Dr. Bernadette Johns
991 Reading Road, Suite # 1
Mason, OH 45040

Client Registration

Client Name:_____ Today's Date:_____

Address:_____

City: State: Zip:_____

SSN:_____-_____-_____ Birthdate:_____ Age: _____

Home Phone #: _____ Work Phone#_____

Cell Phone #: _____

OK to leave message (Please circle where appropriate)? **H** **W** **C**

Emergency Contact Name:_____

Relationship:_____

Telephone:_____

Would you like me to inform your Primary Care Physician that you are in treatment?
(This is entirely optional)

_____ I do **not** wish my primary care physician to be contacted at this time

_____ I **authorize** Dr. Bernadette Johns to contact my primary care physician:

Name of primary care physician:_____

Address: _____

_____

Telephone #_____ Fax # _____

_____ _____

Signature Date

Dr. Bernadette Johns
991 Reading Road, Suite # 1
Mason, OH 45040

OHIO NOTICE FORM
DR. BERNADETTE JOHNS

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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 IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Dr. Bernadette Johns may use or disclose your protected health information (PHI), for treatment, payment (under exceptional circumstances), and health care operations purposes in most instances without your consent under HIPAA, but she obtains consent in another form. To help clarify these terms, here are some definitions:

• "PHI" refers to information in your health record that could identify you.

• "Treatment, Payment and Health Care Operations"

– Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.

- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, audits, administrative services, and care coordination.

• "Use" applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you, such as identifying information for the scoring of psychological tests.

• "Disclosure" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain a written authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage (applicable only under exceptional circumstances), and the law provides the insurer the right to contest the claim under the policy. Note, psychotherapy notes may not be required to be released for eligibility or underwriting purposes.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization as allowed by law, including, but not necessarily limited to, the following circumstances:

• **Child Abuse**: If, in my professional capacity, I know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or mentally retarded/developmentally disabled child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, I am required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or other appropriate governmental agency.

• **Adult and Domestic Violence**: If I have reasonable cause to believe that an elderly adult age 60 or over, or an adult mentally retarded/developmentally disabled person is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, I am required by law to immediately report such belief to the County Department of Job and Family Services and/or other appropriate government agency. If I believe that a patient or client has been the victim of domestic violence, I must note that knowledge or belief and the basis for it in the patient's or client's records.

• **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release this information without written authorization from you or your personal or legally-appointed representative, or upon receipt of 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 I believe that you pose a clear and substantial risk of imminent serious harm, or

a clear and present danger, to yourself or another person I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). I will inform you about these notices and obtain your written consent, if I deem it appropriate under the circumstances.
Worker's Compensation: If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials.

IV. Patient's Rights and Dr. Bernadette Johns' Duties

Patient's Rights:

• Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request, except under certain limited circumstances.

• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me, so you may not want me calling your home and leaving a message on an answer machine. Upon your request, I will send your bills or other correspondence to another address and/or place calls to another number. If your request is reasonable, then I will honor it.

• Right 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.

• Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

• Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process. This does not apply to anytime prior to April 17, 2003, and the accounting is only required to be kept for a six year period.

• Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Dr. Bernadette Johns' Duties:

• I am required by law to maintain the privacy of PHI and to provide you with this notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices described in this notice and to make those changes effective for all of the PHI I maintain.

• If I revise my policies and procedures, I will make available a copy of the revised notice to you on my website and you may always request a paper copy.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I make about access to your records, you may file a complaint with me and I will consider how best to resolve your complaint.
In the event that you are not satisfied with my response to your complaint, or don't want to first file a complaint with me, then you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C.or to:

Region V, Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Ph. (312) 886-2359, Fax (312) 886-1807, TDD (312) 353-5693.

There will be no retaliation against you for filing a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on March 1, 2013.
I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will make available a copy of the latest version on my website, or, upon your request, I will provide it in writing to you via U.S. mail.

ACKNOWLEDGEMENT OF RECEIPT OF DR. BERNADETTE JOHNS' NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Dr. Bernadette Johns' s Notice of Privacy Practices.

_____ _____

Signature of client, or legal guardian Date

_____

Print Name

Dr. Bernadette Johns
991 Reading Road, Suite # 1
Mason, OH 45040

BACKGROUND AND HISTORY QUESTIONNAIRE

Name_____ Today's Date_____

Employment

Are you currently employed? YES NO

Current position?_____

Are you experiencing any work-related problems at this time? YES NO

If yes, please explain: _____

_____

Relationship Status

___ Single ____ Married ____ In a committed relationship ____ Separated ____ Divorced

Living Situation

Who lives in your home?

Name Relationship Age

_____

_____

_____

_____

_____

Medical History

Are you experiencing any medical problems? YES NO

Please specify:

_____

_____

_____

Have you had a significant appetite change in the last 3 months? YES NO (circle)

Weight gain? Loss? (circle)

Comments:_____

Have you had a significant change in sleep patterns in the last 3 months? YES NO

Comments:_____

Behavioral/Emotional Health History

Please indicate any past or present behavioral or emotional concerns:

	Past	Present
Inattention	____	____
Hyperactivity	____	____
Fears/Phobias	____	____
Sad/Depressed mood	____	____
Panic	____	____
Strict dieting	____	____
Overeating	____	____
Binging and purging	____	____
Excessive exercise	____	____
Learning problems	____	____
Difficulty getting along with others	____	____
Social skills problems	____	____
Suicidal thoughts	____	____
Suicide attempts	____	____
Cutting or mutilating body	____	____
Obsessive thoughts and/or actions	____	____
Excessive energy/mania	____	____
Decreased energy	____	____

Other concerns (please specify)

_____

_____

Have you had previous **outpatient** psychological treatment? YES NO

Name of therapist Dates of treatment Reason for treatment

_____

_____

Have you had previous **inpatient** psychological treatment/therapy? YES NO

Name of program/facility Dates of treatment Reason for treatment

_____

Have you taken any medication in the **past** to address emotional, behavioral or academic problems? If so please specify:

_____

_____

Are you **currently** taking any medication (prescription, over-the-counter, vitamins, herbs, or supplements or recreational drugs) for emotional, behavioral, academic, or medical reasons? If so, please specify below, including dosage, frequency and purpose of medication/supplement/drug

Medication/Supplement/Drug Dosage Reason

_____

_____

_____

Name of prescribing physician(s)_____

Alcohol and Drugs

Do you consume alcohol? YES NO

If YES, please give type, amount, & approximate frequency:

_____

Have you or anyone close to you ever been concerned about your alcohol and/or drug usage? YES NO
If yes, please explain

_____

_____

Have you served in the Military? YES NO

If yes, please give details:

_____

_____

Significant Events

Please check any significant events you have experienced:

____ Recent serious illness or injury to a family member or friend
____ Recent death in the family
____ Divorce or separation
____ Change in family structure (someone moved in/out of home, blending of families)
____ Victim of physical abuse
____ Victim of sexual abuse
____ Victim of rape/sexual assault
____ Domestic violence
____ Other significant trauma (please specify)

_____

_____

Family Health History

Have any family members (siblings, parents, aunts, uncles, cousins or grandparents) been diagnosed or treated for a mental health or substance abuse problem?
YES NO DON'T KNOW If yes, please explain:

_____

_____

_____

Present Concerns

Who referred you to me?

_____

What concerns are bringing you to treatment?

_____

_____

_____

_____

What do you hope to accomplish in therapy?

_____

_____

_____

_____

_____

Are there any cultural, racial, sexual orientation and/or religious issues that need to be considered when planning your treatment?

_____

_____

Thank you for completing this questionnaire.

Professional Disclosure Statement

Bernadette R. Johns, Ed.D., L.P.C.C.-S., C.C.T.P.
Psychologist
Ohio Psychology License # 6765
Licensed Professional Clinical Counselor (Ohio License Number E2139)
IATP Certified Clinical Trauma Professional

991 Reading Road, Suite # 1
Mason, Ohio 45040
(513) 770-5888

Education:

1998, Ed.D., University of Cincinnati — Doctoral Degree in Counselor Education Counseling Program, Division of Human Services, College of Education.

1992, M.A., University of Cincinnati — Masters Degree in Counseling, Department of School Psychology and Counseling, College of Education.

1990, C.Q.S.W., Bristol University, U.K. — Certificate of Qualification in Social Work, School of Social Work, Faculty of Arts and Sciences.

Areas of Competence

Holistic Approach (Bio-Psycho-Social-Spiritual) to Counseling and Psychotherapy
Individual, Couples, and Group Counseling and Psychotherapy
Gender and Culture-Sensitive Counseling/Psychotherapy
Childhood Trauma, Family Dysfunction and Abuse
Anxiety, Depression, and Post Traumatic Stress Disorder
Life Transitions and Grief Counseling
Eye Movement Desensitization & Reprocessing (EMDR); Neurofeedback
Family Relations Specialist for Collaborative Divorce
Supervision of Counselors

Fee Schedule

Individual Psychotherapy: $120.00 per (50-minute) therapy hour.
Couple/Family: $140.00 per (50-minute) therapy hour.
Initial Evaluation: Typically exceeds one hour, and is charged pro rata
Missed Appointment fee: $75

This information is required by the Ohio State Board of Psychology, which regulates all licensed Psychologists in the State of Ohio, and by the Counselor and Social Worker Board, which regulates all licensed and registered counselors and social workers in the State of Ohio.

Ohio State Board of Psychology
Vern Riffe Center
77 S. High St, Suite. 1830
Columbus, OH 43215-6108
(614) 466-8808

State of Ohio Counselor, Social Worker and Marriage & Family Therapist Board
50 W. Broad Street, Suite 1075
Columbus, OH 43215-5919
(614) 466-0912