

**Clinical Counselors, PA**  
**Mona Rubenfeld, M. A., LCPC**  
11447 Cronhill Drive – Suite L, Owings Mills, MD 21117  
Phone: (410) 960-3954 Fax: (410) 581-3504 Email: [MRubenfeld@ClinicalCounselors.com](mailto:MRubenfeld@ClinicalCounselors.com)

Dear Client:

Enclosed are some required forms that will need to be signed and returned prior to your scheduled initial consultation. These forms include the Consent + Office Policies and Guidelines, New Patient Information, Financial Policy and Insurance Information, the Notice of Privacy Practices, and any questionnaire that may be included in your packet. Please read them over and sign where required. Please bring the signed forms to your initial consultation. In addition, I will need a copy of both sides of your insurance card. Deductibles, co-payments and full self payments are required before the start of each session. Cash or check will be accepted.

Feel free to contact me with any questions or concerns prior to our scheduled appointment. I look forward to meeting you.

Thank you,

Mona Rubenfeld, M.A., LCPC

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**New Patient Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Email: \_\_\_\_\_  
May I contact you by email? \_\_\_\_ Y \_\_\_\_ N

Employer: \_\_\_\_\_  
Position: \_\_\_\_\_ For how long? \_\_\_\_\_  
Your education: \_\_\_\_\_

Marital/relationship status: \_\_\_\_\_ Spouse/partner's name: \_\_\_\_\_  
Spouse/partner's age and sex: \_\_\_\_\_ How long together? \_\_\_\_\_  
Spouse/partner's education: \_\_\_\_\_  
Spouse/partner's occupation: \_\_\_\_\_

Family members living in the home:

<u>Name</u>	<u>Age (minor only)</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_  
Date of your most recent physical examination: \_\_\_\_\_  
Psychiatrist: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
List any allergies you have: \_\_\_\_\_

<u>Health Problems</u>	<u>Medications/Dosage</u>	<u>Prescribed by:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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**Please write down your reason(s) for seeking counseling** (Be specific).

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**Describe any previous counseling experience you or a family member has experienced.**

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**List three or four specific goals for this counseling?** (Be Specific)

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**How do you best describe your personality? What are your strengths and weaknesses?**

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**Describe any stressful events that have recently taken place in your life (e.g. illness, moved).**

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**Describe any positive events that have recently taken place in your life (e.g. vacation, promotion at work).**

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**Please check all that apply, including how long you have experienced these symptoms.**

	<u>Check Here</u>	<u>Length of time experienced?</u>
Sad or depressed mood (lasting more than 2 weeks)		
Loss of interest or pleasure in usual activities		
Crying spells		
Sleep difficulties ( <b>specify</b> )		
Increased or decreased appetite ( <b>specify</b> )		
Weight loss or weight gain ( <b>specify</b> )		
Decreased sexual drive		
Chronic fatigue or low energy		
Feeling worthless or hopeless		
Trouble concentrating or focusing attention		
Trouble remembering things or thinking clearly		
Social withdrawal		
Thoughts of death or suicide		
Attempts to hurt or kill yourself		
Symptoms worsen in Fall and Winter months		
Periods of excessive energy		
Physically restless		
Can't stop remembering upsetting past events		
Avoiding normal activities or situations due to fear		
Chest palpitations		
Chest pain or discomfort		
Choking or smothering sensation		
Feeling dizzy or unsteady		
Tingling in hands or feet		
Hot or cold spells		
Feeling faint		
Trembling or shaking		
Body pain		
Easily startled		
Stomach problems		
Obsessions or Compulsions		
Anxiety		
Self mutilation to the body		
Emotional or physical trauma		
Emotional outbursts		
Anger		
Frequent arguments or fighting		
Aggressive behavior		
Feeling out of control		
Made myself throw up in order to lose weight		
Used laxatives or exercised excessively to lose weight		
Alcohol use		
Drug use ( <b>name the drugs?</b> )		
Other Symptoms:		

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## Privacy of Information Policies

**This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.** Effective 4-14-03

### **Our Legal Duties**

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

### **Use of Information**

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

### **Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

### **Public Safety**

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

### **Abuse**

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

### **Prenatal Exposure to Controlled Substances**

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

### **In the Event of a Client's Death**

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

### **Professional Misconduct**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

### **Judicial or Administrative Proceedings**

Health care professionals are required to release records of clients when a court order has been placed.

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**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

**Other Provisions**

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

**Your Rights**

You have the right to request to review or receive your medical files. The procedure for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. **The charge for this service is \$ 1.00 per page, plus postage.**

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

**Complaints**

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Maryland Board of Professional Counselors. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: Mona Rubinfeld, LCPC

<b>I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.</b>	
Client's name (please print): _____	
Signature: _____	Date: ____/____/____
Signed by: ____ client ____ guardian	

## **Office Policies, Guidelines, and Consent to Treatment**

This information is intended to inform you about office practices and policies. Because your relationship with your counselor is based on confidence and trust, it is important to be fully informed about some key elements of that relationship. Please be assured that I will be happy to discuss these issues with you in detail so that you may feel comfortable with them. This form also serves to document that these issues have been discussed. I will provide a copy for you if you would like. Please ask if you need clarification on any information in these intake forms.

### **Hours and Appointments**

Office hours are by appointment only. Regular office hours are Monday - Friday, 10 am - 6 pm, and Saturdays from 10 am to 4 pm. Special appointments can be arranged as needed for conflicts in schedules. Individual and family counseling sessions run on a 45-50 minute hour. Your appointment is reserved for you and you alone, it is important to be on time since sessions can not run over your allotted time. There is a 24-hour cancellation policy. **You must call the office 24 hours prior to your appointment to cancel or reschedule. Otherwise, you will be charged for the full cost of your visit. Your insurance company can not be billed for broken appointments.**

### **Termination of Services**

Either the client or counselor may choose to terminate the counseling relationship at any time. If the counselor terminates the relationship, the client may receive a referral for more appropriate services should this be needed.

### **Phone Calls and After Hour Emergencies**

Phone calls between sessions will be returned as soon as possible. In the event of a telephone session lasting more than 10 minutes, you will be charged at the hourly session fee. **Dial 911 for any emergency situation, or go to your nearest hospital.** Filling out required forms or writing letters will be billed to you (not your insurance) at an hourly rate of \$130.00.

### **Payment Procedures**

Self payments, deductibles and copayments are required before each session begins; therefore you will need to come prepared with cash or a check. **Any fees denied or not paid by your insurance company (for any reason), within thirty days of the date of service become the patient's or responsible party's financial obligation.** There is a \$25 fee on all returned checks. A finance charge of 2% per year will be assessed monthly to any overdue balance. A delinquency fee will be assessed on accounts which require additional collection action. Every effort will be made to inform you of all charges in advance. If you have any questions about the fees or any other financial concerns please discuss them with your counselor.

### **Confidentiality**

In order for counseling to be effective, it is important understand that information shared with your counselor is confidential. Release of your information requires your written permission except in the following cases:

- All mental health professionals are required by law to report abuse or neglect of minors and abuse, neglect or exploitation of elderly or disabled persons.
- All mental health professionals are required by law to notify appropriate medical or law enforcement agencies if a threat exists for immediate harm to the client or others.
- Legal issues involving the client that result in the demand for information as per a court order (example: child custody case).
- Information required by managed care companies or other parties responsible for payment.
- Information released as outlined in the HIPAA Notice of Privacy Practice.

### **Consent + Acknowledgement of Office Policies and Guidelines**

I acknowledge that I have fully read and understand the Office Policies, Procedures and Guidelines followed by Mona Rubinfeld, LCPC and Clinical Counselors, PA. I consent to treatment and will comply with the policies and guidelines set forth by Clinical Counselors, PA.

\_\_\_\_\_  
**Patient's Signature or Legal Guardian (of a minor)**

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

\_\_\_\_\_  
**Counselor's Signature**

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

## Financial Policy

Clinical Counselors, PA is committed to providing caring and professional mental health services. As part of the delivery of mental health services, a financial policy has been established to clarify the payment policies and options available at Clinical Counselors, PA.

- Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.
- Clinical Counselors, PA will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates, or for fees that are denied or not paid by your insurance company (for any reason).
- The Person Responsible for Payment will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers. Payments not received after 30 days are subject to collections. A 2% per month interest rate is charged for accounts over 30 days.
- Insurance deductibles and co-payments are due at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere, this amount will be collected by the office until the deductible payment is verified by the insurance company or third-party provider.
- All insurance benefits will be assigned to this office (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance at each session.
- Clients are responsible for payments at the beginning of each session. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan or payment at the time of service.
- Missed appointments and cancellations less than 24 hours prior to the appointment will be billed to you directly, not to your insurance company or third-party provider.
- Telephone sessions lasting more than 10 minutes, will be charged at the hourly session fee.
- Filling out required forms or writing letters will be billed to you (not your insurance) at an hourly rate of \$130.00.
- There is a \$39 fee on all returned checks. A delinquency fee will be assessed on accounts which require additional collection action.
- Payment methods include check or cash.
- Every effort will be made to inform you of all charges in advance. Questions regarding the financial policies can be answered by a staff person.

I (we) hereby certify that I (we) have read, understand, and agree with the provisions of the Office and Financial Policy. I (we) consent to treatment and will comply with the policies and guidelines set forth by Clinical Counselors, PA.

Person responsible for account: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Co-responsible party: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Insurance Information**

**Person Responsible for Counseling Payment (or Co-Payment)**

First Name \_\_\_\_\_ MI \_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Medical Insurance**

Policy Holder \_\_\_\_\_  
Relationship to Client \_\_\_\_\_  
Birth date: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Gender: \_\_\_\_\_ M \_\_\_\_\_ F  
Marital Status \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W  
Employer \_\_\_\_\_  
  
Insurance Name \_\_\_\_\_  
Type of Policy \_\_\_\_\_  
Policy ID \_\_\_\_\_  
Group Number \_\_\_\_\_  
Phone Number \_\_\_\_\_

**Release of Information Authorization to Third Party**

I (we) authorize \_\_\_\_\_ to disclose required treatment plans, a mental health diagnosis, case notes, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment. I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____	Date: ____/____/____
Person(s) receiving services: _____	Date: ____/____/____
Person(s) or guardian(s): _____	Date: ____/____/____

We suggest you confirm mental health benefits with your insurance company. The Person Responsible for Payment of the Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company. Your insurance company may not pay for services that they consider to be not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. Payments, co-payments, and deductible amounts are due at the time of service. There is a 2% per month interest charge on all accounts that are not paid within 30 days of the billing date. Payments, co-payments, and deductible amounts are due at the time of service. There is a 2% per month interest charge on all accounts that are not paid within 30 days of the billing date. Cancellations less than 24 hours in advance or missed appointments are billed directly to the Person Responsible for Payment and not to your insurance or third party provider.

I HEREBY CERTIFY that I have read and agree to the conditions as described above.	
Person responsible for account: _____	Date: ____/____/____

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## Release of Information Consent

Client's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_ to:  
\_\_\_\_\_ (send) \_\_\_\_\_ (receive) the following \_\_\_\_\_ (to) \_\_\_\_\_ (from)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR \*PSYCHOTHERAPY NOTES.*

<input type="checkbox"/> Academic testing results	<input type="checkbox"/> Psychological testing results
<input type="checkbox"/> Behavior programs	<input type="checkbox"/> Service plans
<input type="checkbox"/> Progress reports	<input type="checkbox"/> Summary reports
<input type="checkbox"/> Intelligence testing results	<input type="checkbox"/> Vocational testing results
<input type="checkbox"/> Medical reports	<input type="checkbox"/> Entire record, except progress notes
<input type="checkbox"/> Personality profiles	<input type="checkbox"/> *Psychotherapy Notes
<input type="checkbox"/> Psychological reports	<input type="checkbox"/> Other, specify _____

The above information will be used for the following purposes:

Planning appropriate treatment or program  
 Continuing appropriate treatment or program  
 Determining eligibility for benefits or program  
 Case review                       Updating files  
 Other (specify) \_\_\_\_\_

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year, this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client:  Self                       Parent/legal guardian                       Other (describe) \_\_\_\_\_

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/guardian/personal representative (if applicable)  
Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness (if client is unable to sign)  
Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_