INSTRUCTIONS FOR ENCLOSED FORMS

Each Client Please Complete the Following:

1. "Contact Information" form. This form provides us with your contact information and allows you to specify how you would like to be contacted in the future by Bevill and Associates LLC.

2. "Informed Consent and Authorization for Services" form. This form summarizes important information about confidentiality, fees, cancellation policies, and other practices and policies of Bevill and Associates LLC. Please review it, initial and sign where necessary.

3. Intake Questionnaire". This questionnaire aids assessment and treatment planning by giving your clinician a quick overview of your background and current situation at a glance. Please bring these forms with you to your initial session. All information you provide in this form will be kept as part of your confidential file. Feel free to discuss any questions with your therapist before signing

INTAKE INFORMATION

Client Name:

_____

(Last) (First) (Middle Initial)

Name of parent or guardian (if minor):

_____

(Last) (First) (Middle Initial)

Birth date: _____/_____/_____ Age:_____ Gender: ____Male _____Female

Mailing Address:

_____

Street Address City. State. Zip

_____ _____

Drivers License Number Social Security Number

This must be an address to which we can send correspondence, as needed. The name "Bevill and Associates LLC" will not be displayed on the envelope.

Home Phone: (_____) _____ May a message be left at this number?
Yes □ No □
Cell Phone: (_____) _____May a message be left at this number?
Yes □ No □
Work Phone: (_____) _____May a message be left at this number?
Yes □ No □

Email Address: _____

□ I understand that writing in my email address (above) is giving explicit consent to Bevill and Associates LLC to use that email address to correspond with me in all matters directly related to the provision of services (includes invoicing; appointment bookings, confirmations and reminders; follow-up on services, etc.).

Would You Like to be on Our Email Newsletter List? (Please Check One of the Statements below): Our monthly newsletter contains articles on building strong relationships and mental and emotional wellness, links to online resources and book recommendations that you can use to improve your situation, as well as notices of upcoming workshops or new services.

□ Yes, I would like to receive monthly email newsletters from Bevill and Associates LLC
□ No, I do not wish to receive monthly newsletters

Help us Better Reach Others Who Also Need Help Please let us know who recommended us to you or how you otherwise learned about Bevill and Associates LLC.

□ My Insurance Provider
□ My Employer
□ My Physician or Psychiatrist
□ Another Psychologist or Therapist
□ My Lawyer
□ My Priest, Pastor, Bishop or other Church Leader
□ A Family Member, Friend or Personal Acquaintance

I also searched for Bevill and Associates LLC on the Internet
□ I found you primarily by doing a search on the internet:
□ I found you primarily by doing a search on the internet:
□ I found you in the Psychology Today Online Directory
□ I am a returning client
□ My spouse/partner or other family member was referred to you or found you
□ Other _____

_____ _____

Signature Date

INFORMED CONSENT AND AUTHORIZATION FOR SERVICES

Welcome to Bevill and Associates LLC, This form provides information about the practice and privacy policies of Bevill and Associates LLC. This information is intended to help you make an informed decision about accepting services from us. If you have any questions or concerns about anything on this form, please do not sign the form until you have discussed your concerns with your therapist.

Frequency of Sessions

Weekly or bi-weekly 50-minute sessions are most common. The frequency of sessions is based largely on your needs and situation. How Long is Therapy? The amount of sessions needed varies depending on the nature of each person's concerns, the complexity of the issues involved, the strength of our working relationship, and each person's commitment to work on the presenting issues. There is a direct relationship between effort applied between sessions and progress over time. Anywhere between 1 and 20 sessions is typical, though more sessions may be needed in some situations.

Fees

Individual, Couples and Family Sessions……$150.00*
Individual Therapeutic Groups……..$50.00
Couples Therapeutic Groups…… ……$65.00
Psychological Testing / Assessment……$110.00

We prefer payment at each session rather than a regular billing process.

Additional time beyond the 50-minute hour is billed in 10-minute increments.

Billable services include: face-to-face and telephone consultations (not including the initial intake or dealing with brief scheduling matters), report writing and other requested correspondence, and review of written records from other professionals.
Fees are payable by cash, checks, credit card or debit card

Insurance

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. It is your responsibility to verify your benefits prior to your first session. Any insurance claim that is denied you are responsible for payment of the fees for the session. We do not refile insurance claims after the first denial. For other insurance plans, if requested, we can provide you with a monthly statement for you to submit to your insurance company so they can reimburse you directly for all eligible fees. In all cases, you, not your insurance company, are responsible for full payment of my fees at each session (see "Billing and Payments" above).

It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. You will want to ask, "What are my out of network, outpatient mental health services benefits?"

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I am asked 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.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the potential problems described above.

Privacy

All information you share with your therapist is private and confidential. Your information will not be released to anyone without your written permission (with some exceptions as explained below). When information is to be released with your consent you will be consulted regarding what information is to be released. Your information will be kept on file in a secure and private location.

If your therapist should find themselves in a social setting where you are present (e,g., grocery store, restaurant, social event), They will respect your privacy by not initiating contact or seeking to engage you in a conversation unless initiated by you. Should a colleague, friend, or family member accompany me, They will not introduce them t you.

You may review the contents of your own counseling file upon request. The full privacy policy for Bevill and Associates is available upon request. It can also be viewed at https://www.bevillandassociates.com/privacy

About Privacy When Multiple Persons Are Involved in the Therapy Relationship

Many of our clients consist of multiple family members (i.e. spouses and partners in couple's therapy, family members in family therapy). In such cases, no information obtained from multiple family members may be released to an outside party without the prior written consent of each person from whom the information was obtained, unless 1) a different agreement has been established ahead of time and documentation of such an agreement is attached to this form or 2) information about the non-consenting party can be entirely removed from the information that is shared.

As part of the assessment phase of therapy or as otherwise indicated, your therapist may request to meet with each of you on an individual basis for one or more sessions. Unless you have collectively made a different agreement ahead of time with your therapist and documentation of such an agreement is attached to this form, please be aware that your therapist is free to use his or her clinical judgment to decide whether, when and how to incorporate information you've shared privately with your therapist into your conjoint sessions and that disclosure of such private information by the therapist to others in therapy with you is not considered a breach of confidentiality.

The rationale for this policy is that it can be detrimental to the progress of your therapy or your relationship for your therapist to be in a position of having knowledge of sensitive information that the other spouse is not privy to, as it may put your therapist into a conflict-of-interest position.

No Secrets Policy

Please note that with couples and family therapy the couple and/or the family is the client (e.g. the treatment unit), not the individuals. As such all therapists at Insights Counseling Center practice a no-secrets policy when conducting marital/couples/family therapy. This means that confidentiality does not apply between the couple or among family members when one member of the treatment unit requests an individual session or contacts their ICC therapist outside of the therapy session to share a secret.

On occasion an individual session may be scheduled to assist in the overall therapy process to the treatment unit (e.g. the couple) and will be scheduled only when mutually agreed upon. Please understand that any information given in the individual sessions will not be held in confidence or secret in couples and/or family sessions. Your therapist will encourage the person holding the secret to share the secret in the following session and will support the client in doing so. Your therapist also reserves the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as deemed appropriate or necessary to support the treatment units overall treatment progress and goals. If you are seeking couples therapy or family therapy, please have each member of the treatment unit fill out and sign an intake form.

Conjoint Sessions

On occasion, and only if it benefits the client's therapy goals, your therapist may ask that a family member or significant other join you for a therapy session. It is important to note that this is done only on occasion and at the therapist's discretion when it best serves the client. If a family member or significant other agrees to meet for a session, it will be for the client's benefit. If the person joining the session is your significant other, this does not constitute as couples therapy, rather it is as a support to your work, and/or a check-in session. Additionally, the third party (friend or significant other) is not joining the session for his or her own therapy, nor will your therapist at Bevill and Associates LLC work with them as a therapist. If we decide that this would be beneficial, you will need to sign a written release of information for this type of conjoint session.

Minors

If you are under fourteen (140 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Exceptions to Privacy

A client's confidential information may be released without their consent under the following conditions: When the purpose is to protect individuals (including a client) who are at foreseeable and imminent risk of bodily harm or death as a result of a client's actions.

Under law that requires reporting of child and elder abuse/neglect to authorities.

Under subpoena from a court of law.

In the unlikely event of a client's account becoming 120 days past due or in the event of a dispute over a financial transaction, limited information may be shared with financial or legal agencies connected with the business of Bevill and Associates LLC. (i.e. credit card companies, collection agencies, etc.) as necessary to resolve such disputes or to collect on unpaid accounts. In such cases, any personal information disclosed is limited to only that which is necessary to resolve the dispute or to settle the account (i.e. dates, transaction amounts, etc.) and does not include any clinical information.

Exceptions that apply to personal information disclosed by minors: Generally, but not always, the legal guardian(s) of a minor must give consent for the minor to receive treatment and has a legal right to information disclosed in therapy by the minor in order to provide nurture and protection that is in the best interest of the minor. However, if everyone agrees at the outset of therapy to terms of confidentiality between the minor and his or her guardian(s) then the therapist is bound to abide by these terms. The therapist may subsequently only disclose confidential information obtained from the minor without written consent under the terms agreed upon, or as required by law, or under the exceptions outlined above. Your therapist will discuss these exceptions further with you in session, as applicable. If you disclose in confidence that you have done something illegal, your therapist is not obligated to report this to the authorities, unless the circumstances involve child abuse, abuse against a dependent adult, or a direct threat to another person (as outlined above).

Initial Here 

I have carefully read the preceding sections on privacy and exceptions to privacy (or have had them explained to me) and I am satisfied that I fully understand the above stated policies on confidentiality and the limits of my confidentiality rights and I agree to proceed with counseling under these terms. _____. Initials

Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of] communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with your therapist.

Email and Text Communication

We use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Because text messaging is a very un-secure and impersonal mode of communication, we do not text message to nor do we respond to text messages from anyone in treatment with me. So, please do not text message use unless we have made other arrangements.

S**ocial Media**

We do not communicate with, or contact, any of our clients through social media platforms like Twitter and Facebook. In addition, if we discover that we have accidentally established an online relationship with you, I will cancel that relationship This is because these types of casual social contacts can create significant security risks for you.

Your therapist participates in various social networks, but not in a professional capacity. If you have an online presence, there is a possibility that you may encounter your therapist by accident. If that occurs, please discuss it with your therapist during your appointment We believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to cont

Websites

We have a website that you are free to access. We use it for professional reasons to provide information to others about our practice. You are welcome to access and review the information that we have on our website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

Your therapist will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, We understand that you might choose to gather information about me in this way. In this day and age, there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about your therapist through web searches, or in any other fashion for that matter, please discuss this with your therapist during your time together so that it can be dealt with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with your therapist so he or she can discuss it and its potential impact on your therapy. Please do not rate your therapist's t work with you while you are in treatment on any of these websites. This is because it has a significant potential to damage our ability to work together.

Confidential Electronic Data Storage and Email Transmission

Your confidentiality as a client is of utmost importance. To support and secure your clinical information, Bevill and Associates LLC has set up a system as part of our therapeutic services in order to securely store and protect your information in a confidential and protected capacity. Thus, Bevill and Associates will be utilizing Google Inc. and the following applications: Gmail, Google Calendar, Google Drive and Google Apps Vaults to electronically save and store client information and data and to confidentially communicate with clients in various capacities via the Internet. Gmail, Google Calendar, Google Drive and Google Apps vaults and all client protected health information are covered under the Health Insurance and Portability Act of 1996 and in particular 45 C.F.R, Part 164, Subpart C under HIPPA.

In Case of an Emergency

Our office number is not an emergency number and Bevill and Associates does not offer 24-hour crisis coverage. Therefore the following procedure is to be followed if you experience a crisis:

Call 911 if your in immediate danger; or go to the nearest emergency room
Call the local crisis center (205) 323-7777

Suicide Policy

If you are suicidal, your therapist will take all reasonable steps to prevent harm to yourself. This may include breaking confidentiality if you pose a serious risk of self-harm to yourself. Your signature indicates that you have read and understood confidentiality and limits to confidentiality:

Sobriety Policy

We ask that all clients, couples, families, and group members arrive to therapy sober and not under the influence of drugs and/or alcohol. If your therapist notices that you are intoxicated (such as slurred speech, rapid speech, smelling of alcohol, behavior that indicates intoxication with cocaine, prescription drug abuse, marijuana, or other substances) the therapy session will be immediately terminated. We will also assist you in finding a safe ride home (via a friend, family member or taxi) as driving while under the influence constitutes a risk to others and is a reportable offense. Once you are safely home, your therapist will reschedule the therapy session where this occurrence will be processed. You will be charged your full fee for the session if you arrive intoxicated.

Inactive Client and Case Closings:

Failing to schedule a follow-up session within 30 days of your last scheduled session will result in your therapist attempting to make contact to inquire if continued services are needed. Contact may be made through the client portal, email, telecommunications and/or standard mail. If you fail to respond within the next 30 days (60 days from last your scheduled session), your chart will be flagged as "Inactive." A final attempt will be made to contact you and if we do not hear back from you within the final 30 days (90 days from last your scheduled session) your chart will be moved to close. Once your chart is closed, if you ever feel the need to reinitiate services, you will be required to complete a new Intake package.

Consent For Treatment

Initial Here 

I hereby consent to the treatment provided by Bevill and Associates LLC and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. _____ **Initials**

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Initial Here 

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Bevill and Associates LLC. I authorize Bevill and Associates LLC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Bevill and Associates LLC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. _____ **Initials**

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE NOTIFICATIONS AND THAT YOU ARE CONSENTING TO RECEIVE TREATMENT BY Bevill and Associates LLC:

► _____Date _____

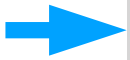
Signature

Payment Information

Terms of agreement regarding payment for sessions at Bevill and Associates LLC

1. Session fees are based on a clinical hour, which is defined by insurance providers as 45-50 minutes direct with the counselor or professional.
2. If I, the patient, fail to appear for an appointment without a 24-hour notice of cancellation, appointment fees will be charged and I will be responsible for payment.
3. I understand that if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.
4. Services including phone calls, emails, record reviews, and professional consults at times other than the scheduled therapy session are the patient's responsibility. These services will be billed per quarter of an hour.
5. I authorize my health insurance to provide payment of benefits to name of clinic.
6. I understand records of my treatment may be shared with my insurance company when necessary to process claims.
7. I understand I am responsible for payment if my insurance company declines payment.

I have reviewed this document and understand the contingencies stated above.

Initial Here  _____ **Initials**

Credit Card Authorization (All clients must maintain a current credit card in file)

I, authorize the maintenance of valid credit card information to guarantee my chosen payment option. Charges will appear on your credit card statement as "Bevill and Associates LLC."

Cardholder Name: _____

Circle Card Type: Visa MC Discover AmEx

Billing Address: _____City: _____Zip:_____

Credit Card # _____

3 digit CVV code: _____

Expiration date ___ / ___

Email Address: _____

Cardholder/Client Signature: _____Date: __/ ____/___

Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fails to make payment promptly when due, I will promptly pay on demand. I understand that if I commit to joining a weekly therapy group, In the event that I dispute a credit card charge without first trying to resolve my concern directly with Bevill and Associates LLC I agree to reimburse Bevill and Associates LLC. $25 per disputed transaction to compensate Bevill and Associates LLC for the costs incurred in trying to recover disputed funds. I understand there is a 24-hour cancellation policy and that I will be charged without providing 24 hours advance notice to cancel a session.I have read, understand and agree to the information, authorization and guarantee stated above.

Signature _____Date _____

Printed Name _____

Insurance Information (Blue Cross only)

Primary Insurance Company_____

Policy Holder Name _____DOB:_____

Social Security #_____

Policy Number_____

Group Number_____

Relation to Patient_____

Employer Name_____

Employer City/State:_____

Copay/Coinsurance_____

Deductible_____ Deductible met? YES NO

Bevill and Associates LLC

2524 Valleydale Road Suite 100 Birmingham, AL 35244

205-610-9319

Your Information. Your Rights. Our Responsibilities.

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.***

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choice

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities

Example: *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.
We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
• We can use or share health information about you:
• For workers' compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Name of Person Responsible for HIPAA Notification:

Al Bevill

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes To The Terms Of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective - January 1, 2017

This Notice of Privacy Practices applies to the following organizations Bevill and Associates LLC, Boyle and Associates LLS and Bevill and Boyle Partnership.

Privacy officer:
Al Bevill
2524 Valleydale Road Suite 100
Birmingham, AL 35244
206-610-9319

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.
I, _____, hereby acknowledge that Bevill and Associates LLC has either offered me or provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information.
I understand that if I have questions or complaints I may contact:

Al Bevill
2524 Valleydale Rd Suite 100
Birmingham. AL 35244
205-610-9319

I also understand that I am entitled to receive updates upon request if Bevill and Associates LLC amends or changes the Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient, if signed by someone other than patient

_____
Date

IF SIGNATURE OBTAINED FROM PERSON OTHER THAN A LEGALLY RESPONSIBLE INDIVIDUAL, ACTION TAKEN TO OBTAIN LEGAL SIGNATURE

- Given to above signee
- Sent home via U.S. Mail
- Advised person bringing in patient that policy is available on our website www.bevillandassociates.com

In either situation the parent/legal guardian must sign and return this form either in person or by mail to:

Bevill and Associates LLC
Attn: HIPAA Contact.
2524 Valleydale Road
Suite 100
Birmingham, AL 35244

THIS SECTION IS TO BE COMPLETED BY MENTAL HEALTH PROVIDER

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:
( ) Patient declined to sign this Written Acknowledgement.
( ) Other (specify): _____

_____ _____
Name and Title Date

INTAKE QUESTIONNAIRE

Today's Date:_____

Your Name: _____

Your Birthdate: _____. Age:_____

I am currently: (Check any that currently apply to you, even if more than one.) .
□ Single
□ Never married
□ Married for _____ months / years
□ Separated for _____ months / years
□ Divorced for _____ months / years
□ Widowed for _____ months / years
□ Dating for _____ months / years
□ Cohabiting for _____ months / years

Have you been married previously (not counting at present)?
□ Yes □ No If yes, how many times? _____

Do you have biological children of your own?
If yes, how many children do you have? _____ How many of your bio-children live with you? _____

Do you have step-children? □ Yes □ No
If yes, how many step-children do you have? _____
How many of your step-children live with you? _____

Education:
(highest level)
□ Some high school □ High school
□ Technical / Trades □ 2-year associate degree □ Some undergraduate college or university
□ Undergraduate degree □ Some graduate level □ Graduate degree:

Current Occupation: _____
Years at Current Job: _____ Hrs per week: _____
Do you enjoy your work? □ A lot □ Moderately □ Very little Career
Goals: _____

Previous Counseling

Have you participated in therapy or counseling in the past?
□ Yes
□ No
If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

General Health and Mental Health Information

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):

_____
_____
_____

Are you on any medication for physical/medical issues? Yes No
If yes, please list:_____

Are you having any problems with your sleep habits? Yes No
If yes, circle those that apply:
Sleep too much Sleep too little Poor quality Disturbing dreams
Other:_____

How many times per week do you exercise? _____ days _____ minutes/hours

Are there any changes or difficulties with your eating habits? Yes No
If yes, circle one:

Eating less Eating more Bingeing Restricting

Have you experienced a weight change in the last two months? Yes No

Do you consume alcohol regularly? Yes No

In one month, how many times do you have four or more drinks in a 24-hour period?

_____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

Have you had any suicidal thoughts recently? Yes No

If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No

If yes, how long age _____

How often did you have these thoughts? Frequently Sometimes Rarely

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

_____

_____

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1=a little, 2=moderate, 3=a lot, 4=extreme) rate how much you have experienced each symptom over **the past two weeks**. (Circle a number)

1. Feeling sad, down or depressed	1234
2. Avoiding certain people or places	1234
3. Loss of interest in activities I normally enjoy	1234
4. Low energy/feeling tired	1234
5. Sleep problems (insomnia, not staying asleep, or early waking)	1234
6. Eating too much or too little	1234
7. Not able to think clearly	1234

8. Feeling no pleasure or joy in life	1234
9. Anxiety attacks	1234
10. Worrying about things	1234
11. Angry outbursts	1234
12. Low self-esteem or low self-confidence	1234
13. Feeling guilty	1234
14. Feeling too stressed	1234
15. Thoughts of suicide	1234
16. Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	1234
17. Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	1234
18. Not getting my work done	1234
19. Feeling unhappy with my workplace	1234

(√) (Check all that apply)

___ Depressed Mood
___ Anxiety
___ Anger Management
___ Self-Esteem or Confidence
___ Social Difficulties
___ Stress Management
___ Substance Abuse (Alcohol/Drugs)
___ Pornography Addiction
___ Sex Addiction
___ Eating Disorder
___ Spiritual Problems
___ Bereavement/ Loss
___ Work problems
___ Education/ Career Concerns
___ Financial Concerns

___ Legal Concerns
___ Medical Issues
___ Domestic Violence or Abuse (Current)
___ Premarital Counseling
___ Communication Problems/Relationship Conflict
___ Sexual Intimacy Concerns
___ Emotional or Sexual Infidelity/affairs
___ Emotionally disconnected from spouse/partner
___ Other Marital/Relationship Concerns
___ Separation / Divorce / Relationship Break-Up
___ Custody Concerns
___ Parenting
___ Parent-Adult Child Relations
___ Blended Family Issues
___ Family Conflict
___ Child – Behavioral Problems
___ Child – Mood / Anxiety Problems
___ Child – Academic Problems
___ Child – Social/ Relational Problems
___ Other _____

Religious/Spiritual Information

Do you practice a religion? Yes No

If yes, what is your faith _____

If no, do you consider yourself to be spiritual? Yes No

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____

Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

Other Information

List your strengths

_____

_____

_____

List areas you feel you need to develop

_____

_____

_____

What do you like most about yourself?

_____

_____

What are some ways you cope with life obstacles and stress?

_____

_____

_____

What are your goals for therapy/what would you like to accomplish?

_____

_____