

Counseling Office of Eileen Dewey, LCSW-C and Associatessm

Eileen Dewey, LCSW-C, SAP, Director
Mike Green, MHS, CSC-AD, BCPC

Judy Jakubowski, MS, CAC-AD, MAC
Camille C. Woodson, MD

Lauren Spivey, BA, ADT
Nicholas Scotto, MD

Today's Date: _____

Client Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____

Zip: _____

Home #: _____

Cell #: _____

E-mail: _____

Emergency Contact Person: _____

Relationship: _____

Phone # _____

What is the primary purpose of today's visit? _____

Do you have another mental health or substance abuse provider at this time? _____

Name: _____ Phone # _____

Pharmacy Name & Phone if you are here to see one of our physicians

Name: _____ **Phone #** _____

Do you have any current substance related legal charges? _____

Who referred you to us? _____

Were you referred to a specific provider? _____

Client Agreement

Welcome to our practice. This document includes important information regarding our professional services and regarding your rights and responsibilities as a patient.

Patient Rights

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law designed to limit the use and disclosure of your Protected Health Information (PHI). In accordance with HIPAA, your PHI will not be released to any entity without your express written consent.

Contacting your Clinician

Clinicians are often not immediately available by telephone, as they are at most times meeting with patients. The administrative staff member taking your call may be able to answer your questions and will leave a detailed message for your clinician. Every effort will be made to return your call within 12-24 hours.

Cancellation Policy

If you are unable to attend your scheduled session, it is important that you call. **We require at least 24 hours advanced notice for cancellations of individual appointments, or the full fee of the appointment will be charged.**

Fees

All fees are due at the time of service. If payment is not current, we are under no obligation to deliver services.

Initial Evaluation	\$175
Psychiatric Evaluation	\$275
SAP Program	\$450
Counseling (individual, family, marriage)	\$135-\$165
Medication Management	\$125
Re-evaluation	\$75
Group Sessions	\$45-50

Operation Breakthrough	\$350
Urinalysis (CAC client/non-client)	\$40/\$50
Urinalysis (special tests)	varies
Insurance Forms or Pre-Authorizations	\$25
Returned Check Fee	\$35
Credit card transaction fee	+2%
Fees as of 1/21/2015	

Consent

Be signing below I understand that I am voluntarily presenting for services. I acknowledge that I am responsible for all charges in connection with care and treatment rendered. I have read this form; I understand and agree to the contents of this form. I acknowledge receipt of the Privacy Practices.

Client Signature (or Parent if client is a minor)

Date

Consent for the Release of Confidential Information

(Spouse, parent, attorney, counselor, physician, etc.)

PLEASE ENTER ONLY ONE NAME ABOVE; A SEPARATE FORM MUST BE COMPLETED FOR EACH PERSON TO WHOM YOU ARE ALLOWING INFORMATION TO BE RELEASED

FULL RELEASE

I authorize Columbia Addictions Center to release information to, and to obtain information from, the person or organization I have written above.

-OR-

LIMITED RELEASE

I authorize Columbia Addictions Center to release *only* the following information to the person or organization I have written above:

- _____ Appointment dates/times
- _____ Account Balance
- _____ Initial Evaluation
- _____ Progress, Attendance and Discharge
- _____ Urinalysis or Breathalyzer results

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

This authorization will be valid for one year unless I otherwise specify.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.