Deborah Hanna, LCSW
Licensed Clinical Social Worker

Tel 904-778-6237
deborahhannalcsw@gmail.com
www.deborahhannalcsw.com

APPLICATION FOR SERVICE

Please email a copy of the front and back of your insurance card along with these client forms.

Today's Date:__________ClientName_________________________________

Referred by:____

Address:____

City, State, Zip: ____

Home Phone: _____________________Work Phone: ____________________Cell Phone:______________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Date of Birth: ____________________ Social Security #: _________________________

Employer: ______________________ Position: ____

Email:____

Primary Care Physician (PCP): ______________________________________ Phone: (_____)__________________

Please state briefly why you are seeking counseling: ____

____

Responsible Party Information (fill out only if different from client info above)

Name: ____ Relationship to Client __________________________

Address:____

City, State, Zip: ____

Home Phone: _____________________Work Phone: ____________________Cell Phone:______________________

Date of Birth: ____________________ Social Security #: _________________________

Employer: ______________________ Position: ____

Insurance Information:

Primary Insurance Carrier: ____________________________ Phone: (_____)______________________________

Insured's Name: ___________________________________ Relationship to Client __________________________

Insured's Date of Birth _______________________________ Insured's SS# ______________________________

Policy/Contract # ___________________________________ Group # ___________________________________

Authorization # ____________________________________ No. of Sessions Authorized ______________________

Emergency Information:

Name: _________________________ Relationship ____________________ Phone: (_____)__________________

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CLIENT FACT SHEET

Welcome. I look forward to working with you. The information that follows will hopefully answers some questions you have and ensure we have a quality experience working together. Please feel free to ask any questions.

1. For the fastest progress, it is best to maintain a steady schedule of appointments.
2. It is important to be on time to get the full benefit of your 50-MINUTE THERAPY HOUR. Longer sessions can sometimes be scheduled on a per-client basis.
3. Our therapeutic relationship is confidential. However, there are several legal limits to confidentiality that include having to notify the appropriate authorities if I suspect child abuse, believe you may pose a threat to yourself or to the life of someone else. Additionally, a judge may order me to disclose information about your case. *Records will not be released to anyone without your written consent.*
4. Fees are payable at each session. There is no charge for appointment cancelled 24 hours before your session. A CHARGE EQUAL TO THE AMOUNT OF YOUR COPAY WILL BE DUE IF YOU MISS YOUR APPOINMENT OR CANCEL WITH LESS THAN 24 HOURS NOTICE. PRIVATE PAY CLIENT WILL OWE THE ENTIRE HOURLY CHARGE.
5. If you experience a crisis after hours or on the weekend, I can be paged by calling 904-778-6237. If your emergency is life-threatening, please go to the nearest emergency room or call 911 for assistance.

I hope this information is helpful in our work together.

Signature: ____Date: _______________________

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Confidential Client Information

Report to Primary Care Physician

_____I do not want information released to my Primary Care Physician (PCP)

_____________________________ ______________
Client Signature Date

_____I want the following information released to my Primary Care Physician (PCP)

_____________________________ ______________
Client Signature Date

(Please fill in all lines marked with an X)

To: Dr. X ____

Address: X ____

City: X______________________ State: X ___________ Zip: X ____________

Phone: X ______________________ Fax: X ______________________

I am seeing the following client for mental health services:

CLIENT NAME: X ______________________ DOB: X ______________________

Date of initial visit _________________

Presenting Problem ____

____

Treatment Plan / Recommendations ____

____

Diagnosis ____

____

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PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to care out:

- treatment;
- obtaining payment from third party payers (i.e. my insurance company);
- the day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature: ____Date: ______________________

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