Demographics

Patient First Name

Patient Middle Name

Patient Last Name

Patient Preferred Name

Home Phone

Cell Phone

Work Phone

Sex

Male | Female | Other

Martial Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed

Age

Date of Birth

Explain

Race

- [ ] White
- [ ] Black/African American
- [ ] Asian
- [ ] American Indian/Alaska Native
- [ ] Native Hawaiian/Other Pacific Islander
- [ ] Other
- [ ] Unreported/Declined to Report

Ethnicity

- [ ] Hispanic or Latino
- [ ] Non Hispanic or Latino
- [ ] Unreported/Declined to Report

Email Address

List

Address

Address 2

City

State

Zip

Emergency Contact First Name

Emergency Contact Last Name

Emergency Contact Phone

Emergency Contact Reletionship

Do you have Insurance?

Yes | No

Primary Insurance Policy Holder

- [ ] Self
- [ ] Spouse
- [ ] Father
- [ ] Mother
- [ ] Family
- [ ] Other

First Name of Primary Insured

Last Name of Primary Insured

Insurance ID #

Insurance Company Name

Group Name

Group Number

Birthdate of Primary Insured

Primary Insured Relationship to Patient

Upload Insurance

Do you have Secondary Insurance?

Yes | No

Secondary Insurance Policy Holder

- [ ] Self
- [ ] Spouse
- [ ] Father
- [ ] Mother
- [ ] Family
- [ ] Other

First Name of Secondary Insured

Last Name of Secondary Insured

Insurance ID #

Insurance Company Name

Group Name

Group Number

Birthdate of Secondary Insured

Secondary Insured Relationship to Patient

Upload Insurance

Patient/ Client First Name

Patient/Client Last Name

Patient/Client Signature

Date

History

General and Mental Health Information

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

Yes No

Previous therapist/practitioner, dates of service and reason for visits.

If yes, please list approximate dates and reason for services.

Are you currently taking any prescription medication?

Yes No

Please List:

If yes, please list.

Have you ever been prescribed psychiatric medication?

Yes No

Please List and provide dates:

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

Please list any specific sleep problems you are currently experiencing:

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any difficulties you experience with your appetite or eating problems:

Do you exercise?

Yes No

How many times per week do you generally exercise?

What types of exercise do you participate in?

Are you currently experiencing overwhelming sadness, grief or depression?

Yes No

If yes, for approximately how long?

Are you currently experiencing anxiety, panics attacks or have any phobias?

Yes No

If yes, when did you begin experiencing this?

Are you currently experiencing any chronic pain?

Yes No

If yes, please describe:

How often do you drink alcohol?

Never Rarely Frequently Moderately Excessively

How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship?

Yes No

If yes, for how long?

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

0 1 2 3 4 5 6 7 8 9 10

What significant life changes or stressful events have you experienced recently?

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate thefamily member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Alcohol/ Substance Abuse

Yes No

List Family Member(s)

Domestic Violence Yes No

List Family Member(s)

Depression Yes No

List Family Member(s)

Obsessive Compulsive Behavior

Yes No

List Family Member(s)

Anxiety Yes No

List Family Member(s)

Suicide Attempts Yes No

List Family Member(s)

Obesity Yes No

List Family Member(s)

Schizophrenia Yes No

List Family Member(s)

Eating Disorder Yes No

List Family Member(s)

Additional Information

Are you currently employed?

Yes No

If yes, what is your current employment situation and job satisfaction?

Do you consider yourself to be spiritual or religious?

Yes No

If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

GAD-7

Name

Over the last 2 weeks, how often have you been bothered by the following problems:?

1. Feeling nervous, anxious or on edge

0 - Not at all | 1 - Several days | 2 - More than half the days | 3 - Nearly everyday

3. Worrying too much about different things

0 - Not at all | 1 - Several days | 2 - More than half the days | 3 - Nearly everyday

2. Not being able to stop or control worrying

0 - Not at all | 1 - Several days | 2 - More than half the days | 3 - Nearly everyday

4. Trouble relaxing

0 - Not at all | 1 - Several days | 2 - More than half the days | 3 - Nearly everyday

5. Being so restless that is is hard to sit still

0 - Not at all | 1 - Several days | 2 - More than half the days | 3 - Nearly everyday

6. Becoming easily annoyed or irritated

0 - Not at all | 1 - Several days | 2 - More than half the days | 3 - Nearly everyday

7. Feeling afraid as if something awful might happen

0 - Not at all | 1 - Several days | 2 - More than half the days | 3 - Nearly everyday

8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people

☐ 0 - Not difficult at all ☐ 1 - Somewhat difficult ☐ 2 - Very difficult ☐ 3 - Extremely difficult

When did symptoms begin?

PHQ-9

Name

1. Little interest or pleasure in dong things
☐ 0 - Not at all ☐ 1 - Several day ☐ 2 - More than half the days ☐ 3 - Nearly every day

2. Feeling down, depressed, or hopeless
☐ 0 - Not at all ☐ 1 - Several days ☐ 2 - More than half the days ☐ 3 - Nearly every day

3. Trouble falling or staying asleep, or sleeping too much
☐ 0 - Not at all ☐ 1 - Several days ☐ 2 - More than half the days ☐ 3 - Nearly every day

4. Feeling tired or having little energy
☐ 0 - Not at all ☐ 1 - Several days ☐ 2 - More than half the days ☐ 3 - Nearly every day

5. Poor appetite or overeating ☐ 0 - Not at all ☐ 1 - Several days ☐ 2 - More than half the days ☐ 3 - Nearly every day

6. Feel bad about yourself - or that you are a failure or have let yourself or your family down
☐ 0 - Not at all ☐ 1 - Several days ☐ 2 - More than half the days ☐ 3 - Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching televison
☐ 0 - Not at all ☐ 1 - Several days ☐ 2 - More than half the days ☐ 3 - Nearly every day

8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
☐ 0 - Not at all ☐ 1 - Several days ☐ 2 - More than half the days ☐ 3 - Nearly every day

9. Thoughts that you would be better off dead, or hurting yourself in some way
☐ 0 - Not at all ☐ 1 - Several days ☐ 2 - More than half the days ☐ 3 - Nearly every day

Privacy Practices

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.
  See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- Health Plans must also:
  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- Covered Direct Treatment Providers must also:
  - Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
  - In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
  - Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.
  See 45 CFR 164.520(c) for the specific requirements for providing the notice.

  Organizational Options.

  - Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
  - Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Name

Patient Signature (Client's Parent/Guardian if under 18)

Date

Fees/Cancellation Policy

The standard rate for services is $160 for the initial evaluation and $135 per standard 53-60 minute session or prorated accordingly. If you have insurance through a third-party payor with whom I have a contract, the rate for psychotherapy services has been predetermined and will be paid by the insurance carrier. Additional services such as lengthy phone calls, written reports or other professional services will be billed at $135 an hour with a minimum of .25 hours. The portion of fees for which you are responsible is due at the time that services are rendered and can be made with cash, check or card. Payment through contracts I have with insurance companies and contracted agencies will be billed by this office. Any arrangements, such as prior authorization for services, should be made before such charges are incurred.

If you are a no show or fail to reschedule/cancel an appointment without giving the 24 hours notice a $100.00 charge will be applied to the card on file for each missed appointment. Please be aware that missing an appointment prevents me from giving you the care needed. However, it is also detrimental to me because it prevents me from scheduling another who needs care as well.

Patient/ Client First Name

Patient/Client Last Name

Patient/Client Signature

Communication Preferences

Patient Name

The transmission of patient information by e-mail and/or texting has a number of risks that patients should consider prior to their use. These include, but are not limited to, the following:

• E-mail and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

• E-mail and text senders can easily misaddress an e-mail or text and send the information to an undesired recipient.

• Backup copies of e-mails and texts may exist even after the sender and/or the recipient has deleted his or her copy.

• Employers and on-line services have a right to inspect e-mails sent through their company systems.

• E-mails and texts can be intercepted, altered, forwarded or used without authorization or detection.

• E-mail and texts can be used as evidence in court.

• E-mails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of e-mail and texts

I, the provider, cannot guarantee but will use reasonable means to maintain security and confidentiality of e-mail and text information sent and received. Provider is not liable for improper disclosure of confidential information that is not caused by provider’s own intentional misconduct. Patients/Parent’s/Legal Guardians must acknowledge and consent to the following conditions.

• E-mail and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular e-mail and/or text will be read and responded to within any particular period of time.

• E-mail and texts should be concise and preferably limited to matters of scheduling or messages about tardiness. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex situations. Provider voice-mail is secure and confidential and sensitive information can be communicated in a voice message. All e-mail will usually be printed and filed into the patient’s medical record. Texts may be printed and filed as well.

• Provider will not forward patient’s/parent’s/legal guardian’s identifiable e-mails and/or texts without the patient’s/parent’s/legal guardian’s written consent, except as authorized by law.

• Patients/parents/legal guardians should not use e-mail or texts for communication of sensitive medical information.

• Provider is not liable for breaches of confidentiality caused by the patient or any third party.

• It is the patient’s/parent’s/legal guardian’s responsibility to follow up and/or schedule an appointment if warranted.

Social Media Policy

Friending/following: Provider does not accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, Snapchat, TikTok etc). Adding patients as friends or contacts on these sites can compromise your confidentiality and respective privacy. It may also blur the boundaries of the therapeutic relationship.

Use of Search Engines

It is not a part of provider's practice to search for patients on Google or or other search engines or social media sites. Provider will not do so except under extremely rare conditions during times of crisis such as if your personal safety is in question.

Signature

Date

Consent

Name

Date

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. You may seek a second opinion from another therepist or terminate therapy at any time.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e.the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship

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

Insurance Providers

Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Patient Signature (Client's Parent/Guardian if under 18)

Date