

Profile Information

Name _____ D.O.B. _____ (age) _____ S.S.# _____

Address _____ Phone (H) _____ (W) _____

City/State/Zip _____ E-mail _____

Emergency Contact _____ Relationship _____ Phone _____

What brings you to counseling: _____

Current Medical Concerns: _____

Please Check All that Apply

APETITE: no changes recent increase recent decrease weight gain/loss (circle which)
 MOOD: happy most days often tearful blah most days feel hopeless
 ANXIETY: excessive worries nightmares fearful often panic attacks
 ANGER: quick to anger lose temper easily often frustrated often irritable
 SLEEP: I average ____hrs/night sleeping a lot interrupted sleep trouble getting to sleep

Current Med's	Dose/Frequency	Date Started	Used for

(Medicine Prescribed By: _____, M.D.)

Alcohol/Drug	Amount/Frequency of Use	Started Using at Age

FAMILY of ORIGIN I am adopted I am a child of divorce I had a single Parent Childhood

Primary Parents (names)

_____ Living Deceased Age _____ # of Children _____ Lived with from age _____ - _____

_____ Living Deceased Age _____ # of Children _____ Lived with from age _____ - _____

Step-Parents/Guardians (names)

_____ Living Deceased Age _____ # of Children _____ Lived with from age _____ - _____

_____ Living Deceased Age _____ # of Children _____ Lived with from age _____ - _____

KEY SUPPORT SYSTEM (Identify the significant people in your life to whom you turn for support)

Name	Relationship	Known How Long?

CHILDREN

Name	Age	Co-Parent(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RELATIONSHIP HISTORY (Please identify ALL SIGNIFICANT Relationships)

Name	Length of Relationship	Reason Ended
_____	Your Age _____ to Age _____	_____
_____	Your Age _____ to Age _____	_____
_____	Your Age _____ to Age _____	_____
_____	Your Age _____ to Age _____	_____
_____	Your Age _____ to Age _____	_____

LOSS HISTORY (Identify all significant deaths you have had in your life)

Name /Relationship to you	Your Age	Cause of Death
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENERAL LIFE EXPERIENCES (please check all that apply, if more than once, place number in blank)

____ Fire/Natural Disaster	____ Childhood Physical Abuse	____ Childhood Sexual Abuse	____ Miscarriage
____ Job Loss	____ Rejection by Family	____ Chronic Health Condition	____ Rape
____ Abortion	____ Victim of Discrimination	____ Child of Alcoholic(s)	____ Divorce
____ Victim of Crime	____ Suicide Attempt	____ Domestic Violence	____ Legal Problems
____ Financial Problems	____ Previous Inpatient Care	____ Previous counseling	____ Bankruptcy

CURRENT HEALTH CONCERNS

EMPLOYMENT

Current Employer: _____ Length of Employment there: _____

Employment Concerns? _____

GOALS

What do you hope to accomplish through your participation in therapy?

How did you learn about me? Advertisement Friend Internet Other _____

Counseling Information and Agreements

CONFIDENTIALITY is absolutely respected in this office. There are, however, some limits to our control over your confidentiality if you chose to communicate with us via e-mail. E-mail is generally only used for scheduling purposes. Additionally, in the event that your therapist runs into you outside of counseling, it is our policy to not acknowledge you unless you initiate a "hello" first. This is to ensure your complete confidentiality.

FEES

Fees are \$90 per 50 minute session. \$175 for a 90 minute session. **Payment is due at the time of service** (preferably prior to session) unless other arrangements are made. Fees are payable by Visa, MasterCard, Flex Card, Health Reimbursement Funds Checks or Cards, personal check or cash. **Checks are payable directly to Michele O'Mara, LCSW.**

CANCELLATIONS and MISSED APPOINTMENTS

Appointments must be cancelled at least 36 hours in advance of the scheduled appointment time. Failure to provide 36 hours notice will result in a "Missed Appointment" charge. **The fee for Missed Appointments is \$40.** Late cancellations due to unusual circumstances (i.e. illness, accident, ill children, etc..) will NOT be considered "Missed Appointments."

In **CRISIS** situations that compromise your safety it is essential that you contact an emergency 24-hour help-line. St. Vincent's is one of the many hospitals offering a help line and their number is 317.338.4800. If you are feeling suicidal, or you question your safety, it is essential that you call the help-line immediately.

TELEPHONE/EMAIL CONTACT

Occasionally a client will need to contact the therapist with questions or concerns between sessions. The fees for occasional and brief (5 minutes or less) telephone/e-mail contact between the therapist and client are included in the fees paid for routine office visits. If frequent or prolonged conversations are required (especially those of a therapeutic nature) a fee of \$5 per minute will be charged. This fee also applies to frequent or prolonged messages left on the therapist's voicemail or email.

INCOME TAX DEDUCTION

Fees for therapy are generally deductible under medical expenses on your income tax return depending on your income and other deductions. Let the therapist know if you need receipts to make these claims.

I _____ have read the above and I understand the information and agreements stated. I consent to receive counseling services from Michele O'Mara and Associates according to the guidelines noted.

Client's Signature | Date

Parent/Guardian | Date

Michele O'Mara and Associates | Date

Notice of Privacy Practices and Summary of Key Issues

This summary provides a summary of privacy practices followed by Michele O'Mara, LCSW, and any contracted or hired office personnel. For more information on our privacy practices, please review the complete Notice of Privacy Practices available at www.micheleomara.com/forms.htm, and posted in the waiting room. The complete list of privacy practices is available upon request.

Uses and Disclosures: All health information used by us is to maximize your treatment benefit, to obtain payment for treatment – or insure that you receive your reimbursement from insurance if applicable, and to evaluate the quality of care you receive. We may use or disclose identifiable health information about you without your consent in specific situations described in the Notice of Privacy Practices. Beyond these situations, however, we will ask for your written authorization before using or disclosing any identifiable health information about you. Neither this summary nor the full Notice of Privacy Practices covers every possible use or disclosure.

Your Rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, there is a usual and customary fee for copying, mailing and other services required to fulfill the request. You will also have the right to receive a list of certain types of disclosures of your information that we may have made other than for the purpose of treatment, payment, and health care operations. If you believe that information in your record is incorrect, you have the right to request an amendment.

Our Legal Duty: We are required by law to protect the privacy of your information, provide the Notice of Privacy Practices, follow the practices described in the notice, and seek your acknowledgement of receipt of the notice. Before we make a significant change in our policies, we will change our Notice of Privacy Practices and post the new notice. You can also request a copy of these at any time.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact us or you may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

I HEREBY ACKNOWLEDGE: I have reviewed the information above and have received (if requested) a copy of the Notice of Privacy Practices.

Please sign and print your name, along with today's date.

Signature: _____

Printed Name: _____

Date: _____

Consent for Mental Health Care

I, the undersigned, agree and consent to participate in the mental health care offered and provided by Michele O'Mara, LCSW, a mental health professional as defined by Indiana law.

I understand that I am consenting and agreeing only to those mental health services that Michele O'Mara is qualified to provide within the scope of her professional license, certifications, and training.

Client's Printed Name: _____ | _____
Date

Client/Guardian's Signature: _____ | _____
Date

Witness Signature: _____ | _____
Date