VISTA EAP/Intentions Yoga

Cynthia N. Herzog, LCSW, CAP, ICADC, E-500 RYT, C-IAYT

CLIENT INFORMATION

CLIENT NAME: _____ DATE OF BIRTH: _____/_____/_____
(If a minor) PARENT /GUARDIAN NAME: _____ MARITAL STATUS: _____
ADDRESS: _____ CITY: _____ ZIP: _____
SS#: _____ EMPLOYER: _____ POSITION: _____

LENGTH OF EMPLOYMENT: _____ SAFETY SENSITIVE JOB? Y or N
MAY WE CONTACT YOU AT HOME? Y or N PHONE#: _____ MESSAGE? Y or N
MAY WE CONTACT YOU AT WORK? Y or N PHONE#: _____ MESSAGE? Y or N
MAY WE CONTACT YOU ON CELL? Y or N PHONE#: _____ MESSAGE? Y or N

EMAIL: _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURED: _____ EMPLOYER: _____
INSURANCE CO. NAME: _____ POLICY ID#: _____
GROUP #: _____ INSURANCE DATE OF BIRTH: _____/_____/_____
AUTHORIZATION#: _____ INSURANCE PHONE#: _____

PERSONAL HISTORY / MEDICAL HISTORY

OTHER MEMBERS OF HOUSE HOLD: NAME AGE RELATIONSHIP

_____
_____
_____

PRIMARY CARE PHYSICIAN / PSYCHIATRIST NAME AND PHONE NUMBER: _____
_____

ARE YOU CURRENTLY UNDER A DOCTORS CARE? Y or N SPECIFY: _____
_____

CURRENT MEDICATIONS? DRUG DOSAGE DOCTOR WHY?

_____
_____
_____

PAST HOSPITALIZATIONS: MEDICAL, PSYCHIATRIC, OR CHEMICAL DEPENDENCY (specify when and why)

_____
_____
_____

PAST COUNSELING, EAP, OR CHEMICAL DEPENDENCY SERVICES: (specify date, counselor, & reason)

_____
_____

WHAT CONCERNS BRING YOU TO COUNSELING AT THIS TIME? _____
_____

SIGNATURE OF PERSON COMPLETING THIS FORM: _____

101 Timberlachen Circle, Suite 201, Lake Mary, FL 32746
www.vistaeap.com Phone: (407) 324-9440

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CLIENT'S STATEMENT OF UNDERSTANDING

- ❑ I understand that while it is Ms. Herzog's policy to file claims as a courtesy for me, payment for ALL services are MY responsibility regardless of whether they are covered by insurance, and I agree to pay for all services rendered. Payments are due at the time of service.

- ❑ I understand and agree to assign all benefits due from any insurance to this counseling facility. I authorize the release of all Personal Medical Information (PMI) and records required to process my claims. I further agree to follow all the guidelines of my Insurance in obtaining any acquired authorization for treatment and payment

- ❑ I understand and agree that the first office visit is purely for evaluation purposes. While I expect to benefit from this treatment, I fully understand that outcomes cannot be guaranteed. I also understand that my counselor is not required to continue to treat me and that both client and counselor are free to discontinue services at any time.

- ❑ I agree to provide 24-hour notification of cancellation of any appointment I cannot make. Failure to provide a 24-hour notice will result in a $75.00 No Show Fee.

- ❑ Ms. Herzog is available for EMERGENCY calls 24/7 or will PROVIDE COVERAGE for same

- ❑ EAP sessions by Statement of Understanding are free & confidential. Depending upon contractual obligations EAP clients may need to be referred to other clinicians or may choose to continue with Ms. Herzog. Please discuss any questions you may have.

- ❑ All insurance and EAP client sessions are 40-45 minutes in length.

- ❑ If desired, clients may pay for additional time at their negotiated rate.

- ❑ All clients can request additional time at 30-minute increments at $75.00/hour. Phone sessions during work hours are similarly charged. After hours, weekend and holiday phone sessions are charged at $125.00/hour. These times can be scheduled as needed and as Ms. Herzog's schedule allows.

- ❑ Those clients who prefer can self-pay. The initial consultation fee is $150.00/hour, and if the client prefers to request additional time, it is available in 15 minute to ½ hour blocks.

- ❑ Checking these boxes acknowledges your understanding and acceptance of these terms.

Signature: _____ Date: _____

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CLIENT NAME: _____

DEPRESSION
Center for Epidemiologic Depression (CES-D)

Scale Items:
Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week by checking the appropriate space.

During the past week:	Rarely	Some	Moderate	Often
	0-1 days	1-2 days	3-4 days	5-7 days
1. I was bothered by things that don't usually bother me.				
2. I did not feel like eating, my appetite was poor.				
3. I felt I could not shake the blues, even with help from friends/family.				
4. I felt that I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people disliked me.				
20. I could not get going.				

References:

Hann, D., Winter, K., & Jacobson, P. (1999). Measurement of depressive symptoms in cancer patients: Evaluation of the Center for Epidemiologic Studies.

(CES_D) Journal of Psychosomatic Research, 46, 437-443

Radloff, L.S. (1997) the CES-D scale: A self-reported depression scale for research in the general population. Applied Psychological Measurement, 1, 385-401.

Item weights:	Rarely	Some	Moderate	Often
	0-1 days	1-2days	3-4 days	5-7 days
Items 4,8,12 and 16				
All other items				

Score is the sum of the 20 items weights. Possible range is 0-60.

Clinical Signature: _____ Credentials: _____ Date: _____

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RECEIPT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES & RIGHT AND RESPONSIBILITIES NOTICE

CLIENT NAME: _____ D.O.B.: _____

As a client, I understand that I have certain rights and responsibilities as it relates to my privacy and healthcare. I understand that it is important to know those rights and responsibilities.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of VISTA Employee Assistance and Counseling Inc.'s Notice of Privacy Practice and the Clients Right and Responsibilities Notice. I understand that if I have any questions regarding this notice, or my privacy rights, that I can contact my provider and/or the privacy officer as outlined in the Privacy Notice.

_____ _____
SIGNATURE DATE

_____ _____
SIGNATURE OF PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE * DATE

**If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)*

CLIENT REFUSES TO ACKNOWLEDGE RECIEPT: _____

_____ _____
SIGNATURE OF STAFF MEMBER DATE