

**Heath H. Hightower, MSW, LCSW, LLC**  
Client Information Form

**Please Print**

Client Name: \_\_\_\_\_ Client DOB: \_\_\_/\_\_\_/\_\_\_

Client Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Client's Address: \_\_\_\_\_

Telephone : \_\_\_\_\_ Ok to leave message? ( )

Client Relationship Status:      Single   Married   Divorced   Civil Union   Other

Client Employment Status: Employed   Full-Time Student   Part-Time Student

Is Client's Condition Related to: Work?   Auto Accident?   Other Accident?

Is the Client the same as the Insured? Yes ( ) No ( )

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Insured's Name: \_\_\_\_\_

Insured's DOB: \_\_\_/\_\_\_/\_\_\_\_\_

Insured's ID Number: \_\_\_\_\_ Insured's SSN \_\_\_\_\_

Insured' Address: \_\_\_\_\_

Client Relationship to Insured: Self   Spouse   Partner   Child   Other

Telephone: \_\_\_\_\_ Ok to leave message? ( )

Primary Insurance Company Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

Primary Care Physician Name/Telephone  
Number: \_\_\_\_\_

Specialist(s) Name(s)/Telephone  
Number(s): \_\_\_\_\_

**Heath H. Hightower, LCSW, LLC**  
**Office Policies, Procedures, and Responsibilities Agreement**

This agreement specifies the policies, procedures, and mutual responsibilities that are essential to healthy and ethical counseling practice. Please read this agreement carefully. If you have any questions, I would welcome the opportunity to address them. After you have read the agreement, please sign and date each form. Your signatures indicate that you have read, understand, and agree to comply with the policies, procedures, and responsibilities fully.

**Services Offered**

- ❖ Individual and couples face-to-face psychotherapy.
- ❖ Individual telephone counseling and/or coaching.
- ❖ Organization, business, agency, and staff trainings.
- ❖ Clinical supervision for pre-licensed social workers.

**Appointments**

Your appointment dates and times have been set aside for you. Thus, it is important that you arrive on time to your appointments so that you can get the maximum benefit of our time together. However, life happens in unpredictable ways and so on rare occasions you might need to re-schedule your appointment at the last moment. As a result, everyone gets a “free” last moment cancellation. If additional appointments are scheduled and missed or cancelled without 48 hours notice, you will be charged the full fee of the service you missed.

**Fees and Billing Procedures**

- |   |                    |
|---|--------------------|
| ❖ Individual and couples face-to-face psychotherapy | \$100.00           |
| ❖ Individual telephone counseling and/or coaching   | \$20/10 min. block |
| ❖ Wellness and professional trainings               | \$200.00/hour      |
| ❖ Clinical supervision                              | \$60.00            |
| ❖ Reports   | \$100.00           |
| ❖ Disability Claim Reports                          | \$75.00            |

Payment is required at the end of every service. For your convenience, I accept Visa, Master Card, cash, and or checks. Credit/debit card payments require you to complete the credit/debit card payment authorization form. Missed or cancelled appointments will be charged to your card of choice. Check payments should be made out to Heath H. Hightower, LCSW. Bounced checks will incur an additional \$50.00 charge.

Your signature indicates that you have read and understand my services and my policies and procedures regarding appointments, fees, and billing. Finally, your signature indicates that I have addressed any questions and/or concerns you might have.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Client Signature (for couples therapy): \_\_\_\_\_ Date: \_\_\_\_\_

**Health Insurance and Informed Consent**

Before your services with me begin, you need to understand your managed care benefits so that you can determine if you want to access them. In order to use your benefits your managed care company may require authorization for services. Please check with your insurance company and obtain authorization before our first session. Authorization for services is usually based on medical necessity and the number of sessions is approved in a limited number of blocks. Most plans have a limited number of blocks annually. After each block of sessions is used, I must request additional visits which require me to release protected health information (PHI) to your managed care company. Additionally, your managed care company will be sent claim forms when I bill for reimbursement. Finally, while insurance companies go to great lengths to secure your information, the information could be accessed by any number of your managed care company's employees and the information can be subpoenaed by law enforcement officials.

Your signature below indicates that you understand your managed care benefits and have assigned/authorized me to be in touch with your managed care company for the purposes of obtaining authorization/re-authorization for treatment; treatment planning and coordination, and billing/reimbursement issues. Finally, your signature indicates that I have addressed any questions and/or concerns you might have.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Client Signature (for couples therapy): \_\_\_\_\_ Date: \_\_\_\_\_

## **Privacy and Confidentiality**

Central to any relationship is trust. Trust is the ability to reliably believe or have faith in something or someone. Earning and maintaining your trust is paramount to me: without it our work together will not be successful.

The primary way I earn your trust is by safeguarding your personal health information (PHI). The content of our telephone, written, and face-to-face communications are private and confidential. My records of our communications are locked in a heavy-duty filing cabinet and the door to the filing room has a lock on it. Internet communications with your managed care company only take place on a password protected computer within a password protected, encrypted portal created and maintained by your insurance company.

While every reasonable measure to secure your privacy is in place, society as whole has decided that there are several instances when personal health information (PHI) can and/or must be shared. The first is obvious: when you give me written permission to release your information to a specific person, agent, social system, and/or organization. The other instances can and will occur without your consent. One of these instances is if you indicate that you are going to harm yourself imminently with the intent of ending your life. I care about you and my ability to serve you is contingent on you being alive. A second instance is if you communicate that you plan on imminently harming someone else. Examples of this include but are not limited to murder, child abuse, and/or elder abuse. In this instance society has decided that my duty to warn and protect others outweighs your right to privacy and confidentiality. A third instance pertains to information officially requested by the legal system. Finally, information about you can be reviewed if my practice is being investigated. Regardless, I will always tell you when and who I am going to contact out of respect for you: there will be no surprises.

Your signature below indicates that you understand the nature and scope of your rights to privacy and confidentiality including its limits. Additionally, your signature indicates that you understand that your protected health information (PHI) can be electronically transmitted even though there is a rare chance it could be viewed by unauthorized sources. Furthermore, your signature indicates that you understand that I am a mandated reporter who has a responsibility to warn and protect. Finally, your signature indicates that I have addressed any questions and/or concerns that you might have.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Client Signature (for couples therapy): \_\_\_\_\_ Date: \_\_\_\_\_

## **Consent to Treatment**

At this time you have chosen me, Heath H. Hightower, MSW, LCSW to provide counseling and/or coaching services. Decisions about treatment will be collaborative in nature, though you as the client make the final decision and are primarily responsible for executing the treatment, growth, and/or action plan(s).

Like any change or growth process, there are no guarantees about what kind of progress or success will occur. There are also no guarantees about when and/or how progress or success will occur for you. Depending on what kind of services you are seeking, you might feel worse at first because of the intensity of our work together. This is normal, predictable, and in all likelihood temporary.

While your growth and change processes cannot be guaranteed, every effort will be made to create a safe, supportive and challenging space for you to grow and achieve your goals.

If at any time you want to change the treatment/service plan or would prefer to work with a different therapist/coach, those changes can be made at anytime.

In the event that you decide to change therapist/coach, please note that our relationship is not technically completed until all fees have been paid in full.

Finally, if you leave treatment unexpectedly and without notice and I have not heard from you for 60 days, your client status will change.

Your signature below indicates that you have chosen me to be your therapist at this time. Additionally your signature indicates that you understand that while every effort will be made to foster your growth and success there are no guarantees about if, when, how, and what growth and success will occur. Furthermore, your signature indicates that you understand you have a right to change treatment or providers at anytime and that you have a responsibility to pay all of your fees in full even if you change providers. Also, your signature indicates that if you leave treatment unexpectedly and without notice for 60 days your client status will change. Finally, your signature indicates that I have addressed any questions and/or concerns that you might have.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Client Signature (for couples therapy): \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Release/Obtain Protected Health Information**

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

When this form is completed, signed, and dated by you, it authorizes me to release and obtain protected health information to/from the designated person, agency, and/or social institution.

Information may be released to/obtained from: Heath H. Hightower, LCSW

129 Ethan Drive

Windsor, CT 06095

T: (860) 204-2051

F: (860) 688-2478

E: [h3mswlcsw@hotmail.com](mailto:h3mswlcsw@hotmail.com)

Information may be released to/obtained from: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The type of information to be released/obtained: assessment, service plan, treatment coordination.

This information is being released/obtained to ensure coordination of services.

This authorization begins on \_\_\_\_\_ and will be in effect for two years hereafter unless withdrawn. You may withdraw this authorization at anytime, in writing. Once received, the authorization will be ineffective immediately as long as all fees and reimbursements have been received by me.

“The confidentiality of this record is required under chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes. A copy of the consent form specifying to whom and for what specific use the communication or record is transmitted or a statement setting forth any other statutory authorization for transmittal and the limitations imposed thereon shall accompany such communication or record. In cases where the disclosure is made orally, the person disclosing the information shall inform recipient that such information is governed by the provisions of Conn. Gen. Stats. 52-146d to 52-146j, inclusive.”

Your signature indicates that you have read this form. Your signature also indicates that you understand that specific information pertaining to your psychosocial, substance abuse, and/or chronic health diagnoses may contain confidential HIV (AIDS) information (initial here \_\_\_\_\_). Additionally, you understand that declining to sign this authorization does not impact your right to obtain treatment unless the disclosure of this information is required for treatment, case management, authorization, billing, payment, and/or collection purposes. Finally, your signature indicates that you understand that information released and used pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer be protected by the HIPPA Privacy Rule.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Client Signature (for couples therapy): \_\_\_\_\_ Date: \_\_\_\_\_

**Credit Card Pre-Authorization for Service Payment Form**

I authorize Heath H. Hightower, LCSW to keep my signature on file and to charge my account for clinical and professional services.

I assign my insurance benefits to Heath H. Hightower, LCSW. I understand that this form is valid for 4 years unless I cancel the authorization via written notice.

Patient's Name: \_\_\_\_\_

Card Holder's Name (as shown on card): \_\_\_\_\_

Card Holders Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

VISA (  )    Mastercard (  )    Other (  )

Card Number: \_\_\_\_\_

Exp. Date: \_\_\_\_\_

AuthorizedSignature: \_\_\_\_\_

Date: \_\_\_\_\_

**Policies and Practices to Protect the Privacy of Your Health Information**  
**PLEASE READ CAREFULLY.**

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) mandates that the policies and practices outlined in this document describe how I manage information about you. It is important for you to understand the policies and practices so that you can make informed decisions about your, and/or your family member's personal health information. Each time you visit any health care provider, information is collected about your physical and psychosocial health. The information is known as your *Protected Health Information* (PHI). Your PHI is securely stored in your records in my office. This information is likely to include the following:

- ❖ Signed and dated copies of your intake forms.
- ❖ Your biopsychosocial history.
- ❖ The presenting reason(s) for seeking my services.
- ❖ The sign and symptoms you're experiencing throughout treatment.
- ❖ Progress notes that reflect what you tell me, what we're working on in general, and how you're doing.
- ❖ Other provider records, notes, and/or lab results.
- ❖ Medication information.
- ❖ Legal issues.
- ❖ Insurance and billing information.

I use this information to assess, plan, coordinate, and evaluate your treatment, or to communicate with other professionals or organizations. Your privacy is very important to me and I will work hard to maintain the privacy of your records. Due to the details and nuance of the HIPPA rules, please feel free to raise questions and/or concerns about the privacy of your records.

**Uses and Disclosures**

Throughout treatment, I may use or disclose your PHI for assessment, treatment, payment, and health care operations purposes with your consent.

**Uses, Disclosures, and Authorizations**

In order to obtain and/or release your PHI, I need your written permission prior to obtaining and/or releasing your PHI. You may revoke all authorizations at any time as long as it is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage.

**Uses, Disclosures, Mandated Reporting, and Legal Orders**

There are specific instances in which I will provide your PHI *without* your consent:

- ❖ Child abuse and elder abuse.
- ❖ The abuse of people with developmental and/or physical impairments.
- ❖ Health oversight activities wherein my practice is being investigated.
- ❖ Court orders/subpoenas.
- ❖ Serious threat to self and others.
- ❖ Worker's Compensation.

### **Client's Rights**

- ❖ Right to Request Restrictions with regard to your PHI.
- ❖ Right to Receive Confidential Communications by Alternative Means and at Alternative Locations.
- ❖ Right to Inspect and Copy your PHI.
- ❖ Right to Amend your PHI.
- ❖ Right to an Accounting of your PHI disclosures.
- ❖ Right to a Paper Copy.

### **Therapist Duties**

- ❖ I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- ❖ I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect.
- ❖ If I revise my policies, I will notify you via U.S. mail or in person during our session.
- ❖ When information is disclosed, I will disclose the minimum amount of information necessary to address the reason the information was requested.

### **Concerns and Complaints**

Please feel free to raise any questions and/or concerns you have about your privacy and/or how I manage your PHI. If you do not feel I have adequately addressed your concerns and/or complaints, feel free to send a written complaint to The U.S. Department of Health and Human Services.

### **Effective Date**

January 1, 2008

**If you'd like a copy of this document, please let me know.**