CLIENT INFORMATION FORM

For Office Use Only
Provider: _____
DX: _____

PLEASE FILL OUT THIS FORM COMPLETELY

TODAY'S DATE: _____

CLIENT NAME: _____
(FIRST) (LAST) (MIDDLE INITIAL)

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE:(_____)_____ WORK/OTHER PHONE: (_____)_____

CLIENT SOCIAL SECURITY#: _____-_____-_____ DATE OF BIRTH: _____

SEX: MALE / FEMALE MARITAL STATUS: _____ RACE/ETHNICITY(OPTIONAL): _____

IS CLIENT UNDER AGE 18: YES / NO
IF YES, NAME OF PARENT/LEGAL GUARDIAN BRING CHILD TO APPOINTMENT:_____

EMPLOYER/SCHOOL (NAME AND ADDRESS): _____

_____
(ADDRESS) (CITY) (STATE) (ZIP)

PCP NAME: _____ PCP PHONE: (_____)_____ PCP FAX: (_____)_____

REFERRED BY: (PLEASE CIRCLE) INSURANCE/EAP PHONE BOOK INTERNET PCP/OTHER MD FAMILY/FRIEND

IF YOU WERE REFFERRED BY YOUR EAP PLEASE PROVIDE EAP PHONE: _____ # OF SESSIONS APPROVED _____

INSURANCE INFORMATION

INSURANCE COMPANY (NAME AND ADDRESS):_____

_____

POLICY HOLDER NAME:_____ DATE OF BIRTH: _____

POLICYHOLDER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ SEX: MALE / FEMALE

HOME PHONE: (_____)_____ WORK PHONE: (_____)_____

POLICYHOLDER'S SOCIAL SECURITY #: _____ MARITAL STATUS: _____

MEMBER ID NUMBER/MEDICAID# _____ GROUP/PLAN/POLICY#: _____

PHONE # FOR MENTAL HEALTH BENEFITS/SERVICES: (_____)_____

DID YOU OBTAIN AUTHORIZATION FOR SERVICES FROM YOUR INSURANCE COMPANY? YES / NO / NOT REQUIRED

AUTHORIZATION NUMBER: _____

POLICYHOLDER'S EMPLOYER (NAME AND ADDRESS): _____

(ADDRESS) (CITY) (STATE) (ZIP)

OVER PLEASE

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ SEX: MALE / FEMALE

HOME PHONE: (_____)_____ WORK PHONE: (_____)_____

PAGER: (_____)_____ CELLULAR PHONE: (_____)_____

SPOUSE'S NAME (IF NOT EMERGENCY CONTACT): _____

HOME PHONE: (_____)_____ WORK PHONE: (_____)_____

PAGER: (_____)_____ CELLULAR PHONE: (_____)_____

MEDICAID/PEACHCARE CLIENTS ONLY

HAVE YOU BEEN SEEN FOR ANY REASON, BY A THERAPIST, PSYCHIATRIST, IN-HOME TREATMENT OR AT A MENTAL HEALTH CENTER IN THE LAST SIX (6) MONTHS? YES or NO (PLEASE CIRCLE)

IF YES, PLEASE LIST WHERE: _____

_____

NOTICE TO CLIENTS

WE CANNOT RELEASE INFORMATION OF ANY KIND, INCLUDING INFORMATION ABOUT APPOINTMENTS, BILLING, AND/OR PRESCRIPTION REFILLS TO ANYONE OTHER THAN THE CLIENT OR PARENT/LEGAL GUARDIAN OF THE CLIENT.

PLEASE SEE THE RECEPTIONIST IF YOU WOULD LIKE A RELEASE FORM TO ALLOW US TO SPEAK TO SOMEONE OTHER THAN YOURSELF REGARDING YOUR CARE WITH US.

CLINIC SATISFACTION

MAY WE CONTACT YOU BY PHONE OR MAIL REGARDING SATISFACTION WITH SERVICES 6 MONTHS AFTER END OF TREATMENT?

PLEASE CIRCLE: YES or NO

PREFERRED ADDRESS FOR MAILING OR SURVEY: _____

_____

_____

PREFERRED PHONE NUMBER: (_____)_____

_____ _____

SIGNATURE OF CLIENT OR LEGAL GUARDIAN DATE

AUTHORIZATIONS AND CONSENTS

CLIENT NAME: _____ GUARDIAN'S NAME (IF CLIENT IS UNDER 18):_____

1. ***Authorization for Release of Information for Insurance Submission and Payment***

If you wish to have our office file your insurance, please present your insurance card. Some companies pay fixed allowances for treatment and others pay a percentage of the charge. **It is your responsibility to pay for any deductible amount, co-pay, any non-covered service, or service in which you are ineligible.** You are responsible for obtaining prior authorization for treatment from your insurance carrier. Failure to obtain authorization may result in increased financial expenses for your services. Authorization of service and payment by the insurance company is contingent on eligibility (at time of service) and benefits available. It is your responsibility to pay co-pay's at each visit. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits directly to the therapist or group indicated on the claim. I hereby authorize release of information (including diagnosis) necessary for treatment and processing of claims for insurance reimbursement. **I understand I am financially responsible for any balance not covered by my insurance.**

_____
Signature of Consumer/Legal Guardian/Legal Representative

2. ***Authorization to Release Information to PCP***

Communication between behavioral health providers and your primary care physician is important to ensure that you receive comprehensive and quality health care. I hereby authorize release of my protected health information related to my evaluation and treatment to my primary care physician (PCP). I understand this information may include diagnosis, treatment plan, progress and medication information if necessary. I understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon.

_____
Signature of Consumer/Legal Guardian/Legal Representative

3. ***Failed Appointments***

I agree to notify this office at least twenty-four (24) hours prior to my scheduled appointment if I decide to cancel/change. I understand I will be charged a fee of $50.00 for an appointment not kept or cancelled at least 24 hours in advance. I also understand that this charge is not the co-pay amount and is not reimbursable by my insurance.

_____
Signature of Consumer/Legal Guardian/Legal Representative

4. ***Client Rights and Responsibilities***

A Person Receiving Services is Entitled to:

A. Mental Health/Chemical Dependency services in accordance with standards of professional practice, appropriate to his/her needs and designed to give him/her a reasonable opportunity to improve his/her condition.
B. Humane care, protection from harm, and to be treated with dignity and respect.
C. The right to participate in the development and review of his/her treatment plan, including the known effects of receiving and not receiving such treatment, or alternative treatment, if any.
D. The right to receive treatment in the least restrictive settings.
E. The right to review his/her own record in the presence of the primary therapist, unless the primary therapist's professional judgment deems this to be potentially detrimental to the person.
F. The right to confidential maintenance of all his/her identifying treatment information; no disclosure of such information without his/her written authorization, except in cases of medical emergency, by court order, or when otherwise dictated by law.
G. The right to register complaints and to have his/her complaints heard and action taken, if required, promptly.
H. The right to waive any of his/her rights, if the waiver is given voluntarily, knowingly, and in a competent state of mind. The waiver may be withdrawn at any time.

_____ _____
Signature of Consumer/Legal Guardian/Legal Representative Date

5. ***Consumer Consent for Use/Disclosure of Health Care Information***

I understand that the consumer's health information is private and confidential. I understand that this office works very hard to protect the consumer's privacy and preserve the confidentiality of the consumer's personal health information.

I understand that my Provider may use and disclose the consumer's personal health information to help provide health care to the consumer, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Examples would be if a consumer threatened to hurt someone or if child abuse is reported.

My Provider has given me a detailed document called the "Notice of Privacy Practices" in my orientation handbook. It contains more information about the policies and practices protecting the consumer's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

My Provider may update this "Notice of Privacy Practices." If I ask, the Privacy Officer or other appropriate administrative employee, they will provide me with the most current "Notice of Privacy Practices."

In effort to protect the individual consumer's PHI, we utilize an electronic scanning system to store medical records of consumers who have been discharged from treatment. This electronically scanned document is an exact photo-duplicate of the paper record and is by law accepted as the original document.

Under the terms of this consent, I can ask my Provider to limit how the consumer's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my Provider does not have to agree to my request. If my Provider does not agree to my request, I understand that my Provider would follow the agreed limits. Requests must be made in writing and my Provider will provide a form for this purpose by request.

I may cancel this consent in writing at any time by doing one of the following:

- Signing and dating a form called "Revocation of Consent for Use and Disclosure of Health Care Information" or
- Writing, signing, and dating a letter to my provider. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the consumer's personal health information for treatment, payment and health care operations.

If I revoke this consent, my Provider does not have to provide any further health care services to the consumer or may require that the consumer pay directly for any service rendered.

My signature below indicates that I have been given the chance to review a current copy of "Notice of Privacy Practices." My signature means that I agree to allow my Provider to use and disclose the consumer's personal health information to carry out treatment, payment, and health care operations.

_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date

6. ***Consent for Treatment Authorization***

I authorize and request my behavioral professional to carry out psychological evaluations, psychiatric evaluations, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my behavioral healthcare professional can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that reactions will be worked on between my behavioral healthcare professional and me. With these understandings, I hereby authorize treatment for myself. I give permission for the Clinical Staff to develop a treatment plan and provide treatment.

_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date

7. **Behavioral Health Orientation**

I have been provided an "Orientation to My Providers Behavioral Healthcare Services, Policies, and Procedures" packet which details policies and procedures. I have read the preceding information and have been given the opportunity to ask questions and agree to abide by these policies.

_____ _____

Signature of Consumer/Legal Guardian/Legal Representative Date

PARENTS QUESTIONNAIRE

Child's Name _____ **Date** _____

Please complete this side at *EVERY* visit

Has your address changed since last visit? ☐ Yes ☐ No ☐ N/A
Has your insurance changed since last visit? ☐ Yes ☐ No ☐ N/A
If Yes to either please tell receptionist

To what extent do the following phrases apply to your child?
0 – not at all 1- a little 2 - moderately 3- very much

1. Restless or overactive	0	1	2	3	
2. Excitable, impulsive	0	1	2	3	
3. Fails to finish things he/she starts	0	1	2	3	
4. Inattentive, easily distracted	0	1	2	3	
5. Temper outbursts	0	1	2	3	
6. Fidgeting	0	1	2	3	
7. Disturbs other children	0	1	2	3	
8. Demands must be met immediately, easily frustrated	0	1	2	3	
9. Cries often and easily	0	1	2	3	
10. Mood changes quickly and drastically	0	1	2	3	
11. Anxious, worries about things	0	1	2	3	
12. Seems sad	0	1	2	3	
13. Trouble falling asleep	0	1	2	3	
14. Trouble waking up in the morning	0	1	2	3	
15. Forgets to bring homework home, forgets to turn it in, or loses it.	0	1	2	3	n/a
16. Thinks about or threatens to hurt self	0	1	2	3	
17. Appetite change, weight loss or gain	0	1	2	3	
18. Has trouble with directions like, "First do ___, then do ___ and then do ___"	0	1	2	3	

Please describe any other problems or concerns you may have concerning your child.

How difficult have these problems made it for your child to do his/her work, get along at home or get along with others?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

If your child is receiving medication now

a. How well is it working? ☐ not at all ☐ somewhat helpful ☐ definitely helpful

b. Side effects? ☐ none ☐ mild ☐ moderate or severe

What side effects are these?

PARENTS QUESTIONNAIRE

Child's Name **Date** _____

Please complete this side if you are a new client

Child's date of birth _____ Age _____ pediatrician _____

What is/are the main reason(s) for your visit today? *check as many as apply*

☐ depression ☐ hyperactivity ☐ anger/irritability

☐ anxiety ☐ need to change doctors ☐ problems paying attention

☐ other *please describe*

About how long have these been problems? (*e.g. days, weeks, months, years)*

Please circle Yes or No

What grade is your child in, or what grade will your child be entering, at school?

Who lives at home with your child?

☐mom ☐dad ☐sister(s) _ how many? ☐ brother(s) __ how many?

Does your child have any medical problems? *If YES, please list*	NO	YES
Is your child taking any medicine? *If YES, please list*	NO	YES
Any medication allergies? *If yes, what?*	NO	YES
Were there any problems with pregnancy or delivery of your child? *If yes, what?*	NO	YES
Did your child learn to walk, talk, control bowels and bladder, etc. at about the appropriate age? *If no, what occurred later or earlier than expected?*	NO	YES
Is your child been treated with medication for behavior, mood or nerve problems? *If YES, please list*	NO	YES
Any other medicine? *If YES, please list*	NO	YES
Has your child been treated with other medication for behavior, mood or nerve problems in the past? *If YES, please list*	NO	YES
Has your child ever been to see a therapist, counselor, etc in the past?	NO	YES
Is your child currently under the care of a therapist, counselor, psychologist, psychiatrist, etc? *If YES, who?*	NO	YES
To your knowledge, have any blood relatives had ADHD or some other emotional, nervous, psychiatric or substance use problem? *If YES, please describe*	NO	YES
Has your child been hospitalized because of an emotional, nervous, psychiatric or substance use problem? *If YES, how often? when was the most recent?*	YES	NO