

Cornelius (Con) Sheehan, Jr., LCSW

720 Tahoe Street, Suite 3

Reno, NV 89509

775-287-7733

Today's Date _____



Please answer this section **ONLY IF** treatment is ordered by the Court or other agency (Social Services, for example):

Name of Court if applicable: _____

Judge: _____

Court Case #: _____

Date of required completion: _____

Name of P.O. or Social Worker if applicable: _____

House arrest completion date: _____

Client Identification Information

Name: _____ Date of Birth: _____
First MI Last

Address: _____
Street (include apt or unit #) City State Zip

Phone: (H) _____ (W) _____ SSN: _____ Age: _____
(required for billing)

Gender: M ___ F ___

With which ethnic group do you identify? _____

Check one: Married ___ Single ___ Separated ___ Divorced ___ Widowed ___

List the members of your family and all others in your home:

Name(s) Age/Birth Date Relationship

Do you have children not currently living with you? Yes ___ No ___

If so how many? _____

Residence throughout life (list cities and length below):

City, State						
Age (Ex. 5-10 years-old)						

Highest level of education completed: _____

Employment Status: Full-time ___ Part-time ___ Laid Off ___ Unemployed ___

Type of Work: _____ Years at job: _____

Place of Employment: _____

Were you referred by employer? _____ Insurance Company _____

Check One: Live Alone ___ Live with partner and/or children ___ Live with Family ___

Homeless ___ Live with roommate ___ Live in Half-Way House ___ Live in motel ___

Live in Transitional House ___ Own my own home ___ Rent ___ Subsidized Housing ___

What is the primary reason you are entering therapy at this time?

Have you ever participated in individual psychotherapy or counseling before? YES / NO. If you circled "yes" please tell me a little about what led you to treatment and what the outcome was.

Emotional and Behavioral

Please circle any of the following symptoms or difficulties, which pertain to you.

Nervousness	Unhappiness	Inferiority feelings	Friends
Depression	Sleep	Concentration	Anger
Fears	Stress	Education	Self-control
Shyness	Work	Career choices	Insomnia
Sexual problems	Relaxation	Health Problems	Making decisions
Suicidal thoughts	Headaches	Temper	Loneliness
Separation	Tiredness	Nightmares	Bowel troubles
Divorce	Legal matters	Marriage	Being a parent
Finances	Memory	Children	My thoughts
Drug use	Ambition	Appetite changes	Stomach Trouble
Alcohol use	Energy	Weight gain/loss	

Would you like to provide additional information about any of the circled items above?
If so, please use the space below:

CONSENT TO TREATMENT

I do hereby seek and consent to treatment with Cornelius Sheehan, Jr. LCSW.

I understand that no promises have been made to me as to the results of treatment or any of any procedures provided by this therapist.

I am aware that in my best interest, legal and professional guidelines limit the treatment relationship to treatment and related functions only. I should expect the treatment provider to have no other role in my life.

I am also aware that the information I share will be kept confidential. I understand that I must sign a written release of information in order for the therapist to communicate with others regarding my care. I understand that there are exceptions to this, those being;

1. If I disclose information which leads my therapist to believe that I have made threats to harm myself or others.
2. If I disclose any information regarding child abuse/neglect or elderly abuse/neglect.
3. If I disclose information which leads my therapist to believe animal abuse/neglect is occurring.
4. If my records are subpoenaed under court order.

My signature below shows that I have read understood and agreed with all of these statements.

Signature of Client or Guardian

Date

Relationship to Client

I, Cornelius Sheehan, Jr. LCSW, have discussed the issues above with the client (and/or the client's parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed and willing consent.

Cornelius Sheehan, Jr. LCSW

Date

Cornelius Sheehan, Jr., LCSW

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Reno, NV 89509

PAYMENT AGREEMENT

I have discussed rates and billing with the provider and agree to pay \$95 (*\$120 for weekends and evenings after 6PM, and/or where billing is required*) per session. Payment is due at the time of service unless other arrangements have been agreed to.

*I acknowledge that I must call to cancel an appointment **at least 36- hours** before the time of the appointment (please initial here _____). If I do not cancel or do not show up, I will be charged agreed upon fee for that appointment.* I also understand that if I have insurance or other payment source they will not be responsible for this charge.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive. I understand that I am responsible for any balance due, including co-payments, deductibles and any amount that the insurance does not cover.

I understand and agree that if my account must be referred to any third party for collections, I will be responsible for any and all costs related to the collection action, including, but not limited to, collect agency percentage fees, court costs and reasonable attorney fees.

Your signature below indicates agreement to the payment policies described above.

Signature of Client or Representative

Date

Insurance Worksheet

I am able to bill some insurance plans directly. *If I am a network provider* for your plan would you like your health insurance company billed for your sessions? No Yes

If Yes, please complete the following information and furnish a copy of both sides of your insurance card. Please Note: **Your sessions cannot be billed unless you provide your insurance card.**

Client's Name: _____

Client's DOB: ____/____/____

Insured's Name: _____

Mailing Address:

Street #/PO Box City State Zip

Telephone #: _____

Relationship to client: Self Spouse Child Other

Marital Status: Single Married Other

DOB: ____/____/____ Sex: Male Female

SSN: ____ - ____ - ____

Employer: _____

Do you have a secondary insurance plan? Yes No

If Yes, you are responsible for submitting claims to secondary insurance.

I understand, agree, and authorize payment of benefits to Cornelius Sheehan, Jr., American Comprehensive Counseling Services or the provider of ACCS.

I am aware that an agent of my insurance or other third party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that I am responsible for any balance due, including co-payments, deductibles and any amount the insurance does not cover.

I understand and agree that if my account must be referred to any third party for collections, I will be responsible for any and all costs related to the collection action, including, but not limited to, collect agency percentage fees, court costs and reasonable attorney fees.

Client Signature

Date

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize Cornelius Sheehan Jr., LCSW and representatives to send and/or receive to and from the following agencies or people:

Professional/Provider/Other Party's Name

Other Party's Address City State Zip Phone

- | | |
|---|--|
| <input type="checkbox"/> Behavior Programs | <input type="checkbox"/> Service Plans |
| <input type="checkbox"/> Case Notes | <input type="checkbox"/> Summary Reports |
| <input type="checkbox"/> Medical Reports | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Personality Profiles | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Progress Reports | |
| <input type="checkbox"/> Drug/Alcohol testing | |

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 my records are protected under Federal regulations governing Confidentiality of Alcohol/Drug abuse patient records, 42 CFR, Part 2 & 45, CFR Parts 160-165, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: Specification of the date, event or condition upon which this consent expires:

_____ there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated in to treatment.

_____ one year after termination of treatment.

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Therapist _____ Date _____

"Disclosure of Client information in a manner not authorized by 42 CFR Part 2 and 45 CFR Parts 160-165, is a Federal criminal offense. Further disclosure to any person or party for which consent has not been provided to client is further prohibited by Law and Statute.