Amanda Costin, Ph.D., LMHC, ACS

Personal Information

Name ____Date of Birth:____________________

Address ____

City _______________________ State ________________ Zip Code ___________________________

Marital Status: Single Married Divorced Domestic Partnership Separated Widowed

Home Tel. ____________________________Cell Tel.____

E-mail address: ____

May I contact you at any of the above phone numbers or email address?____________________________

Emergency Contact and Phone Number:____

Primary Care Physician and Phone Number:____

Payment Information

Please check all that apply:

- ☐ I will be paying in full at my sessions.
- ☐ I will be paying a co-pay of $__________ at my sessions.
- ☐ I have a deductible.
- ☐ Send claims directly to my primary insurance provider.
- ☐ Someone other than myself is responsible for my payment and his/her information is:

Name ____

Address ____

City _______________________ State ________________ Zip Code ______________________________

Home Phone __________________________ Cell Phone ____

Relationship to me: ____

Insurance Information

Primary Insurance Company ____

Insurance ID____

Phone # of Insurance Co. (on back of card____

Secondary Insurance Company ____

Insurance ID____

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1. Please describe the main issue that has brought you to see me:
____
____
____
____
____

2. Have you received any type of mental health services? (Psychotherapy, psychiatric, etc.)
   If so, previous therapist/practitioner:____

3. Please list any medications you are taking: ____

4. Have you taken any psychiatric medications?____

5. How would you rate your current physical health?
   Poor Unsatisfactory Satisfactory Good Very Good

6. How would you rate your current sleeping habits?
   Poor Unsatisfactory Satisfactory Good Very Good

7. Please list any difficulties with your appetite: ____
   ____

8. Are you currently experiencing grief, sadness or depression? ____________________________
   If yes, for how long? ____

9. Are you currently experiencing anxiety, panic attacks, or phobias? If yes, when did you start experiencing this? ____

10. Are you currently experiencing any chronic pain? ______________________________________

11. Do you drink alcohol and if so how frequent? ____

12. How often do you engage in recreational drug use?_____________________________________

13. Are you currently in a romantic relationship? If yes, for how long? _________________________

14. On a scale of 1 – 10, how would you rate your relationship: ______________________________

15. What significant life changes or stressful events have you experienced recently? ______________
____
____
____

16. Please circle if there is a family history of any of the following: Alcohol Abuse, Substance Abuse, Anxiety, Depression, Domestic Violence, Eating Disorder, Obesity, Obsessive Compulsive Disorder, Schizophrenia, Suicide Attempts. Please list family member and describe:_______________________
____
____

17. Are you currently employed? ___ If so, what is your current occupation?________________________

18. Do you enjoy your work? Is there anything stressful about your work? __________________________
____

19. Do you consider yourself religious or spiritual? If yes, please describe: __________________________
____

20. What do you consider to be your strengths? ____
____
____
____

21. What do you consider to be some of your weaknesses? _______________________________________
____
____
____

22. What would you like to accomplish during therapy? ____
____
____
____

23. Is your reason for coming to see me related to an accident or injury? If yes, please describe:
____
____

24. Are there any other legal involvements I should know about? If yes, please describe:______________
____
____

25. Is there anything else you would like to share? ____
____
____
____
____
____
____
____
____

Amanda Costin, Ph.D., LMHC, ACS
Northampton Counseling

Adult Checklist of Concerns

Name: ____ Date: ______________________________

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

❑ I have no problem or concern bringing me here

❑ Abuse–physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals

❑ Aggression, violence

❑ Alcohol use

❑ Anger, hostility, arguing, irritability

❑ Anxiety, nervousness

❑ Attention, concentration, distractibility

❑ Career concerns, goals, and choices

❑ Childhood issues (your own childhood)

❑ Codependence

❑ Confusion

❑ Compulsions

❑ Custody of children

❑ Decision making, indecision, mixed feelings, putting off decisions

❑ Delusions (false ideas)

❑ Dependence

❑ Depression, low mood, sadness, crying

❑ Divorce, separation

❑ Drug use–prescription medications, over-the-counter medications, street drugs

❑ Eating problems–overeating, undereating, appetite, vomiting (see also "Weight and diet issues")

❑ Emptiness

❑ Failure

❑ Fatigue, tiredness, low energy

❑ Fears, phobias

❑ Financial or money troubles, debt, impulsive spending, low income

❑ Friendships

❑ Gambling

❑ Grieving, mourning, deaths, losses, divorce

❑ Guilt

❑ Headaches, other kinds of pains

❑ Health, illness, medical concerns, physical problems

❑ Housework/chores–quality, schedules, sharing duties

❑ Inferiority feelings

❑ Interpersonal conflicts
❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility
❑ Judgment problems, risk taking
❑ Legal matters, charges, suits
❑ Loneliness
❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings
❑ Motivation, laziness
❑ Nervousness, tension
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems (see also "Career concerns ...")
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
❑ Shyness, oversensitivity to criticism
❑ Sleep problems–too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
❑ Other concerns or issues:

____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Amanda Costin, Ph.D., LMHC, ACS
Patient Financial Agreement

Patient Responsibilities

- You are responsible to provide accurate insurance information about yourself; i.e., current ID and address, name changes, etc. and the subscriber of your insurance.
- It is your responsibility prior to your visit to ensure that you have authorization for your visit. Some insurance plans may require a referral from your Primary Care Physician.
- I can provide limited assistance, but cannot resolve disputes between you and your insurance company.
- You will be charged a $75 fee for missed appointments and cancellations made less than 24 hours in advance. Insurance companies do not compensate for these appointments; therefore it is imperative that you communicate if you cannot make an appointment.

My Fees:

- Intake sessions are $150; 45 minute sessions are $125.00; 60 minute at $150.00
- Legal proceedings: $250 preparation + $250 per hour. Administrative support such as letters/reports at $75 per hour.

Co-Pays and Deductibles

- Your insurance company requires you to pay your co-pay at the time of each visit.
- It is your responsibility to understand and pay your insurance deductibles if any apply and in full until deductible is met.
- If your check is returned, a $25 returned check fee will be assessed.
- Presenting an invalid or inactive insurance card will result in full payment by you.

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Amanda Costin, Ph.D. to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions. I agree to pay for any out-of-pocket expenses in full for uncovered or denied services by my presented insurance coverage.

Amanda Costin, Ph.D. is authorized to keep my signature on file and charge my credit card for any outstanding balance for services rendered to me and not covered by my insurance. I understand that this authorization will remain in effect until Amanda Costin, Ph.D. has received written notification from me.

Name of Cardholder (as it appears on the card):____

Address where credit card statements are sent:____

Credit Card Nr. ____Exp.______________CVV________

Signature____Date______________________

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Professional Disclosure Statement
Amanda Costin, Ph.D., LMHC, ACS

With over twenty-five years as a counselor, I maintain a private practice working with a broad spectrum of clients in my Northampton office and through https://costin.breakthrough.com. I earned a Ph.D. in Counselor Education and Supervision with a minor in Couples Counseling from Kent State University in 2000. I also earned a M.Ed. in Mental Health Counseling and School Counseling from the University of Virginia in 1992. I am a Licensed Mental Health Counselor in Massachusetts (#6442), and an Approved Clinical Supervisor (#966).

I believe the therapeutic relationship is the most important element of a helpful counseling experience. As such, I am actively engaged with clients and believe strongly in a collaborative and respectful relationship. Your issues, concerns, personal history, and worldview will inform our work together. My counseling orientation is integrative, and I am most heavily influenced by the person-centered, solution-focused, and the cognitive-behavioral approaches to counseling. I will strive to provide a safe and consistent relationship with you while challenging you to examine how you relate with the world around you.

The ultimate goals of self-awareness and self-acceptance are goals that sometimes take a long time to achieve. Some clients need only a few counseling sessions to achieve these goals, while others may require months of counseling. As a client, you are in complete control and may end the counseling relationship at any point. If counseling is successful, you should feel that you are able to face life’s challenges in the future without my ongoing support. With compassion and understanding, I will work with you to help you build on your strengths so that you can feel more like yourself and/or attain the personal growth you are committed to accomplishing.

Dr. Costin abides by the NBCC and ACA Codes of Ethics as well as the CCE’s Standards for the Ethical Practice of Clinical Supervision. Although clients are encouraged to discuss any concerns with Dr. Costin first, you may file a complaint against Dr. Costin with the organization below should you feel she is in violation of any of these codes of ethics.

Board of Registration of Allied Mental Health & Human Services Professionals
Division of Professional Licensure
1000 Washington Street, Suite 710
Boston, MA 02118
617-727-3080

Records and Confidentiality, Notice of Privacy Practices, and Consent to Use and Disclose your Health Information

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined that you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

This form is an agreement between you and Amanda Costin, Ph.D. When I examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information” (PHI) about you. I use this information in my office to decide on what treatment is best for you and to provide treatment to you. You consent to take part in the treatment and understand that

developing a treatment plan with me and regularly reviewing our work toward meeting the treatment goals are in your best interest. You agree to play an active role in this process.

I may also share this information to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing below, you are agreeing to allow me to use your PHI and to send it to others for the purposes described above. If you do not sign this form, I cannot treat you. If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment or administrative purposes, and you will have to tell me what you want in writing. Although, I will try to respect your wishes, I am not required to accept these limitations. However, if we agree, I promise to do as you asked. Noted exceptions are as follows:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, I am 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, I am required to notify legal authorities.

Abuse of Children and Vulnerable Adults: If a client suggests that he/she is abusing a child or vulnerable adult or has done so in the past, I am required to report this information to legal authorities or the appropriate social service.

Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Prenatal Exposure to Controlled Substances: Mental Health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Insurance Providers (when Applicable): Insurance companies are given information that they request regarding services to clients.

By your signature below, you are indicating that you have read and understand these statements along with the Financial Agreement form, and that any questions you have about this statement have been answered to your satisfaction. The signature below indicates that I have also received a copy of the Notice of Privacy Practices.

______________________________________ ________________________

Responsible Party Date

Email Contact between Counselor and Client

Email is not a secure medium for communication. However, if you choose to contact me using email, you are doing so with the understanding that I cannot guarantee the safety and security of that communication, despite taking all possible actions from my end to protect your privacy. Your signature below is confirmation that you understand this. You also acknowledge that email can disappear or is delayed and that I may never receive an email that is sent.

Patient Printed Name____

Signature____Date:__________________________

NOTICE OF PRIVACY PRACTICES. THIS IS YOUR COPY TO KEEP.

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, the AMHCA and ACA Code of Ethics and Massachusetts statutes and regulations. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, REQUIRING CONSENT

I may use or disclose your PHI for treatment, payment and health care operations purposes with your consent as:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. An example of treatment would be when I consult with another health care provider, such as a family physician or another mental health provider. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your consent. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization:

• most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record;

• most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications;
• disclosures that constitute a sale of PHI;
• other uses and disclosures not described in this Notice of Privacy Practices.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances:

• **Child Abuse**: If I, in my professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, I must immediately report such condition to the Massachusetts Department of Children and Families.

• **Elder Abuse:** If I have reasonable cause to believe that an elderly person (age 60 or older) is suffering from or has died as a result of abuse, I must immediately make a report to the Massachusetts Department of Elder Affairs.

• **Abused of a Disabled Person:** If I have reasonable cause to suspect abuse of an adult (ages 18-59) with mental or physical disabilities, I must immediately make a report to the Massachusetts Disabled Persons Protection Commission.

• **Health Oversight:** The Board of Registration of Allied Mental Health and Human Service Professions has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.

• **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

• **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment, and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.

• **Worker's Compensation:** If you file a workers' compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

• **Specialized Government Functions**. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

• **Public Health**. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

IV. PATIENTS' RIGHTS

You have the following rights regarding PHI we maintain about you:

- **Right of Access to Inspect and Copy**. You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access may be denied in certain circumstances, but in some cases, you may be able to have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy. On your request, I will provide you with details of the amendment process.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of PHI for which you have neither provided authorization nor consent. On request, I will discuss with you the details of the accounting process. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

V. YOUR RIGHTS AND OUR OBLIGATIONS

- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. (For instance, you may not want a family member to know you are seeing us. Upon your request, we will send your bills to another address.) I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice upon request, even if you have agreed to receive the notice electronically.

OUR OBLIGATIONS

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy practices described in this Notice. Unless I notify you of such changes, however, I am required to comply with the terms currently in effect.

COMPLAINTS

If you have any questions or complaints, you may contact me directly by phone or in writing. You may also send a written complaint to the Secretary of Health and Human Services at 200 Independence Ave. , S.W. Washington, D.C. 20201. I will not retaliate against you for filing a complaint.
The effective date of this notice is 01/15/2017.