Animal Assisted Counseling of Indiana, LLC
900 Ridge Rd, Ste T, Munster IN, 46321
708-730-2600

(Please Print)

Today's Date:		**DX CODE:** (office only)

CLIENT INTAKE INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address:	City:		State:		ZIP Code:
Home phone no.: OK to contact? ( )	Cell phone no.: OK to contact? ( )	Social Security no.:	Birth Date: / /		Sex: ❑ M ❑ F

EMAIL ADDRESS:

HOW DID YOU HEAR ABOUT AAC OF INDIANA?

EMPLOYMENT

Employer:	Occupation:	Work phone no.: ( )
Street Address:	City:	State: ZIP Code:

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone no.: ( )	Cell phone no.: ( )
Referring Doctor (if required by insurance):		

INSURANCE INFORMATION

Insured's Last Name **(if different):**	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no.: **(if different)** ( )	Cell/Other contact no.: ( )	Social Security no.:	Birth Date: / /		Sex: ❑ M ❑ F
Insurance Company:	Insurance Billing Address:		Insurance phone no.: ( )		
Policy no.:	Group no.:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company:	Insurance Billing Address:	Insurance phone no.: ( )			
Policy no.:	Group no.:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Juliann Steinbeigel, those acting on the practice's behalf, and my insurance company to release any information required to process my claims.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

Patient/Guardian signature _____ *Date* _____

*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged for the session amount. Thank you for your cooperation.**

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Authorization to Secure Payment

I, _____ authorize Animal Assisted Counseling of Indiana, LLC to process payment on my Visa, MasterCard, or Discover Card for services and/or for any balance due that has not been paid **30 days after it is received.**

I understand that if the appointment is missed and I do not follow the cancellation policy as specified, Animal Assisted Counseling of Indiana, LLC is authorized to charge my credit card the same as the missed appointment.

You will receive a one-time credit card authorization e-mail from NetSource Billing, LLC, to confirm this credit card. Upon receipt of this confirmation, charges will appear for services rendered.

I have read and understand this form. I attest that the information below is true and accurate.

_____

Signature of Card Holder

My credit card information is as follows:

_____ _____

Cardholder's Name Client's Name

_____ _____

Credit Card Account Number Expiration Date

Is this a debit card? CCV Code _____

☐ Yes ☐ No _____

Today's Date

Please indicate if you would like your session Co-pay automatically charged to your

Credit card. ☐ Yes ☐ No Amount of Co-Pay _____

E-Mail Address_____

**The above mentioned charges on your card will appear from NetSource Billing, LLC.

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Notice of Privacy Practices – Summary

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

PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. Though these laws are complicated, we must provide you with this important information. These two pages summarize the Notice of Privacy Practice which you received along with this. You may refer to the complete document for more information. We realize that it is not possible to cover all scenarios in this document, so please consult our Privacy Officer, Owner Dr. Juliann Steinbeigle if you have further questions or concerns.

The health information we will obtain will be documented primarily from you, but may also include information obtained from other family members or professionals involved in you case that you have given us permission to speak with. This information will be used to provide you with effective treatment, to arrange payment for our services or for other business activities, which are called, in the law, health care operations. After you have read the NPP we will ask you to sign a form acknowledging that you have received this notice. If you are not willing to sign this form, we cannot treat you.

If information regarding your treatment here needs to be disclosed to others for family involvement or for coordination of treatment services we will discuss this with you and ask you to sign an Authorization to allow this.

We will keep all of your health information private. However, there are some situations where the law requires us to disclose information about you even without your signed consent, such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

See the complete text of the NPP for the full list of mandated disclosure scenarios.

Your rights regarding your health information

1. You have the right to determine how we get in touch with you if we need to (for appointment changes or cancellations). Let us know if you prefer us to call your home or your cell and whether it is okay to leave a message.

2. You have the right to determine what information is shared with other involved in your treatment.

3. You have the right to review your record, and can request a copy of your record (medical and billing).

4. If you believe the information in your records is incorrect or incomplete, you can request that changes or amendments be made to them. This request must be made in writing, and must include reasons for the request.

5. You have the right to receive a copy of this notice. If our Privacy Practices are changed, we will post a notice in our waiting room and a copy can be requested.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any question regarding this notice our health information privacy policies, please contact our Privacy Officer, Dr. Juliann Steinbeigle, phone number 708-730-2600, Merrillville IN.

The effective date of this notice is January 23, 2018.

Animal Assisted Therapy – Counseling Policy, Procedure and Risk

Therapy animals are a vital part of our counseling team, we hope that you are comfortable with their presence in our office and in your sessions. The purpose of this form is to review the policies, procedures, and risks of working with a therapy dog, as well as request your consent for treatment utilizing AAT-C provided by Animal Assisted Counseling of Indiana. Please note that this form upholds the agreement of procedural and financial terms as stated in the Consent to Treatment.

Introduction Animal-Assisted Therapy in Counseling (AAT-C) is a form of creative therapy that utilizes licensed and credentialed therapy animals and Licensed Professional (who manage the therapy animal partner) to provide therapeutic interventions to individuals of all ages. AAT-C can be used with various types of psychological, emotional, developmental, cognitive, or motivational impairments.

Policies, Procedures, and Risks for Working with Animals in Therapy Although working with a therapy animal, specifically canines, in a therapeutic setting has many benefits, there are risks associated with this intervention. Because AAT-C utilizes a live animal, it is important to note in advance the policies and procedures needed to maximize the intervention and ensure a safe work environment, both for the therapy animal and the patient.

1. Participation in AAT-C is not guaranteed and will be based on the therapist's assessment. If the assessment determines the patient is not a good fit, other treatment options will be discussed and appropriate referrals may be made.
    a. If a history or indication of animal abuse or other risk factors are present, the Therapist will determine whether participation in AAT-C is indicated.
    b. Should a patient become aggressive (hits, kicks, bites, pulls, pinches, etc.) towards the Therapy Animal Partner during therapy, the Therapist will determine if it is appropriate to continue treatment or make the appropriate referrals.
2. Anyone wishing to participate in AAT-C should be screened for allergies before working with the Therapy Animal Partner. All allergies must be reported before beginning treatment so the proper precautionary measures can be taken. Should documentation from a medical professional indicate that allergies, skin or respiratory sensitivities, or other medical conditions exist, the Therapist will determine if it is appropriate to continue treatment or make the appropriate referrals. Neither the Therapist, nor Animal Assisted Counseling of Indiana, LLC can be held liable for allergic or other physiological reactions to the Therapy Animal Partner.

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3. Any fear of dogs must be reported before treatment commences so the proper precautionary measures can be taken and goodness of fit determined.
4. If sick or injured, the Therapy Animal Partner will not be able to provide services until the illness or injury subsides or upon veterinary approval, as sickness or injury could negatively impact the therapy animal partner's behavior.
5. Although the Therapy Animal Partner will remain current on their vaccinations and health screenings, there is always a slight risk of zoonotic disease transmission (i.e., the sharing of diseases between animals and humans) when working with an animal. Every effort will be made by the Therapist to reduce the risk of zoonosis.
6. Every effort will be made by the Therapist to educate/model for the patient and/or guardian appropriate ways to physically engage with the Therapy Animal Partner.
7. Although every effort will be made to cut and file the Therapy Animal Partner's nails, scratching may occur while physically interacting with the dog. Neither the Therapist, nor Animal Assisted Counseling of Indiana, can be held liable for injuries incurred by the Therapy Animal Partner's nails.
8. Dogs play or show affection by licking or nibbling, which may result in oral contact from the dog. Although every effort will be made by the Therapist to monitor this, there is a risk for light biting or licking to occur while interacting with a therapy animal partner. Zoonotic disease transmission may occur when a dog makes oral contact with a person. The Therapy Animal Partner will be allowed to lick the patient upon obtaining this consent unless otherwise discussed and documented. Neither the Therapist, nor Animal Assisted Counseling of Indiana can be held liable for injury or zoonotic disease transmission as a result of oral contact from the Therapy Animal Partner.
9. Dogs use their body to communicate and may brush against or lean into a person. Other body language such as tail wagging or body wiggling may also occur. Such behaviors create a risk for loss of balance, falling, or light bruising. Neither the Therapist, nor Animal Assisted Counseling of Indiana can be held liable for injury incurred by physically engaging with the Therapy Animal Partner.
10. The patient and/or guardian will promptly report all accidents and/or injuries to the Therapist should an injury occur. The Therapist will respond accordingly and take proper action to help the patient get the appropriate medical care.
11. The Therapy Animal Partner cannot be used in therapy without the Therapist present. No other provider, unless credentialed and previously approved by the Therapist, can handle or use the Therapy Animal Partner in a therapeutic capacity.
12. Patients are never to be left alone with the Therapy Animal Partner.
13. If at any time, the Therapy Animal Partner shows signs of distress, irritation, fear, or in any way acts in a negative manner, they will be allowed to take a break. No one, except the Therapist, should touch or interact with the Therapy Animal Partner during these times. The Therapist will assess and determine whether it is safe for the Therapy Animal Partner to return to the session.
14. Animals, like people, have their own moods that determine their level of desire to interact with others. It is therefore understood that the Therapy Animal Partner is allowed to determine if and when to participate in therapy/interact with others. While it may be planned to use the Therapy Animal Partner in a scheduled therapy session, the Therapy Animal Partner will never be forced to interact should they indicate signs of distress and/or Resistance.
15. The Therapy Animal Partner has a designated space in the office where they are free to rest, sleep, or take a break without interruption.
16. If the Therapist and the patient agree, the Therapy Animal Partner may work off leash, which will be noted in the patient's file.

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I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Animal Assisted Counseling of Indiana Privacy Practices. I understand that if I have and questions regarding the Notice or my privacy rights, I can contact Dr. Juliann Steinbeigle, 708-730-2600.

I also verify that I understand the following:

All the information in my sessions is confidential **EXCEPT: If I am threatening to hurt myself, if I am threatening to hurt someone else, or if I tell of a child or an elderly person being abused or neglected, the therapist must tell someone to protect me or another.**

24 hour cancellation fee When I schedule an appointment, the therapist reserves the hour for me and if I cannot attend a session I must give 24hrs notice or I will be charged the full amount for the session.
_____initial

Payment at time of service is expected unless other arrangements have been made.

Health Insurance If health insurance covers my sessions, Animal Assisted Counseling of Indiana will help me seek reimbursement from the insurance company. **ANY** unpaid balance after insurance is **MY** responsibility to pay. I agree that Animal Assisted Counseling of Indiana may release to my insurance company any information needed to secure payment for services.

Unpaid account balances If I do not pay my account balance after receiving two notices of the delinquency, I understand that my account may be turned over to collections.

Insufficient funds In the event that any check I write is returned NSF (insufficient funds) I agree to pay a $30.00 service fee.

CONSENT TO TREATMENT

I hereby authorize and voluntarily consent to all care, treatment, and other related services that may be ordered, requested, directed, or provided by Animal Assisted Counseling of Indiana, LLC providers.
I understand and agree to the above provisions

_____ _____

Signature of Patient/Client **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).

Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date

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ANIMAL ASSISTED THERAPY – COUNSELING CONSENT AND RELEASE OF LIABILTIY

I understand that Animal Assisted Counseling of Indiana incorporates the use of therapy animals within the counseling session. I have received information regarding the benefits and risks of Animal Assisted Therapy Counseling and agree to the use of a Therapy Animal Partner within my counseling sessions. I understand I have the right to request that counseling be conducted without the use of the therapy animal at any time at which time consultation of services and referral may occur.

Minor or Individual With a Custodial Guardian

I, the parent or guardian of _____ understand and agree to the policies, procedures, and risks associated with the use of Animal-Assisted therapy in mental health treatment. I hereby consent to therapeutic services involving the Therapy Animal Partner, a certified therapy dog, provided for him or her by _____(Therapist Name) and accept full liability in the event that Therapy Animal Partner causes injury to my child in any way throughout the course of treatment. Furthermore, I am not aware of any fear, allergy, skin or respiratory sensitivity, or other medical condition my child(ren)'s has/have that would render physical interaction (i.e., touching, handling) with or close proximity to a therapy dog potentially harmful to his or her health.

_____ _____

Signature of Parent/Guardian Date

Adult

I hereby consent to receive therapeutic services utilizing a Therapy Animal Partner, a certified therapy dog from _____(Therapist) and accept full liability in the event that the Therapy Animal Partner causes injury to me/us in any way throughout the course of treatment. Furthermore, I/we are not aware of any fear, allergy, skin or respiratory sensitivity, or other medical condition I/we have that would render physical interaction (i.e., touching, handling) with or close proximity to a therapy dog potentially harmful to my/our health.

_____ _____

Signature Date

_____ _____

Provider Signature Date

_____

Provider Printed Name

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Consent to release information to Primary Care Physician

Communication between your therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire on (1) year from the date of signature, unless another date is specified.

_____ _____ _____

Patient Name | Date of Birth | Patient Social Security #

Please check one:

☐ I agree to allow my Animal Assisted Counseling of Indiana therapist to release mental health/substance abuse information to my Primary Care Physician.

☐ I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name: _____

Physician Address: _____

City, State, Zip: _____

Physician Phone: _____ Fax: _____

_____ _____

Patient Signature | Date

_____ _____

Parent/Guardian Signature | Date

Information for PCP:

This patient was seen by me on (date) _____ for diagnosis_____

_____ _____

Provider Signature | Date

_____

Provider Printed Name

Animal Assisted Counseling of Indiana, LLC
Child / Adolescent New Client Form

Today's Date: _____

Client Name: _____ Birth Date: _____

In your own words, tell us why you are seeking care through Animal Assisted Counseling of Indiana_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What is/are your goals for seeking care through Animal Assisted Counseling of Indiana?_____
_____
_____
_____
_____
_____
_____

What have you tried that has helped your child? _____
_____
_____
_____
_____
_____
_____

Is there anything else you think the therapist should know? _____
_____
_____
_____
_____
_____
_____

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Symptom Check List

Please check all that apply

___ Financial Difficulty
___ Anxiety
___ Difficulty sleeping
___ Restless /on edge
___ Feeling hopeless
___ Life changing event
___ Mood swings
___ Loneliness
___ Weight gain
___ Memory loss
___ Poor Impuls control
___ Picky eator
___ Bullying
___ Sexting
___ fear of animals'
___ Trauma / Abuse
___ School refusal / truancy
___ Problems using/understanding nonverbal communication
___ Problems separating from parents / family
___ thoughts of hurting self
___ Suicidal Attempts
___ Legal Problems
___ Voices in my head
___ Crying Spells
___ Poor concentration
___ Decreased interest
___ Self-abuse
___ Isolation
___ Anger
___ Weight loss
___ Irritable
___ Difficulties at school
___ Sibling rivalry
___ Victim of bullying
___ Fire starting
___ hurt / tortured animals
___ History of delayed development
___ Difficulty with social interactions or situations
___ thoughts of hurting someone else
___ Previous psychiatric hospitalization
___ Depression
___ Suicidal thoughts
___ Difficulty with relationships
___ Muscle tension
___ Nightmares
___ Excessive fear/worry
___ Hyperactive
___ Loss of appetite
___ Eating disorder
___ Mental illness
___ Poor grades
___ Accident prone
___ Vandalism or stealing
___ Viewing pornography
___ Perfectionism

Previous Mental Health Treatment

If your child has received mental health treatment/hospitalization in the past, please tell us:

Provider:_____When seen:_____Helpful? Y / N

Provider:_____When seen:_____Helpful? Y / N

Provider:_____When seen:_____Helpful? Y / N

Provider:_____When seen:_____Helpful? Y / N

Please list any mental health diagnosis given to your child past and present:_____
_____
_____

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_____
_____

Please list any mental health medications your child has taken in the past: _____
_____
_____
_____
_____
_____
_____

Please list all of your child's current medications (including herbs and over the counter medication): _____
_____
_____
_____
_____
_____

Medical History

Medication Allergies: _____`

Food/Animal/Environmental Allergies: _____
_____
_____

Please list any conditions that your child has been diagnosed with or takes medications for: ___
_____
_____
_____
_____

Medical History Check-List: Check all that apply

___ Hospitalizations ___ Surgeries ___ Prematurity ___ Asthma ___ Head trauma
___ Heart murmurs ___ Heart palpitations ___ Fainting ___ Siezures
___ Use of tobacco, alcohol, recreational drugs, or pills (including one time use)
___ Sexual activity in the past 3 years ___ Birth control pill or injection
___ Other _____
_____
_____

Anything else you think your therapist should know: _____

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_____
_____
_____
_____

Alcohol & Drug Screen Questionnaire (please circle)

1. Do you feel you are a normal drinker? ("normal" – drink as much or less than most other people) Yes No
2. Have you ever awakened the morning after some drinking the night before and found you could not remember a part of the evening Yes No
3. Does any near relative or close friend ever worry or complain about your drinking? Yes No
4. Can you stop drinking without difficulty after one or two drinks? Yes No
5. Do you ever feel guilty about your drinking? Yes No
6. Have you ever attended a meeting of Alcoholics Anonymous (AA) Yes No
7. Have you ever gotten into physical fights when drinking? Yes No
8. Has drinking ever created problems between you and a near relative or close friend? Yes No
9. Has any family member or close friend gone to anyone for help about your drinking? Yes No
10. Have you ever lost friends because of your drinking? Yes No
11. Have you ever gotten into trouble at work because of drinking? Yes No
12. Have you ever lost a job because of drinking? Yes No
13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? Yes No
14. Do you drink before noon fairly often? Yes No
15. Have you ever been told you have liver trouble such as cirrhosis? Yes No
16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual hallucinations or auditory hearing hallucinations? Yes No
17. Have you ever gone to anyone for help about your drinking? Yes No

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18. Have you ever been hospitalized because of drinking? Yes No
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward? Yes No

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was a part of the problem? Yes No

21. Have you been arrested for driving under the influence of alcohol Yes No
    If yes how many times? _____

22. Have you ever been arrested, even for a few hours, because of behavior while drinking? Yes No
    If yes how many times? _____

Alcohol & Drug Use

At what age did you have your first drink? _____ At what age did you try a drug? _____

Current use: Alcohol frequency: ____ daily ____ weekly ____ monthly ____ none
Amount at each episode _____

Drugs frequency: ____ daily ____ weekly ____ monthly ____ none
Drug of choice _____

Check any of the following that you have experimented with or used:

Barbiturates (downers) _____ Tranquilizers (Valium, Xanax, etc.) _____

Sleeping pills _____ Amphetamines (uppers) _____ Marijuana _____

Cocaine _____ Hallucinogens (LSD, STP, PCP) _____ Ecstasy _____

Opiates (heroin, morphine, Demerol) _____ Inhalants _____ Other drug _____

Over the counter medication(s) _____

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