Welcome to the Center for Effective Living

20800 Westgate Professional Building Suite 200 Fairview Park, Ohio 44126
21403 Chagrin Blvd Suite 104 Beachwood, Ohio 44122

Patient Information

Name (Last, First, Middle)_____
Date of Birth _____ Social Security Number_____
Address_____
State_____Zip Code_____ City_____
Home Phone_____ Cell Phone_____
Other Contact Number_____

Whom may we thank for this referral?_____

Medical Information

Chief Complaint/Reason for visit_____
List of allergies (medications, food, etc.)_____
_____
List any medications you are currently taking_____
_____
_____
_____
List any conditions we should know about_____
_____

Insurance Information

Only fill out if we did not take a copy of your insurance card.

Primary Insurance_____ID Number_____
Name of Employer_____Group Number_____
Name of the Subscriber_____ Social Security No_____
Subscriber Date of Birth_____

I understand that I am financially responsible for all charges that are not covered by insurance benefits. I also authorize the release for any medical information to process claims.

Signature_____ Date_____

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Practice Privacy Statement

This notice describes how medical information is disclosed about you and how it may be used and disclosed: Please Review this carefully

I. This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice. It is important that all patients and staff understand the importance of protecting patient information.

II. This practice has a legal obligation to maintain all medical records and information as required by law and patient safety. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results, and other information that pertains to a patient's case.

III. This policy indicates that you, the patient, identify and clarify at the time of your first intake or if you are a returning patient with this practice who we can talk to, how we can release information on your behalf and the process for ongoing treatment with our facility. You can change this information at any time with either written or verbal statement, followed up in writing. Changes will only impact the care or information from that point in time forward.

IV. Your protected health information (PHI) is important to your medical care, and can be used or disclosed with your written consent as follows:

- For your treatment in this practice and other locations under the physicians immediate care. This may include any referral for services such as labs, x-rays, other diagnostic testing or treatment related to your condition or medical needs. This may also include conversations with other physicians.
- For obtaining payment from your insurance company for the treatment you are receiving. This would include any documentation related to the treatment that's received by the patient. This includes eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state regulations.
- Appointment reminders and health related benefit services only with your consent identified on the intake form.
- Disclosure to your family and friends concerning any related health care information with you on the intake form, which can be modified at any time verbally, followed by written consent.
- Consent is not required for emergency care. An emergency is identified as a medical condition that in the judgement of the physician or medical individual required immediate and fill information for care on your behalf.

V. Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by the government or law enforcement agencies. Specific areas that require release include gunshot wounds, domestic violence, and victims of abuse or neglect.
- Information used for public health purposes, medical examiners, related to a person's death or for the health department of disease tracking.
- Information used for health care oversight, such as site review by an insurance program.
- Information related to organ donation.

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- Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis).
- Information provided to avoid harm if there is a threat to a patient or their safety.
- Workers compensation review.

VI. Your rights with respect to your protected health information.

- The right to request limit on the uses and disclosure at the initial intake or any time during your care.
- The right to choose how we send this information to you, including alternative address.
- The right to see and obtain copies of this information, but there may be a copy and postage fee.
- The right to get a listing of who we have made disclosures to about your PHI.
- The right to correct and update your file through an amendment process if appropriate.

VII. This practice reserves the right to modify or change this Privacy Statement and Process at any time. Revision to the notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the privacy notice. An updated privacy notice will be posted in the office within 60 days of the revision.

VIII. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our office to see if we can resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

- Contact the office manager by either calling or sending a letter.
  Address: 20800 Westgate mall Suite 200 Fairview Park, Ohio 44126
  Phone: (440)333-4949
- If you are not satisfied with this response, you may report the practice to either.

Regional Manager
Department of Health & Human Services
233 N. Michigan Ave, Suite 240
Chicago, Illinois 60601
(312)886-1827

GBA Palmetto
Part B Operations-HIPAA Compliance Concerns
PO Box 182957
Columbus, Ohio 43218

This privacy plan is a working draft, which became effective January 1, 2013.

Patient signature acknowledging privacy notice_____Date_____

Patient unable to sign due to _____Date_____

Patient refused to sign, witness_____Date_____

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Office Policies

Appointments:

Services are provided by appointments only. In most cases, appointments are scheduled by our office staff. It is not appropriate for children to be dropped off for appointments, unless arrangements have been made in advance. If you cannot keep a scheduled appointment, **please notify us at least 24 hours prior to the appointment.** You could be charged $70 for missed appointments or cancellations with insufficient notice. Late cancellations and/or no shows of three appointments or more will cause your case to be closed with this practice.

Telephone, Calls, Letters:

Our clinicians do not respond to routine phone calls during session. Many of our clinicians are employed by other agencies during the day, and may not be immediately available. Phone calls may be answered by our office staff or by voicemail. We attempt to return routine phone calls within two working days (please leave a number with at least a voicemail available).

Requests for letters and other written information consume a great deal of time for our clinicians. In order to not raise professional fees excessively for all families served by the practice, we are immediately imposing a minimum $25 charge for any special letter or report requested of us by parents or school officials. An evaluation summary will be sent, free of charge, at your request to a clinician and/or primary care physician. We will not charge for any time spent in coordinating care with a primary care physician or referring clinician with whom we have a collaborating agreement.

We receive hundreds of phone calls and e-mails each week, so we ask for your patience. Please note that not all of our clinicians use e-mail and **e-mail is never to be used in an emergency situation. In an emergency, please call our office during scheduled hours or if a live staff person is not available, please contact 911 or go to the emergency room at the nearest hospital.**

We respond to emergencies only for active patients (those who have received services within the past 3 months and have a follow up appointment scheduled).

Prescription Refills:

Patients obtaining medical services through one of our medical practitioners will typically receive enough prescriptions/refills to last to the next follow-up visit. If you cancel, reschedule or need to leave without being seen and need prescriptions or refills, there will be a $15.00 charge. This charge is due at the time of the prescription/refill request. However, it is up to the practitioner's discretion to fulfill the request. Many of the medications our physicians prescribe are controlled and cannot be called or faxed into a pharmacy.

Medication Compliance:

If you or your child is receiving a medication from a prescriber in the office, or if you or your child is being considered for medications prescribed by a provider in this office, a toxicology screen may be required at any time. This is being done for patient safety reasons, and/or to ensure compliance with medication treatment regimes. Patients or a parent/guardian agree that a prescriber may discontinue treatment or decline to offer a prescription if there are issues with a toxicology screen, including the refusal to take one when required.

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Treatment Coordination:

We need to be able to share information for the purposed of coordination of care with other behavioral healthcare professionals involved with your child/family. We may also desire to share information relevant to you or your child's primary care physician. If you or your child is receiving ongoing services from a behavioral healthcare professional from outside our practice, we must have your permission to share appropriate information with that individual/group in order to provide services to you or your child. We reserve the right to request that you discontinue services with other behavioral healthcare professionals if we believe those services interfere with our ability to provide the highest quality of service to you or your child. For continuity of care clients who see a prescriber must participate in counseling monthly. Clients who see prescribers agree to engaging in routine follow up services with the medical practitioner in the office as recommended by the practitioner involved.

Recording of Interviews:

During the course of the interview, the clinicians will be taking notes. We do not audiotape or videotape interviews without the express permission of the individual being recorded (or that individual's legal guardian). We do not record telephone conversations without the same express permission. You will not record telephone conversations or interview sessions, in any manner without express permission.

I have read and understood the above stated policies and procedures.

Signature_____ Date_____
(Relationship to patient_____)

I understand I am responsible for payment of my bill at the time of service.

Signature_____ Date_____
(Relationship to patient_____)

I authorized the release of any medical information necessary to process my insurance claim.

Signature_____ Date_____
(Relationship to patient_____)

I authorized payment of medical benefits directly to The Center for Effective Living.

Signature_____ Date_____
(Relationship to patient_____)

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For parent or guardian only:

I,_____, _____, of _____
(Parent/Guardian) (Relationship) (Child's Name)
Hereby grant The Center for Effective Living permission to exchange information relevant to my child's care with all behavioral healthcare professionals from whom my child receives services, throughout my child's course of treatment at The Center for Effective Living.

Signature_____ Date_____

I,_____of_____
(Parent/Guardian) (Child's Name)

Hereby grant The Center for Effective Living permission to exchange information relevant to my child's medical care with_____, my child's primary care physician.

Signature_____ Date_____

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Self-Assessment Form

Name: _____ Date: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone (Home) _____ Phone(Cell) _____

With whom do you live (relationship if any)? _____

Age: _____ Date of Birth: _____ Place of birth: _____

Name of person to call in emergency: _____

Relationship: _____ Phone (Home): _____ Phone(Cell) _____

Address: _____

Name of person filling out paperwork, if not patient: _____

Check those that apply to your situation:

Race:

- ☐ Caucasian
- ☐ Asian
- ☐ Hispanic
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ African American
- ☐ Other

Occupation: _____

Marital Status:

- ☐ Never Married
- ☐ Living Cooperatively
- ☐ Married
- ☐ Divorced
- ☐ Marriage Annulled
- ☐ Widow/Widower

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Gender:

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ _____(Fill in the blank)

Religion:

- ☐ Protestant
- ☐ Muslim
- ☐ Jewish
- ☐ Christian
- ☐ Other

Highest level of education completed:_____

Marital Status:

- ☐ Never Married
- ☐ Living Cooperatively
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Engaged
- ☐ Widow/Widower

Check any of the following that have occurred in your relationship in the last two years:

- ☐ Serious argument
- ☐ Breakup of important relationship
- ☐ Child left home alone
- ☐ Bad health (behavior) of family members
- ☐ Difficulties with family members
- ☐ Personal injury or illness
- ☐ Sexual difficulties
- ☐ Difficulties, changes at school or work
- ☐ Retired, lost job
- ☐ Changed residences
- ☐ Legal difficulties
- ☐ Financial difficulties

Have you ever thought about suicide?

- ☐ Yes
- ☐ No

If "yes" when was the last time?_____

Have you ever attempted suicide?

- ☐ Yes
- ☐ No

If "yes" when and how?

_____

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Do you have thoughts about suicide now?

- ☐ Yes
- ☐ No

Have you ever thought about hurting someone else?

- ☐ Yes
- ☐ No

If "yes" when was the last time?

_____

_____

_____

Have you ever hurt someone else?

- ☐ Yes
- ☐ No

If "yes" when and how?

_____

_____

_____

Are you thinking about hurting someone now?

- ☐ Yes
- ☐ No

How many drinks do you think you consume in the average day? _____

At what time of day do you have your first drink? _____

What is the most you have had to drink in a 24 hour period? _____

Was there ever a time when you felt (or someone else told you) that you were drinking too much?

If "yes", under what circumstances?

_____

_____

_____

Check any drugs that you have used:

- ☐ None
- ☐ Marijuana
- ☐ Amphetamines/speed
- ☐ Heroin/opiates
- ☐ PCP
- ☐ LSD/hallucinogens
- ☐ Cocaine/crack
- ☐ Barbiturates/sedatives

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If you checked one or more of the drugs, under what circumstances did you take it/them?_____

_____

_____

When did you most heavily use drugs? _____

_____

When was the last time you took such drugs? _____

Past History

Check any that apply to you.

- ☐ Mother's pregnancy with you was abnormal
- ☐ Mother's delivery of you was abnormal

Check if during childhood you:

- ☐ Were afraid to go to school
- ☐ Had difficulty with reading, math or writing
- ☐ Were truant (played hooky)
- ☐ Failed or repeated a grade
- ☐ Had frequent falls
- ☐ Were awkward at games
- ☐ Wet bed after age 5
- ☐ Had tics
- ☐ Had trouble with eyes
- ☐ Were (are) left handed
- ☐ Mispronounced words/ had a lisp
- ☐ Had nightmares, disturbed sleep, fear of the dark
- ☐ Ran away from home
- ☐ Were cruel to animals
- ☐ Frequently lied to family or others
- ☐ Set fires
- ☐ Moved frequently
- ☐ Were exposed to incest
- ☐ Were promiscuous

Medical History

What is your weight in pounds? _____

What is your height in inches? _____

Has your weight increased or decreased by more than 10 pounds in the last 5 years?

- ☐ Yes
- ☐ No

If "yes" explain circumstances._____

_____

_____

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Check if you:

- ☐ Have difficulty falling asleep
- ☐ Have difficulty waking up and falling back asleep
- ☐ Are tired upon waking
- ☐ Have bad dreams, wet bed, sleep walk, or other sleep disturbance

Do you smoke?

- ☐ Yes
- ☐ No

If "yes" how much and how long have you? _____

Do you drink coffee, tea or soda?

- ☐ Yes
- ☐ No

If "yes", how much? _____

Legal History

Do you have any convictions?

- ☐ Yes
- ☐ No

If "yes" please explain: _____

_____

_____

_____

_____

_____

_____

Family History

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Name	Age	List all major illnesses, psych, neurologic alcoholism, drug abuse, suicide, and suicide attempts.

Mother:

Father:

Brother(s):

Sister(s):

Children:

Grandparents, Uncles Aunts (relationship):

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Fee Agreement

Co-pays, payments, or balances are due at time services are rendered, or after claims have been submitted to insurance depending on type of claim and insurance. Arrangements can be made accordingly through the billing department.

Self-Pay:

- Alcohol assessment $58.00
- Sub Oxone (excluding Med. Mutual, Tri-care, and Mutual Health) $250.00 initial consultation, $145.00 2nd consultation, $85.00 thereafter. IOP $20.00 per session.
- Psychotherapy: $75.00 for initial consultation, $60.00 per session thereafter.
- Psychiatrist: $220.00 for initial consultation, $145.00 25 min session, or $85.00 for 15 min session.
- Legal Related: $250.00 per hour for psychologist, $300.00 per hour for Psychiatrist.
- Forensic Related: $275.00 per hour.
- Retainers for legal matters start at $2000.00
- Court appearances start at $1000.00

If we are providing services to a child, the parent signing this fee agreement assumes responsibility for payment.

Cancellations that fail to give 24-hour notice could result in a $70.00 fee for time reserved. This will be charged to the patient directly.

IT IS YOUR RESPONSBILITY TO UPDATE ANY CHANGES IN INSURANCE INFORMATION. If claims fail to meet timely deadlines due to insurance not being updated by the patient or responsible party, these services will become self-pay, and the patient will become responsible.

When an account becomes 90 days past due, professional collection or legal action may be utilized. Note any payments made on the account by the patient are applied to the oldest date of service to help avoid these actions. Payment arrangements can be set up to avoid this action. If collection action is required, you agree to pay any fees, which may be based on a percentage at a maximum of 35% of the debt, all cost and expenses, including reasonable attorney fee, we incurred. The Center for Effective Living agrees to contact the client in advance for any fee changes. It is assumed this agreement will continue if services are actively being provided. No refunds will be issued until all account balances are paid in full.

My signature below indicates that I have read and understand the fee agreement.
Name: _____

Signature: _____ Date: _____