Gregory S. Rusk, LISW, DCSW
*1117 Fehl Lane*
*Cincinnati, OH 45230*
*513.800.3588*

**Welcome**
We welcome you as a new client and appreciate the opportunity of providing behavioral health services to you. Please read the following introduction to this office.

**Treatment Process**
You and Mr. Rusk will work together to identify treatment goals and options. The length of time in treatment will vary according to individual needs and will be discussed throughout the course of your care. You are encouraged to talk as openly as possible about the problem(s) you are experiencing so that Mr. Rusk can better assist you.

**Confidentiality**
Mr. Rusk takes very seriously the responsibility to hold in confidence what you discuss with him. Written permission is required to release any information to another provider/agency and to receive any information from another provider/agency except as specified under HIPAA rules. The only exceptions to this policy is when there are concerns about possible elder or child abuse or neglect, or when there is a serious threat of self harm or harm to others. We are required by law to notify the appropriate authorities under these circumstances.

**Patient Responsibilities**
Office hours are by appointment. It is important that you are on time for your appointments or call us 24-hours in advance when you are unable to keep your scheduled appointment. If you are running late for your appointment a call informing us when you expect to arrive is appreciated. Failure to show up for your appointment, or failure to cancel without 24-hours notice, will result in a **$125** charge that is not covered by insurance.

**Fee Policy**
Please read and sign the **Fee Schedule.** It lists the cost of services provided to you. According to the terms of your insurance plan, or Employee Assistance Plan (EAP), you may need to get an authorization number, specific co-pay information or whether your plan has a deductible or HSA. As a courtesy we will submit your insurance or EAP claim. Any amount that your insurance does not cover is due from you at the time of service. You are responsible for providing copies of your insurance card, EAP authorization numbers or forms, and any changes in your insurance or coverage. Failure to do so may result in the denial of your claim and the bill will be sent to you.

**Your Satisfaction is Important to Us**
Please feel free to raise your concerns at any time. Please sign below to acknowledge that you have read the above information.

**Your Initial Appointment is on**_____**at**_____**(PM)**

**Signature of client/legal guardian** **Date**

**2/20**

# Gregory S. Rusk, LISW, DCSW

1117 Fehl Lane, Cincinnati, Ohio 45230 • 513-800-3588

## CONFIDENTIAL CLIENT REGISTRATION and HISTORY

**Today's Date:** _____

| Last Name | FIRST | Middle Initial | AGE | DOB | GENDER |
|---|---|---|---|---|---|
| | | | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Social Security # | Home Phone | Work Phone |
|---|---|---|
| | | |

| Single Married Divorced Separated Widow/er | YES NO |
|---|---|
| Marital Status (Circle one) | Military Veteran |

| Religion | Education (highest grade) | Other Training |
|---|---|---|
| | | |

| Current Employer | Occupation | How long employed? |
|---|---|---|
| | | |

| Previous Employer | Occupation | How long employed? |
|---|---|---|
| | | |

| Name of Spouse or Partner | Spouse/Partner Address if different from above address |
|---|---|
| | |

Names and ages of children and/or stepchildren

Names and ages of other persons living in household

IF THIS IS A REGISTRATION FOR A MINOR/CHILD: List residential and non-residential parents' names

IF THIS IS A REGISTRATION FOR A MINOR/CHILD: List residential and non-residential parents' addresses

| REGISTRATION FOR STUDENT: Current School | Grade | Course of Study |
|---|---|---|
| | | |

EMERGENCY CONTACT FOR YOU: Name, Address, Phone

## CONFIDENTIAL CLIENT REGISTRATION and HISTORY

**Client Name:** _____

| |
|---|
| Your Doctor's Name, Address, Phone |
| Current Health and/or Medical Problems |
| Current medications prescribed and over the counter |
| Allergies and drug sensitivities |
| Date of last physical examination and results of physical exam |
| Serious physical illness: Most recent hospitalization: Where? When? |
| Mental health/substance abuse treatment: When? Where? With whom? |
| Do you drink alcohol? How much per day? How many times per week? |
| What do you drink? Beer, wine, whiskey, etc. |
| Do you often drink more alcohol than you planned to drink? How many DUI/OVI in the past five years? |
| Do you have blackouts after drinking? How often? |
| Who has expressed concern about how much you drink? When? |
| Do you use non-prescribed drugs? Which drugs do you use? How often? |
| Do you take more prescription medication than the prescribed dose? How often? |
| Who has expressed concern about your drug use? When? |
| Have you been arrested for alcohol/drug offenses? When? Where? |
| What additional information do you want to share about your health? Use blank sides of papers if needed. |

## Behavioral Health and Medical Information * Patient Coordination of Care

### Patient Information

| Print last name, first, middle initial | Birth date mm/dd/yyyy | Insurance ID number |
|---|---|---|
| Street address City, State, ZIP | | Daytime telephone |

### Medical Information ☐ I do not have a doctor

| Print doctor's name | Doctor's phone number |
|---|---|
| Doctor's street address City State ZIP | Fax number |

**Patient Rights**

- You can end this authorization (permission to use or disclose information) at any time by contacting Gregory S. Rusk, LISW.
- If you request to end this authorization, it will not include information that has already been used or disclosed based on your previous consent.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information disclosed on this form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

**Patient Authorization**

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expire six months from the date of my signature, unless another date I specified. I have read and understand the above information and give my authorization.

**PATIENT, CHECK ONE BOX BELOW.**

☐ I DO authorize the release of any applicable medical information and/or mental health/substance abuse information between Gregory S. Rusk and my doctor.

☐ I DO NOT authorize the release any mental health/substance abuse information to my doctor.

| Patient signature | Date |
|---|---|

**The section below may include important patient information. With permission, it may be sent to the doctor.**

| Behavioral health (BH) provider<br>***Gregory S. Rusk, LISW*** | BH provider phone<br>***513-800-3588*** | Best time to reach me<br>***Afternoons*** |
|---|---|---|
| Street address, City, State, ZIP<br>***1117 Fehl Lane, Cincinnati, Ohio 45230*** | | Fax number<br>***513-832-2993*** |
| Patient diagnosis | | Comments |
| Patient medications/herbal remedies/dosages | | |
| Risks/Concerns (homicidal/suicidal ideation, etc)\ | | |

**WARNING NOTICE TO RECIPIENT(S) OF PATIENT INFORMATION**

**Unauthorized interception of this telephonic communication could violate Federal and State law.**

This electronic message transmission contains information belonging to Gregory S. Rusk, LISW that is solely for the recipient named above and may be confidential or privileged. Gregory S. Rusk, LISW EXPRESSLY PRESERVES AND ASSERTS ALL PRIVILEGES AND IMMUNITIES APPLICABLE TO THIS TRANSMISSION. If you are not the intended recipient, know that any disclosure, copying, distribution, or use of this communication is STRICTLY PROHIBITED. If you have received this electronic communication in error, notify sender by telephone at the number above to arrange for the return of the original documents. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 CFR, Part 2) and/Q1 state laws regarding confidentiality of patient records. These rules prohibit you making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. General authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. ***Thank you.***

Gregory S. Rusk, LISW, DCSW
*1117 Fehl Lane*
*Cincinnati, OH 45230*
*513.800.3588*

## CONSENT TO BE TREATED

I, (print name)_____, agree to receive counseling or social psychotherapy, including the diagnosis and treatment of possible mental or emotional disorders and/or substance abuse problems, given the problems and symptoms I have presented to Gregory S. Rusk, LISW. In signing this form I consent to the treatment, treatment recommendations, or referrals to other qualified clinicians for adjunctive treatment, that may be made on my behalf.

I consent to participate in the following treatment modalities as determined clinically appropriate by Gregory S. Rusk, LISW:

1. Individual psychotherapy
2. Couple's or marital therapy
3. Family therapy
4. Group therapy
5. Clinical hypnosis
6. Behavioral medicine interventions
7. Substance abuse treatment
8. Referral for more intensive treatment
9. Referral for medication evaluation/management
10. Referral to community support/self-help groups

I will be fully informed of treatment recommendations and realize that following them is my own choice. I further agree to fully participate in a mutually agreed upon treatment plan that is designed to improve the problem(s) and/or symptom(s) for which I am seeking treatment. I accept the responsibility to negotiate this treatment plan to the best of my ability.

I also understand that I, or Gregory S. Rusk, LISW, can terminate this agreement for treatment at any time. I have the responsibility to ask questions about my treatment and seek clarifications as necessary.

Signature:_____Date:_____

Witness:_____Date:_____

Gregory S. Rusk, LISW, DCSW
*1117 Fehl Lane*
*Cincinnati, OH 45230*
*513.800.3588*

## PATIENT RIGHTS & RESPONSIBILITIES

**As a patient of Gregory S. Rusk, LISW, you have the following rights:**

1. To be treated with courtesy and respect by this provider and his staff.
2. To make recommendations regarding your rights and responsibilities.
3. To receive appropriate behavioral health care.
4. To obtain information about services and treatments, including risks and benefits.
5. To receive information about your insurer's clinical guidelines and member's rights and responsibilities for coverage.
6. To participate in the planning of your treatment, including the option to consult with other professionals at your own expense.
7. As a competent person, to refuse treatment.
8. To participate in experimental research, but only when you have been provided written, informed consent to do so.
9. To be free from mental and physical abuse as defined by law. This includes freedom from any act that constitutes assault, sexual exploitation, or criminal sexual conduct. It also includes the intentional and non-therapeutic infliction of physical pain or injury, or any conduct intended to produce mental or emotional distress.
10. To confidential and private behavioral healthcare treatment and the confidentiality of your treatment record. This includes your right to approve, or to refuse the release of information in this record, outside this provider's office.
11. To voice complaints about this provider, or the care that is provided according to this provider's professional Disclosure Statement, and/or the guidelines of the behavioral health care company that is paying for your treatment.

**And the following responsibilities:**

12. To give to this provider all information needed in order to provide appropriate care for you, including insurance coverage information.
13. To follow the treatment plan and instructions for care that you and this provider have agreed upon.
13. To participate, to the degree possible, in understanding your behavioral health problems and in developing with your provider, mutually agreed upon treatment goals.

Please sign and date to acknowledge that you have read your rights and responsibilities. A copy will be furnished if you request one.

Signature:_____ Date:_____

Gregory S. Rusk, LISW, DCSW
*1117 Fehl Lane*
*Cincinnati, OH 45230*
*513.800.3588*

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and provider certifications

I have received, read and understood the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I also understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that the use of my PHI be restricted in how it is disclosed to carry out treatment, payment or health care operations. I also understand that this office is not required to agree to my requested restrictions, but if this office does agree then they are bound to abide by those restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices Acknowledgement* but was unable to do so as documented below:

Date:_____Initials:_____Reason:_____

Gregory S. Rusk, LISW, DCSW
*1117 Fehl Lane*
*Cincinnati, OH 45230*
*513.800.3588*

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other identifiable health information used or disclosed by us in any form, whether electronically, or on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we use and disclose your health information.

We may use and disclose your mental health records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be a physical exam.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by your written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health care information.
- The right to receive an accounting of disclosures of protected health care information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protect health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of your Notice of Privacy Practices and to make new provisions effective for all protected health information that we maintain. We will post and you may request a copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Gregory S, Rusk, LISW
1117 Fehl Lane
Cincinnati, OH 45230
513.800.3588

For more information about HIPAA or to file a complaint:
U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

02/20

THIS YOUR COPY TO KEEP

# Gregory S. Rusk, LISW, DCSW

1117 Fehl Lane
Cincinnati, Ohio 45230
513.800.3588


New____ Change____

## Patient Information

Name (Last, First. Mi); Sex M F Birthdate: Social Security number:

Address:

City: State: Zip:

Home telephone: Work telephone: Employer:

Responsible party:

## Primary Insurance Information

Name *of* subscriber (Last. First, Mi): Sex: M F Birthdate: Social Security number:

Address: City:

Zip: Marital Status: Single Married Divorced Widowed

Relationship.to patient (spouse, child, etc.): Employer: Work telephone:

Insurance company name: Insurance Co. Phone:

Address *of* insurance company:

Member identification number. Group number: Effective date:

## Secondary Insurance Information

Name of subscriber(Last. First, Mi): Sex: M F Birthdate: Social Security number:

Address: City: State:

Zip: Marital Status: Single Married Divorced Widowed

Relationship to parent (spouse, child, etc.): Employer: Work telephone:

Insurance company name: Insurance Co. Phone:

Address *of* insurance company:

Member identification number: Group number: Effective date:

Workers Compensation number: Employer:

Employer address: Data of injury:

Have you listed all your insurance coverage? ☐ YES

☐ No

I authorize payment of medical benefits to Gregory S. Rusk, LISW. I hereby guarantee payment of all charges incurred for this account and authorize release of any medical information necessary to process this claim.

**Responsible Party Signature** **Dependent Signature (over18)**

OFFICE USE ONLY. Forward form and copy of insurance cards to Billing Dept.

Gregory S. Rusk, LISW, DCSW
*1117 Fehl Lane*
*Cincinnati, OH 45230*
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## FEE SCHEDULE[1]

| | |
|---|---|
| 1. Individual Therapy | $125 per session[2] |
| 2. Family Therapy (WITH/WITHOUT THE PATIENT) | $125 per session |
| 3. Conjoint Therapy | $125 per session |
| 4. Substance Abuse Professional Service | $125 per session[3] |
| 5. Letters & Reports | $100 per letter/report[4] |
| 6. Court Appearance | $1200 retainer |

- Clients are responsible for providing information necessary for billing purposes – including authorization numbers, copay or deductible amounts.
- Clients who do not want to use their insurance agree to pay the full fee for the provided service.
- Clients are responsible for payment at the time of service.
- Insurance copayments or deductibles are due at the time of service.
- All insurance, including EAP, payments will be assigned to the provider – Gregory S. Rusk, LISW.
- A payment agreement is necessary for continuation of services if there is an outstanding balance due.
- Missed appointments or cancellations less than 24 hours prior to the appointment are charged $125 payable prior to the next appointment.
- A $25 fee is charged for all returned checks.

I acknowledge that by signing below I have read and agree to the terms stated above.

Signature of patient/legal guardian Date

Signature of witness Date

This information is required by the Counselor, Social Worker, and Marriage and Family Therapist Board, which regulates the practices of professional counseling, social work, and marriage and family therapy in this state.

State of Ohio
Counselor and Social Worker, Marriage and Family Board
50 West Broad St., Suite 1075
Columbus, OH 43215-5919
614.466.0912

[1] Fees listed are fee-for-service and insurance billing rates. Different insurers contract insurance reimbursement for services at different rates.

[2] A "session" is 45 minutes of psychotherapy and 10-15 minutes of documentation.

[3] Includes reports.

[4] Minimum charges. Additional charges for extensive reports.

Rev. 2/20