Olive Branch Counseling Associates, Inc.

Client Name _____ Age _____ Date of Birth_____

Address _____

City & State_____ Zip _____

Home Phone (___)_____Work Phone (___)_____

Cell Phone (____)_____ Email Adress: _____

Occupation: _____ Education:_____

How many hours a week do you work? _____Employer or School_____

Spouse _____ Occupation: _____

Names and Ages of Children _____

_____

Name of Physician _____ Date of Last Physical Exam _____

Would you like your therapist to contact your physician? _____ Phone # _____

Have you seen a therapist before? _____ How long ago?_____For how long?_____

Name of Therapist: _____

Do you have any diagnoses made by a physician or therapist? _____ If so, with what have you been diagnosed? _____

Please list any medications you take: _____

Names and Ages of Siblings _____

Is your mother living? _____If not, cause of death? _____

Is your father living? _____If not, cause of death? _____

How do you describe yourself culturally/ethnically? _____

Have there been any changes in your life recently? (death of a loved one, divorce, etc.)

_____

What kinds of difficulties bring you to our office? _____

_____

Is there anything else you want your therapist to know about you right now?

_____

Please tell us how you found Olive Branch:_____

Symptom Checklist

Your Name _____ Todays Date_____

***Please rate the degree to which you have been experiencing the following problems during the LAST WEEK. **Make an X on or near the numbers that best describe the severity of the item listed below.

	Not a Problem										Very Severe Problem
1. Anxiety (Nervousness)	0	1	2	3	4	5	6	7	8	9	10
Panic Attacks	0	1	2	3	4	5	6	7	8	9	10
2. Depression	0	1	2	3	4	5	6	7	8	9	10
3. Disturbing Thoughts	0	1	2	3	4	5	6	7	8	9	10
4. Thinking about hurting yourself	0	1	2	3	4	5	6	7	8	9	10
How likely is it?	0	1	2	3	4	5	6	7	8	9	10
5. Thinking about hurting others	0	1	2	3	4	5	6	7	8	9	10
How likely is it?	0	1	2	3	4	5	6	7	8	9	10
6. Fears/Fearfulness	0	1	2	3	4	5	6	7	8	9	10
7. Repetitive thoughts/Obsessions	0	1	2	3	4	5	6	7	8	9	10
8. Impuslive thoughts, specify: _____											
9. Impulsive behaviors, specify: _____											
10. Loss of appetite/Not Eating:	0	1	2	3	4	5	6	7	8	9	10
11. Overeating	0	1	2	3	4	5	6	7	8	9	10
12. Binge Eating	0	1	2	3	4	5	6	7	8	9	10
13. Have you gained weight recently? Y N How Much? _____ In how much time? _____											
14. Have you lost weight recently? Y N How Much? _____ In how much time? _____											
15. Not sleeping enough	0	1	2	3	4	5	6	7	8	9	10
16. Sleeping too much	0	1	2	3	4	5	6	7	8	9	10
17. Waking up at night	0	1	2	3	4	5	6	7	8	9	10
18. Trouble falling asleep	0	1	2	3	4	5	6	7	8	9	10
19. Nightmares	0	1	2	3	4	5	6	7	8	9	10
20. Other sleeping problems	0	1	2	3	4	5	6	7	8	9	10
Specify:_____											
21. How many hours do you sleep most nights? _____											
22. Do you ever not sleep at night? Y N How often? _____ Why? _____											
23. Fatigue	0	1	2	3	4	5	6	7	8	9	10
24. Attention/Concetration Difficulties	0	1	2	3	4	5	6	7	8	9	10
25. Adjusting to change	0	1	2	3	4	5	6	7	8	9	10
26. Sexual Problems	0	1	2	3	4	5	6	7	8	9	10
Specify:_____											
27. Alchohol Problems	0	1	2	3	4	5	6	7	8	9	10
Specify:_____											
28. Drug Problems	0	1	2	3	4	5	6	7	8	9	10
Specify: _____											
29. Gambling problems	0	1	2	3	4	5	6	7	8	9	10
Specify: _____											

30. Work/School Problems 0 1 2 3 4 5 6 7 8 9 10
31. Marriage Problems 0 1 2 3 4 5 6 7 8 9 10
32. Child-rearing problems 0 1 2 3 4 5 6 7 8 9 10
33. Extended family problems 0 1 2 3 4 5 6 7 8 9 10
34. Problems getting along with others 0 1 2 3 4 5 6 7 8 9 10
35. Anger 0 1 2 3 4 5 6 7 8 9 10
36. Violence 0 1 2 3 4 5 6 7 8 9 10
Specify: _____
37. Spiritual Problems 0 1 2 3 4 5 6 7 8 9 10
38. Do you attend church? If so, which one? _____
39. Health problems 0 1 2 3 4 5 6 7 8 9 10
Specifiy: _____
40. Self-Esteem 0 1 2 3 4 5 6 7 8 9 10
41. Cultural/Ethnic Identity 0 1 2 3 4 5 6 7 8 9 10
42. Self Image (How you see yourself) 0 1 2 3 4 5 6 7 8 9 10
43. Legal Problems 0 1 2 3 4 5 6 7 8 9 10
Specify: _____
44. Are there one or more firearms in your house **Y N**
Specify:_____
45. Financial Problems 0 1 2 3 4 5 6 7 8 9 10
46. Spending too much money 0 1 2 3 4 5 6 7 8 9 10
47. Feeling hopeless 0 1 2 3 4 5 6 7 8 9 10
48. Feeling sad 0 1 2 3 4 5 6 7 8 9 10
49. Feelings of loneliness 0 1 2 3 4 5 6 7 8 9 10
50. Do you exercise? **Y N** What type of exercise? _____How often? _____
51. How much caffiene do you consume each day? _____
52. Do you drink energy drinks? **Y N** How often? _____
53. Other problems 0 1 2 3 4 5 6 7 8 9 10
Specify _____

What kind of car do you drive? Make: _____ Model: _____ Year _____
Color: _____ License Plate Number:_____

Is there another car you drive sometimes? Make: _____ Model: _____
Year _____ Color: _____ License Plate Number:_____

Emergency contact: Name: _____Phone # _____
Address: _____

What are your three main concerns?

_____

_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

Olive Branch Counseling Associates, Inc.

6819 W. 167th Street, Tinley Park, Illinois 60477

The credit card information below is used for the purpose of service fees, insurance fees (including co-pays, deductible payments and co-insurance) and missed or late cancelled appointment payments incurred at Olive Branch Counseling Associates, Inc. Please complete the form below. This card will be kept on file and charged after each appointment or missed appointment, or when we receive information from your insurance company. A minimum of a 24-hour notice is required for rescheduling or canceling an appointment for reasons other than emergencies and illness. If proper notice is not given for the rescheduling or cancellation of any appointment, the full session fee will be charged. By signing, you are providing permission for payments to be charged to your credit card.

Therapist: _____

Client Name: _____

Name on Card: _____

Visa ____ Discover _____ MasterCard _____ AmEx_____

Card Number: _____

Expiration Date: _____

Security Code: _____

Zip Code: _____

Signature: _____ Date: _____

Printed Name: _____ Date: _____

Olive Branch Counseling Associates, Inc. has transitioned from the standard telephone land-line already being used to the use of "Google Voice" telephone numbers for more efficient communication between clients and their therapists.

Please read and sign below acknowledging your understanding of how this transition impacts you, our client:

I understand that using "Google Voice" does not provide a secure line according to the Health Insurance Portability and Accountability Act (HIPAA). Therefore telephone conversations and messages, either text or voice, should only be utilized for communication of setting, changing or confirming appointment times.

By signing below you agree to abide by this policy as it is designed to protect you, the client.

Signed_____ Date_____

Printed Name_____

Now, about how your therapist may contact you:

I give my permission for my therapist to leave a voice-mail message and/or a text message on my phone relating to appointment information only.

I agree to communicate with my therapist via email only for appointment changes or confirmations.

Olive Branch Counseling Associates, Inc. does not provide Internet counseling services.

I understand that giving permission for my therapist to leave a voice mail message or send a text message regarding appointment times is entirely voluntary and I am not obligated in any way to sign below. If I agree to any part of this agreement I may withdraw my decision at any time by filling out a new agreement form stating such. I hereby agree my therapist may leave voice or text messages on the following

Phone Number____-____-_____ Is this your Cell, Home, Work or Other number?_____

Phone Number____-____-_____Is this your Cell, Home, Work or Other number?_____

Email address: _____

Signed_____Date_____

Printed Name_____

I acknowledge that I have received the attached copy of the Notice of Privacy Practices and Social Media Statement.

Signed_____ Date _____

I give my consent to receive an evaluation and treatment that my therapist and I deem appropriate. I am entering into treatment voluntarily and am aware I can discontinue treatment at any time.

Signed_____ Date _____

*I understand that I am responsible for the payment of professional services rendered to me, including any unpaid balance remaining after insurance benefits have been paid.

*Should it become necessary for Olive Branch Counseling Associates, Inc. to employ the services of a collection agency or lawyer to collect my unpaid balance, I agree to pay the expenses associated with that collection process.

Signed_____ Date_____

When you schedule an appointment in our office, that time is reserved just for you. In an effort to be fair to our therapists who reserve that time for you, we ask you to sign below.

I acknowledge and agree to comply with the Policy of Olive Branch Counseling Associates that a twenty-four (24) hour notice is required for sessions that will be missed for reasons other than emergencies.

If a twenty-four hour notice is not given, I accept full financial responsibility for the session. I will mail or bring cash or a check payable to Olive Branch Counseling Associates, Inc. within a week of the missed session in the amount of $_____ to pay for the missed session.

Signed_____ Date_____

Printed Name_____

Olive Branch Counseling Associates, Inc.
6819 W. 167th St.
Tinley Park, IL 60477
(708) 633-8000

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I) Uses and Disclosures for Treatment, Payment, and Health Care Options

I may use of disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
    - *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be consulting with another health care provider.
    - *Payment* is when we obtain reimbursement for your healthcare. An example of payment is when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of Olive Branch Counseling Associates, Inc. Examples of health care operations are quality assessment and improvement activities, business- related matters such as adults and administrative services, and case-management and care coordination.
- *"Use"* applies only to activities within Olive Branch Counseling Associates, Inc., such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of Olive Branch Counseling Associates, Inc., such as releasing, transferring, or providing access to information about you to other parties, or mental health care provider within Olive Branch Counseling Associates, Inc.
- *"Authorization"* is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II) Other Uses and Disclosures Requiring Authorization

Olive Branch Counseling Associates, Inc. may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. Olive Branch Counseling Associates, Inc. will also need to obtain an authorization before releasing your Psychotherapy Notes.

"Psychotherapy Notes" are notes your therapist has made regarding conversations during a private group, joint or family counseling session, which are kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

is maintained in the record and Psychotherapy Notes. On your request, your therapist may deny your request. On your request, your therapist will discuss with you the details or the request for access process.

- Right to Amend- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your therapist may deny your request. On your request, your therapist will discuss with you the details of the amendment process.
- Right to an Accounting- You have the right to obtain a paper copy of the notice from your therapist upon request, even if you have agreed to receive the notice electronically.

Mental Health Care Provider's Duties:

- Olive Branch Counseling Associates, Inc. is required by law to maintain the privacy of your PHI and to provide you with a notice of your legal duties and privacy practices with respect to PHI.
- Olive Branch Counseling Associates, Inc. reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If Olive Branch Counseling Associates, Inc. revises our policies and procedures, we will provide you with a written notice regarding any changes and make them available to you.

V) Social Media Policy

This document outlines Olive Branch Counseling Associates, Inc.'s policies regarding the use of Social Media. If you have any questions or concerns about the information provided, we encourage you to discuss them with your counselor.

Olive Branch Counseling Associates, Inc. is present on social media platforms, allowing us to share our practice's information, news, and events, as well as blog posts and mental health related literature. However, your confidentiality is our priority and commitment. While you are welcome to follow us on these platforms, please acknowledge that doing so may compromise your confidentiality. We encourage you to consider your confidentiality and privacy prior to "liking" us on any platforms. All of the information on our social media platforms can be viewed without "liking" or "following" the pages.

Please note that these accounts are public, thus any "likes" or comments can be seen by whomever you are connected with on social media, as well as with whomever visits our pages. We have no expectation of our clients to "like" or follow Olive Branch Counseling Associates, Inc. on any of our platforms.

Clinicians at Olive Branch Counseling Associates, Inc. are not permitted to accept "friend" requests from their clients on their personal social media sites, including LinkedIn. Adding clients on these platforms can compromise confidentiality and safety, as well as blur boundaries in the therapeutic relationship.

Please note that our listings on Google, Yelp, Facebook, Twitter, Instagram, etc. are not requests for testimonials, ratings, or endorsements from our clients. In alliance with the American Counseling Association's Code of Ethics, we do not solicit testimonials.

Above all, your confidentiality is our priority. Thank you for reviewing the Social Media Policy. If you have any questions regarding this policy, please contact your therapist, or call us at (708) 633-8000 ext. 3.