William B. Hazel III, MA, MSW, ACSW, LCSW, LADC
Licensed Drug & Alcohol Counselor (LDAC), License #000589
Licensed Clinical Social Worker (LCSW), License #006619
National Provider Identification # 1326376104

Client Questionnaire

Please fill out this biographical background form as completely as possible. It will help me in our work together. All information is confidential as outlined in the informed consent form.

Name:_____Date:_____

Address:_____City:_____Zip:_____

Social Security #:_____Date of Birth: _____

Telephone: H: _____W: _____Cell: _____

May I leave a message? If so, on which number? _____

E-mail:_____May I e-mail you?_____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:_____Employer/School:_____

Emergency Contact: _____Phone:_____

Medical Doctor/s (Name/Phone): _____

Referral Source: _____

Education: _____Current Marital Status: _____

Children (Names/Ages)_____

Insurance Carrier: _____Phone Number on Card:_____

Policy ID Number:_____Group Number:_____

Primary Policy Holder's Name:_____Date of Birth:_____

Reason for Visit:_____

_____

_____

_____

_____

_____

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Please indicate if the following symptoms are affecting you:
(Leave blank if not applicable):

- ☐ Depression
- ☐ Feel Hopeless
- ☐ Think about suicide
- ☐ Feel irritable
- ☐ Cry easily
- ☐ Loneliness
- ☐ Feel guilty
- ☐ Feel worthless
- ☐ Withdrawal from people
- ☐ Unable to have a good time
- ☐ Lost interest in usual activities
- ☐ Unmotivated to complete daily tasks
- ☐ Decreased energy/fatigue
- ☐ Confusion
- ☐ Lost interest in sex
- ☐ Sexual performance problems
- ☐ Trouble falling asleep
- ☐ Trouble waking up
- ☐ Trouble staying asleep
- ☐ Recent weight gain or loss
- ☐ No appetite
- ☐ Binge eating
- ☐ Intentional vomiting
- ☐ Panic Attacks /Frequency _____
- ☐ Rapid heartbeat/palpitations
- ☐ Constant worry
- ☐ Fear of social gatherings
- ☐ Feel anxious, on edge
- ☐ Unwanted or distressing thoughts
- ☐ Repetitive behaviors
- ☐ Nightmares
- ☐ Phobias, unreasonable fears
- ☐ Thoughts about traumatic events
- ☐ Bowel disturbances
- ☐ Headaches
- ☐ Chronic Pain
- ☐ Other medical problems
- ☐ Decreased attention span
- ☐ Inattentive/distractible
- ☐ Memory problems
- ☐ Spending sprees
- ☐ Racing thoughts
- ☐ Hear voices
- ☐ See things that are not there
- ☐ Think about hurting someone
- ☐ Anger outbursts

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Do you have any suicidal feelings? _____For how long have you had them?_____

Have you ever attempted suicide? _____How? _____

Were you ever in a psychiatric hospital? _____

Have you previously received any type of mental health services?_____

Have you ever been prescribed psychiatric medication?_____

Are currently taking any prescription medication?_____

How often do you drink alcohol? ☐ Daily (# of Drinks/Day ____) ☐ Weekly (# of Drinks/Wk____)

☐ Infrequently ☐ Never

How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Infrequently ☐ In the Past ☐ Never

Is there a family history of any of the following?

	(Please Check)		(Family Member)
Alcohol Abuse:	☐ yes	☐ no	_____
Substance Abuse:	☐ yes	☐ no	_____
Depression:	☐ yes	☐ no	_____
Suicide Attempts:	☐ yes	☐ no	_____
Bipolar Disorder:	☐ yes	☐ no	_____
Schizophrenia:	☐ yes	☐ no	_____
Eating Disorders:	☐ yes	☐ no	_____

Patient Name: _____Date: _____

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Informed Consent for Treatment

Appointments: A scheduled full session consists of a 50 minute time period. Clients are generally seen either weekly or more or less frequently depending on need. I have a telephone voice mail that is available at all times for routine messages. I collect my messages frequently and make every attempt to return calls within 24 hours. If it is after hours or the weekend and you are experiencing a mental health emergency (thoughts of harming yourself or someone else) and are unable to reach me, **call 911 or go to your nearest emergency room for assistance.** You may also telephone a mental health or suicide hotline listed in your telephone book. If you are not in danger of hurting yourself or someone else, then you may proceed to register for our Internet-Based Session Options..

Payment and Fees: Payment is due at the time of the appointment unless other arrangements have been made or if you are using insurance. Clients are responsible for co-payments, co-insurance, and deductibles. **Except where there is a clear emergency, sessions missed or cancelled with less than 24 hours notice will be charged for the full session.** Insurance companies do not pay for missed appointments. Fees are discussed prior to the first appointment. I accept payment via PayPal. All financial and personal information is kept in a secure, locked file. If you have insurance which provides coverage for out of network mental health treatment, please let me know as some insurance plans reimburse a portion of the fee.

Confidentiality: Contents of all therapy sessions are confidential and generally no information will be released without your consent. If it is necessary to speak with other mental health providers, physicians, school professionals, or family members, I will ask you to sign a release of information form so that I may communicate with them.

There are noted exceptions to confidentiality. I am required by law to report suspected child or elder abuse and take action when a client is a danger to self or others or gravely disabled. In cases in which a client implies a plan for suicide, I am required to report to authorities and make reasonable attempts to notify the client's family. Additionally, when a client discloses intentions of a serious threat of violence against another person, I am required to warn the intended victim and contact legal authorities. Insurance companies and other third-party payers are given information that they request regarding claims for therapy services. Information that may be requested includes dates of service, diagnosis, treatment plans, progress in therapy and case notes. Confidentiality is also subject to waiver when disclosure is court ordered or if there is litigation that calls into question your mental health.

Consent for Treatment: By signing below, I am indicating that I have read the above information and consent to participate in evaluation and treatment. I agree that I have been informed of the fee schedule, late cancellation policy, and the limits of confidentiality.

_____

Client Name (Please Print)

Signature Date

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HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your health information privacy:

As part of providing professional care, I am committed to maintaining the privacy of your personal health information. I am also required by law to keep your information private. HIPPA (The Health Insurance Portability and Accountability Act) requires that I provide you with this notice of privacy practices.

I will use information about your health mainly to provide you with treatment, to arrange payment for our services, to file claims with insurance companies, and for some other business activities that are legally referred to as “health care operations.”

If it will be useful to disclose or release your information for any other purposes, I will ask you to sign an authorization form for release of information.

Your health information is confidential. However, there are instances when the law requires me to share it. For example:

- If there is a serious threat to your health and safety or the health and safety of another individual or the public. I only share information with the person or organization that is able to help to prevent or reduce the threat.
- If there is any suspicion of child abuse, neglect, molestation, or sexual abuse. If there is any suspicion of elder abuse or neglect.
- If you are unable to take care of basic needs for yourself.
- If disclosure of your health information is court ordered.

Your rights regarding your health information:

- You can ask me to communicate with you about your health and related issues in a way that is more private for you. For example, you can ask me to call you at work and not at home, or ask me not to leave a telephone message on a home answering machine.
- You have the right to ask me to limit what I tell people who are either involved in your care or the payment for your care, such as family members and friends. I will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.
- You have the right to look at the health information I have about you, such as your treatment and billing records. Please contact me to arrange how to see your records.
- If you believe certain information in your record is incorrect or missing, you can ask me to make some kinds of changes to your health information. You must make this request in writing and tell me the reasons you want to make the changes.

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You have a right to copy of this notice. If I change this notice, I will post the new version on my website http://onlinehelp.pro or you can obtain a new copy from me.

You have the right to file a complaint if you believe your privacy rights have been violated. You can contact the United States Secretary of Health and Human Services at:

The Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue S.W. Room 515F, HHH Bldg.
Washington D.C., 20201.

Filing a complaint will not change the health care I provide you in any way.

If you have any questions regarding this notice or your health information privacy, please discuss them with me. My contact information is:

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1961 Broadbridge Avenue
Stratford, CT 06614

Phone: (203)-377-1562
Website: http://onlinehelp.pro
Email: admin@onlinehelp.pro , support@onlinehelp.pro
Skype: onlinehelp.pro
AOL/AIM screen name: OHelpPro
Twitter: onlinehelppro
Yahoo! ID and Email Address: onlinehelppro@yahoo.com

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Client Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices of William B. Hazel III, MA, MSW, ACSW, LCSW, LADC, effective October 01, 2011.

Print Name of Client or Responsible Party (if client is under the age of 18)

Signature of Client or Responsible Party

Date