

Please read through this entire packet. Fill out pages 2 and 3, and sign pages 4 and 7. Bring pages 2, 3, 4 and 7 to our first meeting.

Pages 5 and 6 describe my privacy practices and should be read before signing page 6.

Pages 8 and 9 describe my policies regarding email, texting, and social media.

If you have any questions or concerns regarding these forms and policies I'm happy to discuss them with you.

Personal Information

Name(s): _____ Date: _____
Preferred name: _____
Address: _____
Home Phone : _____ OK to call at work? Y N Work Phone: _____
Mobile Phone Number: _____ E-mail: _____
Date of Birth: _____ Age: _____ Ethnicity: _____
My gender Identity is: _____ My sex assigned at birth is: _____
My marital status is: _____ My sexual orientation is: _____
My pronoun is: _____
Occupation: _____
Employer/School: _____
Referral Source: _____ Phone : _____

Emergency Contact

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____

Responsible Party Information (if different from above)

Responsible Party Name: _____
Relationship to client: _____
Address: _____
City: _____ State: VA Zip Code: _____
 Home Mobile Phone: _____ Mobile Work Phone : _____

Insurance Information (if applicable)

Policyholders Name: _____
Policyholders Address: _____
City: _____ State: _____ Zip Code: _____
Policyholder date of birth: _____
Clients Relationship to Policyholder: _____
Insurance Carrier Name: _____
Insurance Address: _____
Insurance Phone Number: _____
Policy Number: _____ Group Number: _____
Policy Effective Date: _____

This pdf form can be filled out in your browser, however you cannot save the file - you must print it out first, otherwise you will lose all your information.

You can also print out as a blank form and fill it in by hand.

Legal Custody of Client *(if applicable)*

Legal Guardian: _____
Address: _____

City: _____ State: _____
Zip Code: _____ Employer: _____ Occupation: _____

Visitation Privileges, etc. of Non-Custodial Caregiver(s)/
Parent(s): _____

Criminal Justice Status *(if applicable)*

Charges Pending Y/N _____ In Probation Y/N _____ Other _____

Explain: _____
Contact Name: _____ Relationship: _____
Address: _____
Phone Number: _____

Special Conditions/Needs/Questions

Consent to use and disclose your health information

This form is an agreement between you, _____ and myself, Don Chiappinelli, LCSW. When I use the word “you” below, it can mean your child, relative, or other person if you have written her or his name here _____ .

When I consult, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices I cannot treat you.

In the future I may change how I use and share your information and so may change our Notice of Privacy Practices. If I do change it, you can get a copy from me by contacting me.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative’s authority

Date of NPP: 01/01/2018 Copy given to refused by client/parent/personal representative.

Notice of Privacy Practices – Brief Version

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.

My commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. **I am also required by law to keep your information private.** These laws are complicated, but I must give you this important information. This is a shorter version of the full, legally required NPP which you can request from me at any time and refer to it for more information. However, I can't cover all possible situations so please talk to me, as the designated Privacy Officer (see below) about any questions or problems.

I will use the information about your health which I get from you or from others mainly to provide you with **treatment**, to arrange **payment** for my services, and for some other business activities which are called, in the law, health care **operations**. After you have read this NPP I will ask you to sign a **Consent Form** to let me use and share your information. If you do not consent and sign this form, I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes I will discuss this with you and ask you to sign an Authorization form to allow this.

Except in the specific instances mentioned below, I will not release any PHI about you without your specific written permission, even though the HIPPA laws may allow me to do so. Another way of stating this is that though the HIPPA laws may allow me as a healthcare professional to release PHI about you in many circumstances, it is my privacy policy and my professional ethics not to release any PHI about you without your specific written permission and authorization to do so.

Here are examples of when the laws require me to use or share your information:

When required by law

There are some federal, state, or local laws which require me to disclose PHI.

- I have to report suspected child or elder abuse.
- If you are involved in a lawsuit or legal proceeding and I receive a subpoena, discovery request, or other lawful process I may have to release some of your PHI. I will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.
- I have to disclose some information to the government agencies that check on me to see that I am obeying the privacy laws.

To Prevent a Serious Threat to Health or Safety. If I come to believe that there is a serious threat to your health or safety or that of another person or the public I can disclose some of your PHI. I will only do this to persons or organizations who are able to help prevent or reduce the threat or danger.

For specific government functions

I may be required to disclose PHI to government benefit programs relating to eligibility and enrollment, including Workers Compensation and Disability programs.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. I will do so except if it is against the law, or as required above, or when the information is necessary to treat you.
3. You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records but I may charge you. You can discuss this with me, as the Privacy Officer, at any time to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to me as the Privacy Officer. You must tell me the reasons you want to make the changes.
5. You have the right to a copy of this notice. If I change this NPP I will post the new version in my waiting area and you can always get a copy of the NPP from me.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me as the Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please contact me as the designated Privacy Officer; I can be reached by phone at 540-455-7401 or by e-mail at dclcsw1@gmail.com.

The effective date of this notice is January 1, 2018

Consent to Treatment

I do hereby seek and consent to take part in the treatment by Don Chiappinelli, LCSW. I understand that developing a treatment plan with him and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Don Chiappinelli, LCSW.

I am aware that I may stop my treatment with Don Chiappinelli, LCSW at any time. The only thing I will still be responsible for is paying for the services I have already received. I am aware that any outstanding balances due will be charged interest at 1.9% monthly. I understand that I may lose other services or may have to deal with other problems if I stop treatment.

I understand that Don Chiappinelli, LCSW may disclose information about me in consultations with other professionals in order to provide the best possible treatment. In such cases my name, or any identifying information about me, is not disclosed. Clinical information about me is discussed.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged in full for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given Protected Health Information about the type(s), cost(s), date(s), of any services or treatments I receive as well as diagnosis(s) and treatment progress. I thereby authorize payment of medical benefits to Don Chiappinelli, LCSW. I understand that if payment for the services I receive here is not made, Don Chiappinelli, LCSW may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or person acting for client)

Date

Printed name

Relationship to client
(if necessary)

I, Don Chiappinelli, LCSW have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Don Chiappinelli, LCSW

Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

My Private Practice Social Media Policy

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc), or following on Twitter. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

You are welcome to view my Facebook Page and read or share articles posted there, but I do not accept clients as Fans of this Page. I believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list.

Social Media Policy

My primary concern is your privacy. I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Interacting

Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you need to contact me between sessions, the best way to do so is by phone. Direct email at dclcsw@dclcsw.com is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

Use of Search Engines

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual

situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Business Review Sites

You may find my psychotherapy practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

Email and mobile phone text messaging

I prefer using email only to arrange or modify appointments, and texting if the situation is particularly emergent. Please do not email or text me content related to your therapy sessions, as they are not completely secure or confidential. If you choose to communicate with me in this way, be aware that all emails and texts are retained in the logs of your and my Internet service and mobile phone providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by their system administrator(s). You should also know that any communications that I receive from you and any responses that I send to you become a part of your legal record.

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.