Northwoods clinic

92 Northwoods Blvd., C1&C2
Columbus, OH 43235

Demographic Information

Patient/Client first name | Patient/Client middle initial | Patient/Client last name | Patient/Client DOB | Patient/Client SS #

Street address | City | State | Zip | Client phone #

email address

(Providing an email address is crucial in order to receive all billing notices and appointment reminders)

Insured's first name | Insured's middle initial | Insured's last name | Insured's DOB | Insured's SS #

Insured's street address | Insured's city | Insured's state | Insured's zip | Insured's phone #

Insured's employer | Insurance company | Insurance ID #

Insurance Group #

Secondarily responsible person's first name | middle initial | last name | DOB | SS #

Secondarily responsible person's street addresss | city | state | zip | phone #

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Notice of Privacy Practices

This notice is being sent to you, to inform you that we are H.I.P.A.A. compliant, and to describe to you an "overview" of your privacy rights.

The H.I.P.A.A. law was created for companies who now transfer your personal and medical information electronically (via the Internet, email, etc.) As stated previously, we do not transfer any personal and/or medical documents electronically without your consent at this time and are not foreseeing doing this in the future.

Our Statement to You: We acknowledge your right to your privacy and will abide by both the H.I.P.A.A. and Privacy Act laws and regulations, we understand the meaning of the word "confidential" and we respect your rights to your privacy.

If you have any questions or you would like to exercise any of your rights described in this brochure, you must submit your request in writing to our H.I.P.A.A. manager; or you may call and leave a detailed message and our H.I.P.A.A. manager will get back to you as soon as possible.

A full copy of the H.I.P.A.A. Law and regulations is located at our place of business for your review, or you can visit these Government web sites for further information:
www.CMS.hhs.gov/hipaa
www.hhs.gov/ocr/hipaa
www.hhs.gov/ocr/hipaa/privacy.html

Notice:

Our office does not transfer "Personal Health Information" electronically; we are however H.I.P.A.A. compliant and we are regulated by the Federal Privacy Act.

Our Responsibility:

The confidentiality of your personal health information is very important to us. All information kept in your file is confidential and will not be released unless we obtain written consent to do so and/or it is stated by the law that we may release this information without your consent.

What we are allowed to do without your Consent:

Under federal and Ohio law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. [However, the American Psychiatric Association's Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal health information.] [If relevant: Participants in this organized health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.]

Examples of these are:

Asking a nurse to assist with taking your temperature and to document the results. Supplying your insurance company with a diagnosis or other related health information that will assist payment for services rendered. Supplying the billing department with demographic and diagnostic information, etc.

Under Federal and Ohio State law, we are permitted to use and disclose personal health information without authorization, for treatment, payment, and health care operations. **Note:** If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure. Instances where your consent is not needed. *(examples)*

- Abuse, Neglect, or Domestic Violence
- Appointment reminders and other health related services (**this would include leaving messages on answering machines, unless directed not to**)
- Business Associates such as a Billing Company
- Communicable Disease Control
- Communications with family, only if they are the responsible party for your care and/or payment

- Coroners, Medical Examiners, and Funeral Directors
- Disaster relief or to assist in disaster relief efforts
- Food and Drug Administration (FDA)
- Judicial or Administrative Proceedings
- Law Enforcement

There are other instances where your PMI (Personal Medical Information) may be given out. But our office policy is to always try to get permission from you first before we disclose any such information.

In general our practice will only release actual medical information, such as a diagnosis, medications you have been prescribed. Length of treatment, etc.

Session notes that document diagnoses, medications prescribed and the content of our sessions will only be released upon your signing of a specific release of information allowing me to share that information with those you designate. This is mostly done via fax. Please advise if this is not acceptable.

Your Health Information Rights:

Under the law, you have certain rights regarding the health information that we collect and maintain about you.
This includes the right to: *(examples)*

- Request that we restrict certain uses and disclosures of your health information. We are not, however, required to agree to a requested restriction.
- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in the reason for the denial and your right, if any, to request a review of the decision.
- Request that we amend or update the health information about you that is maintained in our files. This does not include therapy notes however.
- Request a list of whom we sent your health information to.

(Please remove lower portion and send back in the self-addressed stamped envelope)

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge and understand Northwoods Clinic is abiding by the H.I.P.A.A., Ohio state and federal privacy act law(s) and regulations; and I hereby acknowledge that I have reviewed and/or received a copy of the **Notice of Privacy Practices**

Patient Name: _____

Responsible Party (If applicable): _____ Relationship: _____

Signature of Patient or Responsible Party: _____ Date: _____

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Practice Policies

Northwoods Clinic: Therapists working in the clinic enjoy a collegial and educational professional relationship with several therapeutic disciplines within the Northwoods Clinic network. In your particular situation, your therapist works as an independently credentialed clinician through the Clinic and its affiliation with OhioHealth group CIN. Services will be billed to your insurance company via that realtionship.

Your Therapist: Sessions with therapists are by appointment only. The best way to contact your therapist is by calling her direct phone number or sending an e-mail to the email provided by him or her. Voice mail will be checked throughout the day and at least once in the evenings and on the weekends. I will return your phone call as soon as possible. In the event of an emergency, please contact Riverside Hospital Behavioral Health Emergency Services at (614) 566-5056, NetCare Access at (614) 276-CARE or 911.

Appointments: Appointments are typically 50-60 minutes long. **Missed appointments are not covered by insurance and may be paid out of pocket. There is a $60 no show fee if there is not 24 hours notice of a cancellation.**

Payments & Insurance: Co-payments are due at the time of the appointment. Payments can be given to the therapist and made out to Northwoods Clinic. If you are unsure about your balance or have any questions regarding billing, please contact czuccaro2@gmail.com. **Policy requires you to place a credit card on file for balances, coinsurance, and missed appointments, etc.**

Confidentiality: Everything that takes place in psychotherapy is confidential and may not be released without your expressed written permission. There are two exceptions to this: if you or your child becomes a danger to self or others; and if you or your child is involved in child abuse. In these situations I am legally bound to break confidentiality in order to protect all involved. Confidentiality for children and adolescents in situations other than those listed above will be discussed with you during the evaluation phase of treatment.

By signing this document, I understand and agree with the policies described above. I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. If my account is more than 90 days in arrears, I authorize that pertinent billing information can be released to a professional service for purpose of collection of the outstanding balances.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

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Credit Card Authorization Form

I hereby authorize Northwoods Clinic &/or Dr. Richards and his associates to charge my credit card for fees incurred. This may include fees for deductibles, appointments, appointments missed or canceled without 24-hour notice, copays, coinsurance, or fees for completion of paperwork requested or extended phone contacts per the practice policy signed upon admission to the practice.

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address (for receipts): _____

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____

Exp Date: _____

Security Code: _____

Signature: _____ Date: _____

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Consent for Treatment

I give my consent to receive treatment and related services from _____

I understand that this consent is for the duration of the services provided.

Client Name (please print) _____

Client Signature _____ Date _____

For minors receiving services:

I give my consent as parent of guardian for the following individual to receive treatment and related

services from _____

I understand that this consent is for the duration of the services provided.

Client Name (please print) _____

Parent or Guardian Name (please print) _____

Parent or Guardian Signature _____ Date _____

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Release of Information

I hereby authorize _____(or designate) to exchange with/obtain from:

(Name of person or organization)

Information specified below regarding the care of: _____ _____

(Name of patient or client) (Date of birth)

Evaluation, progress/therapy notes, and summaries. This may contain information that includes alcohol and drug use.

Other (Listed, if applicable): _____

The above information is for the following purpose:

For coordination of care

Other (Listed, if applicable): _____

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to your therapist/Northwoods Clinic. I understand that your therapist/Northwoods Clinic may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

_____ _____ _____

(Signature) (Relationship) (Date)

_____ _____

(Witness) (Date)

PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE SUBJECT TO PROSECUTION UNDER FEDERAL LAW. THE FEDERAL RULES RESTRICT ANY USE OF THIS INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT [52 FR 2 1809, June 9, 1987; 52 FR 4 1997, Nov. 2, 1987]

Psychiatric Checklist

For Patients

Date

Person Completing Form

1. Do you seem to have trouble paying attention, getting things done, listening or sitting still?

☐ NO → Skip to Question #2

☐ YES → Answer A Through R

	Never	Some	Often	Very Often
A. Fail to give close attention to details, make careless mistakes	☐	☐	☐	☐
B. Have difficulty keeping your attention on play or tasks	☐	☐	☐	☐
C. Don't seem to listen, even when spoken to directly	☐	☐	☐	☐
D. Don't follow through. Schoolwork or chores, once started, don't get done	☐	☐	☐	☐
E. Can't seem to get organized with tasks or activities	☐	☐	☐	☐
F. You avoid or try to get out of activities that might require sustained attention	☐	☐	☐	☐
G. Lose things necessary for tasks, school or play (toys, assignments, pencils, tools)	☐	☐	☐	☐
H. Easily distracted by the smallest noise or object in the periphery	☐	☐	☐	☐
I. Forgetful	☐	☐	☐	☐
J. Fidgets with hands or feet, or you seem to squirm in your seat	☐	☐	☐	☐
K. Leave your seat in class, or other places that sitting in one place is expected	☐	☐	☐	☐
L. Run about or climb in places where you know you should not.	☐	☐	☐	☐
M. Can't seem to play or do much of anything quietly	☐	☐	☐	☐
N. Seem to be "on the go"' or "driven by a motor"	☐	☐	☐	☐
0. You talk too much	☐	☐	☐	☐
P. Blurt out answers even before the question is completed	☐	☐	☐	☐
Q. Can't seem to wait your turn	☐	☐	☐	☐
R. Interrupt or intrudes in to other people's space	☐	☐	☐	☐

2. Do you seem to have an "attitude" more often than not? Do you seem to be hostile, negative, and contrary most days?

☐ NO → Skip to Question #3

☐ YES → Answer A Through I

	Never	Some	Often	Very Often
A. Are negative, hostile, and defiant in behavior	☐	☐	☐	☐
B. Lose temper	☐	☐	☐	☐
C. Argue with adults	☐	☐	☐	☐
D. Actively defy, or refuse to abide by, adults' requests or rules	☐	☐	☐	☐
E. Deliberately annoy people	☐	☐	☐	☐
F. Blame others for your mistakes or "bad" behavior	☐	☐	☐	☐
G. Are touchy or easily annoyed by others	☐	☐	☐	☐
H. Are angry and resentful	☐	☐	☐	☐
I. Are spiteful and unforgiving	☐	☐	☐	☐

3. Do you bully, threaten, intimidate, steal etc.? In other words, do you persistently violate the rights of others or the rules of society?

☐ NO → Skip to Question #4

☐ YES → Answer A Through P

	Never	Some	Often	Very Often
A. You have developed a pattern where the basic rights of others or society's rules are violated	☐	☐	☐	☐
B. Bully, threaten, or intimidates others	☐	☐	☐	☐
C. Initiate physical fights	☐	☐	☐	☐
D. Have used a weapon toward someone (bat, brick, broken bottle, knife, gun)	☐	☐	☐	☐
E. Are physically cruel to people	☐	☐	☐	☐
F. Are physically cruel to animals	☐	☐	☐	☐
G. Have stolen by mugging, purse snatching, armed robbery or other means of direct confrontation	☐	☐	☐	☐
H. Have forced someone into sexual activity	☐	☐	☐	☐
I. Have started a fire with the intent of causing serious damage	☐	☐	☐	☐
J. Have destroyed someone's property on purpose (other than by fire setting)	☐	☐	☐	☐
K. Have broken into someone's house, building or car	☐	☐	☐	☐
L. You "Con" or lie to obtain favors, goods or to avoid obligations	☐	☐	☐	☐
M. Have stolen items of value (not gum or candy etc.) without confronting a victim (shoplifting, forgery etc.)	☐	☐	☐	☐
N. Stay out at night, despite being told not to. (Must begin before age 13)	☐	☐	☐	☐
0. Have run away from home for a significant period of time	☐	☐	☐	☐
P. Skip school (Must begin before age 13)	☐	☐	☐	☐

4. Do others say, or do you feel you have problems with your mood? Are you sad or irritable for several days in a row, have less energy, or have become withdrawn or isolated?

☐ NO → Skip to Question #5

☐ YES → Answer A Through H

	Never	Some	Often	Very Often
A. Are there periods where your mood seems down OR irritable most of the day nearly every day	☐	☐	☐	☐
B. Have you had a significant decrease in interest or pleasure in things	☐	☐	☐	☐
C. Has there been weight loss (or failure to make expected weight gains) when not dieting	☐	☐	☐	☐
D. Are you sleeping less because you can't fall asleep or stay asleep	☐	☐	☐	☐
E. Do you feel, or have others said that you appear, slowed down OR restless	☐	☐	☐	☐
F. Do you have feelings worthless or feeling excessively "guilty" about something	☐	☐	☐	☐
G. Having a hard time making decisions; can't seem to think or remember	☐	☐	☐	☐
H. Are you thinking of suicide or death	☐	☐	☐	☐

5. Do you have periods where rage or excitability seem to last for hours or days or do you feel the opposite of depressed where you are "high on life," have boundless energy and drive etc. ?

☐ NO → Skip to Question #6

☐ YES → Answer A Through I

	Never	Some	Often	Very Often
A. Are there periods (lasting at least several hours) where your mood is abnormally irritable, elevated or uninhibited	☐	☐	☐	☐
B. During these periods do you feel inflated in your self-esteem or do you feel extra special	☐	☐	☐	☐
C. During these periods do you seem to need much less sleep (appears rested after only 3 hours etc.)	☐	☐	☐	☐
D. During these periods are you much more talkative and does your speech seem "pressured" to get words out	☐	☐	☐	☐
E. During these periods do their thoughts seem to come from "nowhere"; difficult to follow or understand	☐	☐	☐	☐
F. Are you much more distractible during these periods	☐	☐	☐	☐
G. Do you have much more energy to complete tasks, achieve conquests or gain accomplishments	☐	☐	☐	☐
H. Have you been physically aggressive during these specific periods	☐	☐	☐	☐
I. Do you become involved in pleasurable activities that have a high potential for painful consequences	☐	☐	☐	☐

6. Do you have trouble with nervousness or fearfulness in situations where other people usually do not? Do you have fears or worries that seem to cause significant distress?

☐ NO → Skip to Question #7

☐ YES → Answer A Through V

	Never	Some	Often	Very Often
A. Do you have fears that seem excessive or unreasonable	☐	☐	☐	☐
B. Do these fears come about when they think about or come in contact with a certain object or situation	☐	☐	☐	☐
C. The fears described above involve animals, getting a shot, airplanes, storms or any other specific object or situation	☐	☐	☐	☐
D. Exposure to that object or situation causes you to "freeze", have tantrums or be clingy	☐	☐	☐	☐
E. You avoid the object or situation or you endure it with intense anxiety or distress	☐	☐	☐	☐
F. You recognize that the fear is excessive, extreme or unreasonable	☐	☐	☐	☐
G. The avoidance of (or distress from) the object or situation causes loss of esteem or problems at school or home	☐	☐	☐	☐

	Never	Some	Often	Very Often
H. Do you have unusual or uncomfortable thoughts, images or impulses that enter into your mind and cause distress (Note: These are not simply excessive worries about real-life problems)	☐	☐	☐	☐
J. Do you attempt to ignore or suppress the thoughts/images by doing rituals or repeated "magical" acts or thoughts	☐	☐	☐	☐
K. Do you realize that the thoughts/images are a product of his or her mind	☐	☐	☐	☐
L. Are these worries or thoughts seen as excessive, extreme or unreasonable	☐	☐	☐	☐
M. The acts or images cause marked distress, or are very time consuming or interfere with normal life	☐	☐	☐	☐

	Never	Some	Often	Very Often
N. Is there, or has there been, excessive anxiety about being away from home or significant individuals in your life?	☐	☐	☐	☐
O. When separation is anticipated or occurs, is there excessive and recurrent distress?	☐	☐	☐	☐
P. Do you worry excessively about something bad happening to significant others?	☐	☐	☐	☐
Q. Is there a fear that some event (being kidnapped or lost etc.) may cause separation from significant other	☐	☐	☐	☐
R. Is there a reluctance or refusal to go to school (or elsewhere) because of the fear of separation?	☐	☐	☐	☐
S. Is there excessive fear in being alone (or without significant others) at home or in other settings?	☐	☐	☐	☐
T. Is there reluctance or refusal to go to sleep without being near a significant other, or sleep away from home?	☐	☐	☐	☐
U. Are there nightmares involving themes of separation?	☐	☐	☐	☐
V. Are there physical complaints when separation is anticipated or occurs?	☐	☐	☐	☐

7. Do you pull your own hair, resulting in noticeable hair loss?

☐ YES ☐ NO

8. Do you seem to just worry excessively about many things at once (school performance, the future etc.), rather than just one area, as described above? If so, do you seem to have difficulty controlling the worry. Are you irritable and almost physically affected by the worry (restless, fatigued, tensed muscles, can't sleep etc.)?

☐ YES ☐ NO

9. Do you worry about being in a social or performance situation where you might be studied or examined (eating in public, talking in front of class)? If so, do you have an intense fear that you may embarrass yourself?

☐ YES ☐ NO

10. Do you, or did you, refuse to speak in specific social situations when it would be expected to speak (not due to stuttering or not knowing the language etc.)?

☐ YES ☐ NO

11. Do you seem to have a lot of physical complaints (not just to avoid obligations, school, or separation)? If so, are there more than 3 "pain" complaints, 2 "stomach" or gastrointestinal complaints and other physical complaints all occurring together during one time?

☐ YES ☐ NO

12. Have you suddenly lost the ability to use an arm or a leg, or to feel, or see without any medical explanation?

☐ YES ☐ NO

13. Have you been exposed to a trauma where you were threatened of death or serious injury, or witnessed a similar circumstance? If so, did you respond with fear, helplessness, horror, or disorganized/agitated behavior?

☐ NO → Skip to Question #14

☐ YES → Answer A Through F

	Never	Some	Often	Very Often
A. Do you have repeated and intruding memories of the event	☐	☐	☐	☐
B. Are there distressing dreams that appear to relate to the trauma	☐	☐	☐	☐
C. Do the events seem to be relived. There may be "flashbacks" or reenactment of the trauma during everyday life	☐	☐	☐	☐
D. Is there intense distress when exposed to thoughts or objects that symbolize or represent the trauma	☐	☐	☐	☐
E. Do you seem to avoid things that are associated with the trauma	☐	☐	☐	☐
F. Are you more aroused or agitated since the trauma (can't sleep, outbursts of anger, startle easy, etc.)	☐	☐	☐	☐

14. Do you frequently awaken with bad dreams where you can recall these dreams upon awakening? Do these dreams then involve, usually in great detail, threats to your survival or security? If yes to the 2 statements above, are these dreams frequent and/or intense enough to cause interference with school, social, or other important areas of functioning?

☐ YES ☐ NO

15. Do you frequently awaken at night with a panicky scream where you may be sweating, breathing fast and appearing frightened? Or, do you sleepwalk so frequently as to cause distress at home or with daytime activities? If so, do others then tell you that you appeared unresponsive to them and, later, do you not remember even having the "bad dream?"

☐ YES ☐ NO

16. Have you ever expressed a real and persistent interest in being the opposite sex? If so, did it get to the point where you consistently dressed as the opposite sex, took on the "role" of the opposite sex and express discomfort with being your own sex?

☐ YES ☐ NO

17. Do you suspect (or has it been documented) that your reading, mathematics or writing skills are substantially low for your age or level?

☐ YES ☐ NO

18. Have you or has anyone noted persistent problems with coordination or clumsiness?

☐ YES ☐ NO

19. Have you or has anyone noticed problems with you having a limited vocabulary, making frequent mistakes in producing sentences, difficulty understanding words or having trouble with words or grammar that might be below that expected for other people your own age?

☐ YES ☐ NO

20. Do you stutter or have trouble talking?

☐ YES ☐ NO

21. Do you notice any twitches, tics, noises that you make that might be repetitive and recurrent (this may be eye blinking, facial or arm twitches, throat clearing, etc.)?

☐ YES ☐ NO

22. Do you have a great deal of concern about your weight? If so, are you over concerned with becoming fat, aging weight or do you overeat and make yourself vomit etc.?

☐ NO → Skip to Question #23

☐ YES → Answer A Through F

	Never	Some	Often	Very Often
A. Does you refuse to maintain body weight at or above a "normal" body weight for your age and height?	☐	☐	☐	☐
B. Is there an intense fear of gaining weight or becoming fat, even though underweight?	☐	☐	☐	☐
C. Do you not see yourself as underweight, or do you deny the seriousness of your low body weight, or place undue influence of body weight or shape on your self-evaluation?	☐	☐	☐	☐
D. In girls, has there been an absence of at least 3 menstrual cycles?	☐	☐	☐	☐
E. Are there recurrent episodes of binge eating and a sense of lack of control over the eating during that episode?	☐	☐	☐	☐
F. Are there recurrent episodes of behavior in an attempt to prevent weight gain such as vomiting, misuse of laxatives, fasting or excessive exercise?	☐	☐	☐	☐

23. Does you see or hear things that others don't hear or see?

☐ YES ☐ NO

24. Do you have unusual beliefs or perceptions that defy logic and your family's beliefs?

☐ YES ☐ NO