# IN HOME
# Clinical & Casework Services, Incorporated

Est. 1994

1711 Church Street
Suite D
Norfolk, VA 23504

Office (757) 623-8985
Fax (757) 623-4516
Email: ihccs1711@gmail.com

## INTAKE REQUEST FOR SERVICES

Name of Identified Client (Last, First, Middle) _____ Date of Request _____

Street Address _____ Apt # _____ Home telephone _____

City _____ State _____ Zip _____ Work/Cell Telephone _____

Gender _____ Ethnicity _____ Age _____ Date of Birth _____ Social Security Number _____

Marital Status _____ Legal Status (Parole, Probation, etc.) _____

Names of Parent(s)/Emergency Contact _____ Telephone _____ Relationship _____

Referring Agency _____ Referring Agent _____

Street Address/Suite _____ Telephone _____

City _____ State _____ Zip _____

| SERVICE REQUESTED | | | |
|---|---|---|---|
| ☐ Outpatient | ☐ Benny's Place | ☐ MHSB | ☐ Intensive In-Home |

Client Identification Number: _____

## CURRENT SITUATION SUMMARIZED

## AREAS OF CONCERN

## DESIRED GOALS

I, _____, request that I/the above referenced client be provided the indicated services under the In Home Clinical and Casework Services Program.

_____ _____

Requestor Date

**FOR OFFICE USE ONLY:**

Admitted? Yes____ NO___ Date_____ Refused/Date _____

Reason _____

Signature of IHCCS Representative _____

Client Identification Number:_____

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## EMERGENCY MEDICAL INFORMATION

Last Name: _____ First: _____ Middle: _____

**Emergency Contact (Authorized Representative)**

_____ (____) _____
Name (Last, First) Telephone

_____ (____) ____ - _____
Street Address Telephone

_____ _____ _____
City State Zip

**Primary Care Physician**

_____ (____) ____ - _____
Name (Last, First) Telephone

_____ (____) ____ - _____
Street Address Fax

_____ _____ _____
City State Zip

**Insurance**

Insurance Company:_____

Insurance ID #: _____ Group #: _____

## Medical Information

For the Following Questions please circle yes or no, if you select yes please explain.

Do you have medication and or food allergies: Yes / No

Yes, Explain:_____

Do you have a history of Substance Abuse: Yes / No

Yes, Explain:_____

Do you have any significant medical problems or conditions: Yes / No

Yes, Explain:_____

Do you have any significant ambulatory or sensory problems: Yes / No

Yes, Explain:_____

Do you have any special communication needs: Yes / No

Yes, Explain:_____

Do you have any Advance Medical Directives (i.e., living will/special medical power of attorney):

Yes / No

Yes, Explain:_____

| Current Medications | | |
|---|---|---|
| **Medication Name** | **Dosage/Frequency** | **Prescribing Doctor** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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## INSURANCE INFORMATION

| Primary Insurance | Secondary Insurance |
|---|---|
| Subscriber's Name: _____<br>Client's Name: _____<br>Carrier: _____<br>Insurance ID #: _____<br>Group #: _____<br>Client's Relationship to Subscriber: _____ | Subscriber's Name: _____<br>Client's Name: _____<br>Carrier: _____<br>Insurance ID #: _____<br>Group #: _____<br>Client's Relationship to Subscriber: _____ |
| Person Responsible for portion not covered by Insurance: _____ | |
| **Tricare Only** | |
| Sponsor's Social Security #: _____<br>Branch of Service: _____<br>Duty Station: _____<br>Authorization #: _____ | ☐ Active ☐ Retired ☐ Deceased<br>Rank/Rate: _____<br># of Sessions Authorized: _____ |

## STATEMENT OF AGREEMENT

IN HOME CLINICAL AND CASEWORK SERVICES, INC. believes in enhancing the confidential relationship between client and therapist. Therefore, we request that you discuss all financial arrangements and appointment hours directly with your therapist, and that you make all payments directly to your therapist. Because appointment hours are reserved for you, you will be charged for missed appointments, a charge which is NOT covered by insurance, unless ample advance notice is given **(24 hours)**. The charge of failing to keep or cancel an appointment is $75.00. The patient is responsible for supplying correct insurance information, any necessary insurance forms, and for payment of any personal portion within 25 days of receiving a monthly bill. An interest charge of 1.5% per month will be charged for balances over 30 days. Patient agrees to pay all costs of collection, including reasonable attorney's fee. I have read the above office policy and agree to comply with its terms as presented. My signature below also constitutes authorization for my insurance company to make payments directly to In Home Clinical and Casework Services, Inc. and /or Bernard N. Curry, PhD, LCSW, to release information to my insurance company in order to process our claims.

_____ _____

Client or Legal Guardian Date

**Do not write below this line- For therapist to complete and sign, prior to initial session:**

**Y____ N____**

**Fee Arrangement: Client Portion: $_____, Insurance Portion $ _____ for Initial Session and _____ for Follow-up sessions. Adjustment $ _____**

**Therapist Signature:_____**

**Date: _____, 20 _____**

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## ACKNOWLEDGEMENT OF YOUR RIGHTS

☐ Member was provided a copy of the **HIPPA** policy and the policy has been read and explained to member so that they understand them.

_____ _____

Signed (Parent,Guardian. Authorized Representative, if applicable) Date

_____ _____

Signed (Witness / Relationship) Date

---

☐ Member refused copy.

Member is unable/unwilling to sign that he/she understands the rights.

_____ _____

Staff Name Date

_____ _____

Signed (Witness / Relationship) Date

In Home Clinical and Casework Services, Inc.

# 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. **THE PRIVACY OF YOUR MENTAL HEALTH INFORMATION IS IMPORTANT TO US**

## OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your MENTAL HEALTH information. We are also required 10 give you this notice about our privacy practices. our legal duties. and your rights concerning your MENTAL HEALTH information. We must follow the privacy practices that are described in this notice, while it is in effect. This notice takes effect May 6, 2013 and "ill remain in effect until we replace it-

We reserve the right to change our privacy practices and the terms or this notice at any time, provided such changes are permitted applicable by law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all MENTAL E IEALTH information that we maintain, including MENTAL HEALTH information "we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.
You may request a copy of our notice at any time. For more information about our private practices, or for additional copies of this notice. please contact us using the information listed at the end of this notice.

## USES AND DISCLOSURES OF MENTAL HEALTH INFORMATION

We use and disclose MENTAL HEALTH information about you for treatment, payment. and MENTAL HEALTH care 01k•rations, For example:

Treatment: We may use or disclose your MENTAL HEALTH information to a physician or other MENTAL HEALTH care provider providing treatment to you.

Payment: We may use and disclose your MENTAL HEALTH information to obtain payment for services we provide to you.

Mental Healthcare Operations: We may and disclose your MENTAL HEALTH information in connection with our MENTAL HEALTH care operations. MENTAL HEALTH care operations include quality assessment and improvement activities, reviewing the competence or qualifications of MENTAL HEALTH care professionals. evaluating practitioner and provider performance. conducting training programs. accreditation. and certification, licensing, or credentialing activities.

Your Authorization In addition to our use of your MENTAL HEALTH information for your treatment, payment or MENTAL HEALTH care operations, you may give us written authorization to use your MENTAL HEALTH information or disclose it to anyone for any purpose. If you give us an authorization. you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your Mental Health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your MENTAL HEALTH information to you, as described in the Patient Rights section of this notice. We may disclose your MENTAL HEALTH information to a family member, friend, or other person to the extent necessary to help with your MENTAL HEALTH care or with payment for your MENTAL HEALTH care, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose MENTAL HEALTH information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use of disclosure of your MENTAL HEALTH information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, well will disclose MENTAL HEALTH information based on a determination using our professional judgement disclosing only MENTAL HEALTH information that is directly relevant to the person's involvement in your MENTAL HEALTH CARE.

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## CONSENT FOR OUTPATIENT TREATMENT

The consent and authorization of the undersigned is hereby given to the **In Home Clinical and Casework Services, Inc. (IHCCS, Inc)**

_____
Name of Client

1. To render to the client such treatment considered therapeutically necessary.

2. To release information communicated to or learned by **IHCCS, Inc.** only through a **"Release of Information"** form signed by the client and/or his/her legal guardian, if applicable.

3. I understand that a relationship with a physician and/or other professionals not employed by **IHCCS, Inc** is independent and will be billed separately.

4. **I understand that, in the event that I have to cancel a scheduled appointment, it is my responsibility to provide 24 hours' notice in advance, otherwise I am responsible for the missed appointment fee of $75.00 before I can reschedule another appointment.**

IT IS UNDERSTOOD AND AGREED THAT I WILL PARTICIPATE **IN ALL ASPECTS OF** THE IN HOME CLINICAL AND CASEWORK SERVICES PROGRAM.

_____ _____
Client Date

_____ _____
Parent or Legal Guardian Date

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## AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____

Patient's Address: _____ Phone: _____

I hereby authorize: In Home Clinical & Casework Services, Inc.

To release / obtain / exchange my behavioral health and medical information as described below with the following person(s):

_____

(Name and address(es) of person(s) to receive / release information)

This includes the following information:

- ☐ Assessments/Evaluations
- ☐ Med/Progress Notes
- ☐ Academic/Discipline Records
- ☐ Telephone Communication
- ☐ Meds (dosage & frequency)
- ☐ Discharge Summary (Most Recent)

For the following purpose(s):

☐ Coordination of Care ☐ Treatment Planning ☐ Payment/Billing ☐ Emergency Purpose ☐ Client Request

This authorization may be revoked at any time that action is taken. I understand that if I revoke this authorization I must do so in writing and present my revocation to the records administrator of the agency. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will automatically expire upon completion of this transaction but no later _____ (Exp Date/Event).

I understand that this authorization is voluntary, and I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law. By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the disclosure of my health information maintained by the agency in accordance with the terms of the authorization.

Prohibition on Redisclosure: This information has been disclosed from records whose confidentially is protected by Federal law. Federal regulation (42CFR Part 2) prohibits further disclosure of this information except with the specific written consent of the individual. A general authorization for release of information if held by another party is NOT sufficient for this purpose.

_____ _____

Witness Signature of Patient

_____ _____

Date Parent and/or Legal Guardian