient emergency response system. Do not leave emergency messages on voice mail, as these may not be heard until the next day or after the weekend. If you need emergency services, please call St. Joseph Behavioral Health's 24 hour number (260-425-3606) or go to the nearest emergency room.

Supervision of Children

Family Care Center is not responsible for children left unattended in the waiting areas. If you must bring a child to therapy with you, please provide a babysitter over the age of 13 to attend to your child while you are in therapy.

Non-Covered Services

Many services provided to clients are not covered by insurance. This may be due to your insurance contract differing from other insurance companies or be an extra-ordinary service. For those clients who do not have mental health insurance benefits, Family Care Center offers a sliding fee scale based on family income. Please ask your provider or the office staff if you have any further questions.

NOTICE OF PRIVACY PRACTICES

FAMILY CARE CENTER (FCC)

7407 Turkey Run
Fort Wayne, IN 46815
260-493-0055

This client notification describes how psychological and related medical information about you may be handled and how you can get access to this information. It is to help you understand recently initiated government guidelines for new laws.

Please review it carefully.

This notice is effective as of April 14, 2003.

Our (FCC) Mission:

As in the past, we are committed to protecting your privacy. You may even experience awkward dialogue while standing at our receptionist's counter. This is our staff's effort to avoid sharing your information in a setting where others are present. We avoid using your full name for the same reason.

Legal Requirements:

FCC is required by State and Federal laws to maintain the privacy of your Mental Health Information (MHI) and to provide you with a notice of our legal duties and privacy practices with respect to MHI. MHI is information about you, including basic demographic, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. This notification describes how we may use and disclose MHI about you to carry out mental health billing/payment or communication with other providers, or for other specified purposes that are permitted or required by law. The notification also describes your rights with respect to MHI about you.

FCC will not use or disclose MHI about you without your written authorization, except as described in this notification. We reserve the right to change our services, practices, and this notification, and to make the new notification effective for all MHI we maintain. Upon request, we will provide a revised notification to you whenever such occasions are required. The following paragraphs will reflect how we may use or disclose MHI about you.

We will use MHI for treatment. For example: information obtained by FCC will be used to provide appropriate treatment to you. We will document, in your chart, information related to the treatments provided to you in order to monitor treatment effectiveness and ensure continuity of care.

We will use MHI for billing/payment. For example: we will contact your insurer or managed care provider to determine whether it will pay for your treatment and the amount of your co-payment responsibility. We will bill you or a third party payer for the cost of treatment provided to you as appropriate. The information on or accompanying the billing may include information that identifies you, as well as the diagnosis for which you are being treated.

We will use MHI for health care operations. For example: FCC may use information in your health record to monitor the performance of the therapist providing treatment to you. This information will be used in an effort to continually improve the quality and effectiveness of the mental health care and support services we provide.

We are likely to use or disclose MHI for the following purposes, as well:

Business associates: There are some services to us through contracts with business associates. An example of this is the company that writes and maintains our billing software. When these support services are contracted for, we may disclose MHI about you to our business associates so they can perform the job we have asked them to do and to bill you or third party payers for mental health and related services rendered. To protect MHI about you, we require the business associate to appropriately safeguard the MHI.

Communication with individuals involved in your care or payment for your care: Mental health professionals, using their professional judgment, may disclose your MHI to a family member, other relative, close personal friend, or any person you and your therapist identify as relevant to your care. Such disclosure will require a Release of Information be signed and witnessed.

Personal communications: We may contact you regarding scheduling information, as in the event of a missed appointment.

Public health: As required by law, we may disclose MHI about you to a public health or legal authority charged with preventing injury to yourself or others.

Law enforcement: We may disclose MHI about you for law enforcement purposes as required by law or in response to a valid court order, or to a subpoena approved by you or related guardian.

As required by law: We must disclose MHI when required to do so by law, including cases of child abuse or neglect, or domestic violence. We may disclose MHI about you to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else, or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you.

Mental health oversight activities: We may disclose MHI about you to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our licensure and for the government to monitor the mental health system, government programs, and compliance with civil rights laws.

Judicial and administrative proceedings: If you are involved in a lawsuit or dispute, we may disclose MHI about you in response to a court or administrative order. We may also disclose MHI about you in response to a subpoena, discovery request, or other lawful purposes, by someone else involved in the dispute, but only if efforts have been made to tell you about the request or we have failed to obtain an order protecting the requested MHI.

We are permitted to use or disclose MHI about you for the following purposes:

Research: We may disclose MHI about you to researchers when their research has been approved by an institutional review board that has received the research proposal and established protocols to ensure the privacy of your information. MHI about your diagnosis, age, gender, and treatment could be used without revealing your identity.

Notification: We may use or disclose MHI about you to notify or assist in notifying a family member, personal representative, or other person responsible for your care, of your location and general condition should it be suspected you are in danger.

Authorizing Records Release:

The FCC will obtain your written authorization before using or disclosing MHI about you for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing MHI about you, except to the extent that we have already taken action in reliance on the authorization.

YOUR MENTAL HEALTH INFORMATION RIGHTS

The FCC administrative staff can answer questions regarding privacy practices as well as respond to information requests or complaints. You have the following rights with respect to MHI about you:

Records Copying:

You may request a copy of this notice at any time. Even if you have agreed to receive the notice electronically, you are still entitled to a paper copy. To obtain a paper copy, you may request one in person at any FCC site.

Records Review:

You have the right to review your clinical record for as long as the FCC maintains the MHI. Your chart/the clinical record will usually include both treatment and billing records. To inspect your MHI, you must send a written request to our clinical director (at FCC address). Forms for this are available at any FCC site. It is necessary to use this form to facilitate our processing your request. If the clinical director views your records as requiring supervision to safely interpret the contents, you will be billed at the same rate you receive treatment. Supervision will be scheduled as rapidly as possible according to staff availability. We will charge you a fee for the cost of copying, mailing, or other supplies that are necessary to grant your request (for example: when sending your records to another caregiver or for court-related services). We may deny your request to inspect the copy in certain limited circumstances. If you are denied access to MHI about you, you may request denial be reviewed.

Amendments to Records:

If you feel that the MHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the MHI. To request an amendment, you must send a written request to the clinical director (address listed above). Forms for this are available at any FCC site. You must use this form to ensure we receive adequate information to process your request. In addition, you must include a reason to support your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement or disagreement with the decision, and we may give you a rebuttal to your statement. This statement, and possible rebuttal, will be added to your MHI.

Monitoring Records Releases:

You have the right to receive an accounting of the disclosures we have made of your MHI (after April 14, 2003, for most purposes other than treatment, or billing operations). The accounting will exclude disclosures we have made directly to you and disclosures for scheduling purposes. The right to receive an accounting is subject to certain other expectations, restrictions, and limitations. To request an accounting, you must submit your request in writing to our clinical director (address listed above). Forms for this are available at any FCC site. You must use this form to ensure we receive adequate information to process your request. Your request must specify a time period, which may not be longer than six years. We will notify you of the cost involved and you may choose to withdraw or modify your request at any time.

Need Help (?):

If you require more information or need to report a problem, you may contact our administrative staff or clinical director, or you may mail us a letter (address listed above). If you believe your privacy rights have been violated, you can file a complaint with the clinical director or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Family Care Center Client Intake Form

Client Information

First Name _____ Middle Initial _____
 Last Name _____
 Address _____
 City _____
 State _____ Zip _____
 Home Phone _____
 Work/Cell Phone _____
 Can we leave msg. at home ___ work/cell ___
 Social Security # _____
 Birthdate: _____ Age: _____
 Marital Status: _____
 Occupation: _____
 Employer: _____
 Student/Employment Status: Full/Part-time
Please circle one Please circle one
 Spouse's Name: _____

If a Minor (Must Sign Custody Addendum)

Parent(s)/ Guardian _____
 Address _____
 City, State, Zip _____
 Home Phone _____
 Work Phone _____ ext _____

Insurance Information

(this must be filled out completely if we are filing your claims)

Primary Insurance _____
 Name of Insured _____
 Address _____
 City, State, Zip _____
 Relationship to Client _____
 ID # _____ Group # _____
 Social Security # _____
 Birthdate of Insured _____ Sex: M F
 Place of Employment _____
 Address _____
 City, State, Zip _____
 Auth. Code _____

Secondary Insurance

Name of Insured _____
 Address _____
 City, State, Zip _____
 Relationship to Client _____
 Policy # _____ Group # _____
 Social Security # _____
 Birthdate of Insured _____ Sex: M F
 Place of Employment _____
 Address _____
 City, State, Zip _____

OFFICE USE ONLY

Supervision	Yes	No	
Treatment Plan	Yes	No	
Pre-certification Required	Yes	No	
Deductible _____		Max Visits _____	
Fee: \$ _____		Client: \$ _____	
Self pay _____	Church Assisted _____		
Christ Church @ G. _____	LSF _____		
Whitley Co EAP _____	Benevolence _____		
Reduced Fee _____	Brotherhood _____		
Insurance (we file) _____	Insurance (they file) _____		

Responsible for Payment

Name/Agency _____
 Address _____
 City, State, Zip _____
 Phone # _____
 Contact Person (if an agency) _____
 FCC reserves the right to contact this person/agency and verify their agreement to be financially responsible.

Please Turn Page Over

INITIAL “ ” EACH TOPIC AFTER REVIEWED:

CONFIDENTIALITY

- The FCC will maintain the practice of holding all communication between the therapist/mediator and the client in strictest confidence and will not allow information to be released to anyone without written permission or according to law. Your mental health record will be handled according to the following legal requirements: 1) Therapists are required to report circumstances wherein a client states an intention to harm self or others, in cases of recent or ongoing abuse, and with court related custodial concerns; 2) Indiana law requires reporting any activity wherein a child or adolescent describes participating in circumstances involving sexually oriented activities. It is the FCC's legal responsibility as a care provider to report such to the respective division of Family and Children's Services (welfare) and respective police department. Thus, such information cannot be considered confidential information within the counseling setting, and so it also cannot be maintained only between the client and therapist/care provider; 3) Court ordering of unlicensed therapists to do so; 4) Notice of Privacy Practices (attached sheet).

CANCELLATIONS

- Making an appointment is a contract between the therapist/mediator and the client that both will be present at the appointed hour. However, we are aware that genuine emergencies do arise which preclude the keeping of the appointment. Late cancellations, however, do not allow us to fill the hour with persons who are waiting for an appointment. **Cancellations require 24 hour notice. There is a minimum \$20.00 fee for late cancellations or missed appointments*.**
- *Note: **Missed appointments without cancellation notice will be expected to be paid at the full-fee rate and cannot be billed to insurance.** Even if your therapist uses the reminder call system, you are still responsible for payment of missed appointments whether or not a reminder call was placed. FCC reserves the right to exercise the option of discontinuing treatment after the second occurrence and assessing a full-fee charge against missed appointments.

FEES

- Checks are to be made payable to **Family Care Center or FCC.**
- I understand and agree that I am personally and fully responsible to pay for all services rendered; I am to pay in full at the time of appointment and I am responsible to file any claim for reimbursement with my insurance carrier, unless FCC is contracted to do so (the therapist will provide reasonable information [e.g., Diagnosis Code] needed to process such claims). If I am covered by Medicare or have insurance with a carrier which has a contract with the Family Care Center, FCC will file claims on my behalf. I agree to pay any deductible or copayments required by my insurance company. I also agree to pay for any services not covered by my insurance carriers contract with FCC.
- One working day's notice is required to release copies of any record for medical, billing or legal purposes (see Notice of Privacy & Practices). FCC reserves the right to bill for these services, as is customary.
- I HAVE READ, UNDERSTAND THE ABOVE POLICIES & PROCEDURES, AND CONSENT TO TREATMENT.
- I HAVE RECEIVED THE INFORMATION SHEET.

Signed: _____ Date _____
Client/Guardian/Custodial Parent

Witnessed: _____ Date _____

DO YOU, THE CLIENT, HAVE A HISTORY FOR ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

- | | | |
|--|---|--|
| <input type="checkbox"/> chronic lying | <input type="checkbox"/> hostile/angry mood | <input type="checkbox"/> extreme worrier |
| <input type="checkbox"/> stealing | <input type="checkbox"/> indecisive | <input type="checkbox"/> self-injurious acts |
| <input type="checkbox"/> violent temper | <input type="checkbox"/> immature | <input type="checkbox"/> impulsive |
| <input type="checkbox"/> fire setting | <input type="checkbox"/> bizarre behaviors | <input type="checkbox"/> easily distracted |
| <input type="checkbox"/> won't sleep alone | <input type="checkbox"/> night terrors | <input type="checkbox"/> poor concentration |
| <input type="checkbox"/> repeats words of others | <input type="checkbox"/> distrustful | <input type="checkbox"/> overeating |
| <input type="checkbox"/> not trustworthy | | <input type="checkbox"/> other _____ |

Family History/ Family of Origin

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parents' current marital status:

- married to each other
- separated for ___ years
- divorced for ___ years
- mother remarried ___ times
- father remarried ___ times
- mother involved with someone
- father involved with someone
- mother deceased for ___ years
age of client at mother's death _____
- father deceased for ___ years
age of client at father's death _____

Describe childhood family experience:

- outstanding home environment
- normal home environment
- chaotic home environment
- witnessed physical/verbal/sexual abuse toward others
- experienced physical/verbal/sexual abuse from others
- other _____

Describe Siblings (Brothers & Sisters): _____

Describe parents:

Father
 full name _____
 occupation _____
 education _____
 general health _____

MOTHER
 full name _____
 occupation _____
 education _____
 general health _____

Age at leaving childhood home: _____ **Circumstances:** _____

Special circumstances in childhood: _____

IMMEDIATE FAMILY

Intimate relationships:

- single, never married
- never been in a serious relationship
- not currently in relationship
- currently in a serious relationship
- engaged _____ months
- married for _____ years
- divorced for ___ years
- separated for ___ years
- divorce in process ___ months

- live-in for ___ years
- ___ prior marriages (self)
- ___ prior marriages (partner)

Relationship satisfaction:

- very satisfied with relationship
- satisfied with relationship
- somewhat satisfied with relationship
- dissatisfied with relationship
- very dissatisfied with relationship

Describe any past or current significant issues in intimate (eg; spousal) relationships: _____

Name _____ Last First Middle Date _____ Client # _____

List all persons currently living in client's household:

Name Age Sex Relationship to client

List children not living in same household as client:

Name Age Sex Relationship to client

Frequency of visitation of above: _____

Describe any past or current significant issues in other immediate family relationships: _____

SOCIO-ECONOMIC HISTORY (check all that apply for client)

Living situation:

- housing adequate
- housing inadequate, why? _____

Financial situation:

- no current financial problems
- large indebtedness
- poverty or below-poverty income
- impulsive spending
- relationship conflicts over finances

Military history:

Branch in military: _____
Honorable discharge: Yes No

Years of Schooling Completed: _____

Current Employment, how long?: _____

Spouse's Employment (if applicable): _____

Employment Satisfactory? Yes No

If no, why? _____

Social support system:

- close relationship with family/friends
- few friends
- substance-use-based friends
- no friends
- distant from family of origin

Legal history:

- no legal problems
- now on parole/probation
- arrest(s) not substance-related
- arrest(s) substance-related
- court ordered this treatment
- jail/prison _____ time(s)
- total time served: _____
- describe last legal difficulty: _____

Church/spiritual/recreational history:

- Y N
- Do you attend a church/religious group?
If yes, where? _____
 - Are you active in your church/religious group?
Describe your relationship with God/Higher Power: _____

- Y N
- Currently active in community/recreational activities?
 - Formerly active in community/recreational activities?
 - Currently engage in hobbies? _____
 - misc.: _____

Name _____ Date _____ Client # _____
Last First Middle

