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Psychologist – Client Contract

Outpatient Services Contract

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Psychological Services

Psychological services are not easily described in general statements. It varies depending on the personalities of the psychologist and the client and the particular problems presented. There are many different methods I may use to deal with the problems that you and your family hope to address. Psychological services are not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for treatment to be successful you and your family will have to work on the things we talk about both during our sessions and at home.

Psychological services can have benefits and risks. Since treatment often involves discussing many aspects of you and your family's life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, treatment has also been shown to have benefits for those who go through it. Psychological treatment may lead to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Treatment involves a large commitment of time, money and energy so you should be very careful about the psychologist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another behavioral health professional for a second opinion.

Meetings

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide whether I am the best person to provide the services you need in order to meet your treatment goals. If treatment is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will try to find another time to reschedule the appointment.

Professional Fees

My hourly fee is $125. A sliding scale fee schedule is available for those families who qualify. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of the services provided, and the amount due.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for behavioral health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what behavioral health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Manage health care plans such as HMO's and PPO's often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. [Some managed care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find you another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our session. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

Contacting Me

Due to the nature of my work, I am often not immediately available by telephone. I do have call in hours between 8:00 and 9:00 pm and between 6:30 and 7:30 am. I can be reached on my cell phone (914) 805-3094 and when I am unavailable; my telephone is answered by voice mail [which I monitor frequently]. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of times when you will be available. [In emergencies, you can try me at my home number (845-386-1406). If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the clinician/psychologist/psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are

professional records, the can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the content. [I am sometimes willing to conduct a review meeting without charge.] Clients will be charged an appropriate fee for any professional time spent responding to information requests.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together; unless I fell there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have about what I am prepared to discuss. At the end of your treatment, I will prepare a summary of our work together for your parents, and we will discuss it before I send it to them.

Confidentiality

In general, the law protects the privacy of all communications between a client and a psychologist, and I can release information about our work to others only with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am [may be] required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking action. I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object I will not tell you about these consultations unless I feel it is important to our work together.

While this written summary of expectations to confidentiality should prove helpful in informing you of potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you

need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signiture:_____

Name (printed):_____

Date:_____

Returned Check Policy

Our practice is happy to accept personal checks as payment for sessions and copays. However, if a check is returned for any reason, a $25 charge will be added to your account balance. Payment must be made within thirty days of receiving the returned check.

_____

Patient Name (Please Print)

_____

Date

_____

Signature of Patient/Guardian

Appointment Cancellation/No Show Policy

The policy of this office is to encourage clients to notify our office at least **24 hours in advance** if you are unable to keep an appointment. Likewise, we require clients to arrive punctually for their scheduled appointment to avoid any unnecessary delays or inconveniencing of others.

It is further understood that failure to give 24-hour notice of cancellation or not showing up for an appointment can result in a charge of $25.00 with reasonable consideration of circumstances, including unforeseen emergencies or sickness. This charge is non-covered by your insurance company and is your financial responsibility. The signature of the patient and/or guardian below acknowledges the understanding of the above.

_____ _____

Patient Name (Please Print) Date

_____

Signature of Patient/Guardian

Notice of Privacy Practices

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

Privacy is a very important concern for all those who come to this office. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you probably will have to read them several times to understand them. If you have any questions, our privacy officer will be happy to help you understand our procedures and your rights. His or her name and address are at the end of this notice.

Contents of this notice

A. Introduction: To our clients

This notice will tell you how we handle your medical information. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask our privacy officer for more explanations or more details.

B. What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests and treatment you got from us or from others, or about payment for health care. The information we collect from you is called **"PHI,"** which stands for **"protected health information."** This information goes into your **medical or health care records** in our office. In this office, your PHI is likely to include these kinds of information:

_ Your history: Things that happened to you as a child; your school and work experiences; your marriage and other personal history.
_ Reasons you came for treatment: Your problems, complaints, symptoms, or needs.
_ Diagnoses: These are the medical terms for your problems or symptoms.

_ A treatment plan: This is a list of the treatments and other services that we think will best help you.
_ Progress notes: Each time you come in, we write down some things about how you are doing, what we notice about you, and what you tell us.
_ Records we get from others who treated you or evaluated you.
_ Psychological test scores, school records, and other reports.
_ Information about medications you took or are taking.
_ Legal matters.
_ Billing and insurance information
There may also be other kinds of information that go into your health care records here.
We use PHI for many purposes. For example, we may use it:
_ To plan your care and treatment.
_ To decide how well our treatments are working for you.
_ When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to us.
_ To show that you actually received services from us, which we billed to you or to your health insurance company.
_ For teaching and training other health care professionals.
_ For medical or psychological research.
_ For public health officials trying to improve health care in this area of the country.
_ To improve the way we do our job by measuring the results of our work.
When you understand what is in your record and what it is used for, you can make better decisions about who, when, and why others should have this information.

Although your health care records in our office are our physical property, the information belongs to you. You can read your records, and if you want a copy we can make one for you (but we may charge you for the costs of copying and mailing, if you want it mailed to you). In some very rare situations, you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing, you can ask us to amend (add information to) your records, although in some rare situations we don't have to agree to do that. If you want, our privacy officer, whose name is at the end of this notice, can explain more about this.

C. Privacy and the laws about privacy
We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and our privacy practices. We will obey the rules described in this notice. If we change our privacy practices, they will apply to all the PHI we keep. We will also post the new notice of privacy practices in our office where everyone can see. You or anyone else can also get a copy from our privacy officer at any time.

D. How your protected health information can be used and shared
Except in some special circumstances, when we use your PHI in this office or disclose it to others, we share only the **minimum necessary** PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So we will tell you more about what we do with your information. Mainly, we will use and disclose your PHI for routine purposes to provide for your care, and we will explain more about these below. For other uses, we must tell you about them and ask you to sign a written authorization form. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

1. Uses and disclosures with your consent:

After you have read this notice, you will be asked to sign a separate **consent form** to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share it with other people or

organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations." In other words, we need information about you and your condition to provide care to you. You have to agree to let us collect the information, use it, and share it to care for you properly. Therefore, you must sign the consent form before we begin to treat you. If you do not agree and consent we cannot treat you.

a. The basic uses and disclosures: For treatment, payment, and health care operations

Next we will tell you more about how your information will be used for treatment, payment, and health care operations.

For treatment. We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services.

We may share your PHI with others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team, we can share some of your PHI with the team members, so that the services you receive will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we all can decide what treatments work best for you and make up a treatment plan. We may refer you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. We will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment. We may use your information to bill you, your insurance, or others, so we can be paid for the treatments we provide to you. We may contact your insurance company to find out exactly what your insurance covers. We may have to tell them about your diagnosis, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we met, your progress, and other similar things.

For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and your payment. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

b. Other uses and disclosures in health care

Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work, or you prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

Other benefits and services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research. We may use or share your PHI to do research to improve treatments—for example, comparing two treatments for the same disorder, to see which works better or faster or costs less. In all cases, your name, address, and other personal information will be removed from the information given to researchers. If they need to know who you are, we will discuss the research project with you, and we will not send any information unless you sign a special authorization form.

Business associates. We hire other businesses to do some jobs for us. In the law, they are called our "business associates." Examples include a copy service to make copies of your health records, and a billing service to figure out, print, and mail our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information.

2. Uses and disclosures that require your authorization

If we want to use your information for any purpose besides those described above, we need your permission on an **authorization form.** We don't expect to need this very often. If you do allow us to use or disclose your PHI, you can cancel that permission in writing at any time. We would then stop using or disclosing your information for that purpose. Of course, we cannot take back any information we have already disclosed or used with your permission.

3.Uses and disclosures that don't require your consent or authorization.

The law lets us use and disclose some of your PHI without your consent or authorization in some cases. Here are some examples of when we might do this.

a. When required by law

There are some federal, state, or local laws that require us to disclose PHI:

_ We have to report suspected child abuse.

_ If you are involved in a lawsuit or legal proceeding, and we receive a subpoena, discovery request, or other lawful process,we may have to release some of your PHI. We will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.

_ We have to disclose some information to the government agencies that check on us to see that we are obeying the privacy laws.

b. For law enforcement purposes

We may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

c. For public health activities

We may disclose some of your PHI to agencies that investigate diseases or injuries.

d. Relating to decedents

We may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

e. For specific government functions

We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. We may disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

f. To prevent a serious threat to health or safety. If we come to believe that there is a serious threat to your health or safety, or that of another person or the public, we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and disclosures where you have an opportunity to object

We can share some information about you with your family or close others. We will only share information with those involved in your care and anyone else you choose, such as close friends or clergy. We will ask you which persons you want us to tell, and what information you want us to tell them, about your condition or treatment. You can tell us what you want, and we will honor your wishes as long as it is not against the law. If it is an emergency, and so we cannot ask if you disagree, we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you don't approve we will stop, as long as it is not against the law.

5. An accounting of disclosures we have made

When we disclose your PHI, we may keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

E. Your rights concerning your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or with payment for your

care, such as family members and friends. We don't have to agree to your request, but if we do agree, we will honor it except when it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you. Contact our privacy officer to arrange how to see your records. (See below.)
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new one in our waiting area, and you can always get a copy from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems
If you need more information or have questions about the privacy practices described above, please speak to the privacy officer, whose name and telephone number are listed below. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact the privacy officer. As stated above, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. We promise that we will not in any way limit your care here or take any actions against you if you complain.

If you have any questions or problems about this notice or our health information privacy policies, please contact our privacy officer, who is Sara Belmont and can be reached by phone at 845-395-0066 or by e-mail at sara_belmont@yahoo.com. The effective date of this notice is September 7, 2012.

Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPPA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPPA applies to all health care providers, including mental health care and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this on from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My "Notice of Privacy Practices" is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Sincerely,
William Mack Bartels, Psy.D.

Name (print)_____ Date_____

Signature _____

When patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Print Name_____ Date_____

Signature of Representative_____

Relationship to Patient_____

Informed Consent For Treatment

I hereby request that _____born_____and
Participant Name Date of Birth
residing at _____
Street Address City State Zip Code
_____be accepted for psychiatric, mental health, or alcohol
Telephone Number
and drug abuse treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from_____.
Provider
2. I have been given information regarding my rights and responsibilities as a participant.

3. I have been given information regarding the limits of confidentiality of my records.

4. I have been given information regarding the cost of services from _____. I understand that I responsible to pay a copay and
Provider
that it is payable each time I come from treatment.
5. I understand that I may address any concerns or grievances with my therapist or any other insurance company representative at any time. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.
6. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
7. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.

_____ _____
Signature of Participant or Legal Consenter Date

_____ _____
Witness Date

MINOR (Emancipated Minors Only):
Due to the following reason _____,
Reason
I have the legal capacity under applicable _____ law to apply for
State
consent to such treatment and services mentioned in this form, without parental consent.

_____ _____
Signature of Participant Date

_____ _____
Witness Date

PARENT OR GUARDIAN:

I, _____, do hereby state that I am the
Parent or Legal Guardian
Natural parent or legal guardian of the participant; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____ _____
Signature of Participant Date

_____ _____
Witness Date

Brief Health Information Form

A. Identification

Client's name: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment Received	Treated By	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the- counter vitamins, supplements, herbs, and others.

Medication/drug	How much?	Taken for	Prescribed By

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address / Phone #	Date of last visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address / Phone #	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get? _____

2. How much coffee,cola,tea,or other sources of caffeine do you consume each day? _____

3. Do you try to restrict your eating in any way? How? Why? _____

4. Do you have any problems getting enough sleep? _____

E. For women only

1. At what age did you start to menstruate (get your period): _____

2. Menstrual period experiences:

   a. How regular are they? _____

   b. How long do they last? _____

   c. How much pain do you have? _____

   d. How heavy are your periods? _____

   e. Other experiences during period? _____

3. Please list all of your pregnancies:

Your age	What happened with this pregnancy?			Problems?
	Miscarriage	Abortion	Child born	
1.				
2.				
3.				
4.				
5.				
6.				

4. Menopause:

a. If your menopause has started, at what age did it start? _____

b. What signs or symptoms have you had? _____

F. Other

Do you use tobacco? 0 Yes 0 No If yes, how many cigarettes/cigars/other (circle all that apply) per day?: _____ Have you ever injected drugs? 0 Yes 0 No Ever shared needles? 0 Yes 0 No

Have you had HIV testing in the last 6 months? 0 Yes 0 No If yes, results: _____ Are there any other medical or physical problems you are concerned about?_____

Client Intake Folder

Please fill in the information below and bring it with you to your first session.
Please note: Information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date; _____
Address: _____
Home Phone: _____ May we leave a message ___ Yes ___ No
Cell/Work/Other Phone : _____ May we leave a message ___ Yes ___ No
Email: _____ May we leave a message ___ Yes ___ No
Please note: Email correspondence is not considered to be a confidential medium of communication
Date of Birth: _____ Age: _____ Gender: _____
Marital Status: ___ Never Married ___ Domestic Partnership ___ Married ___ Separated
___ Divorced ___ Widowed

Referred By (If Any): _____

History

Have you ever previously received any type of mental health services? (psychotherapy, psychiatric services, etc.)?
____ No ____ Yes, previous therapist/practitioner: _____

Are you currently taking and prescription medications? ____ Yes ____ No
If yes, please list any: _____

Have you ever been prescribed psychiatric medication? ____ Yes ____ No
If yes, please list any and provide dates: _____
_____

General and Mental Health Information

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing: _____
_____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or any eating problems_____
_____
If yes, for approximately how long?_____

Are you currently experiencing anxiety, panic 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: _____

Do you drink alcohol more than one time a week? ____ Yes ____ No

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 to 10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?_____

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 the family member's relationship to you in the space provided (e.g. father, uncle, grandmother)

	Please Circle	**List Family Member**
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

Additional Information

Are you currently employed? ____ No ___ Yes
If yes, what is your current employment situation?_____
Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____
Do you consider yourself to be spiritual or religious? ___No ___ Yes
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? _____
_____
_____

Mental Health Provider/
Primary Care Physician Communication Form

Client Name_____ Date of Birth _____
Health Plan: _____
I, _____, authorize/do not authorize _____,
(Please Print) **(Circle one)** **(Provider's Name)**

my Mental Health Provider, and _____, _____,
(Primary Care Physician Name) (PCP Address and Phone Number)
my Primary Care Physician, to exchange information regarding my mental health /substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above Mental health care provider. I also understand that it is my responsibility to notify my Mental health care provider if I choose to change my Primary Care Physician.

_____ _____
I Authorize Communication between My PCP and Mental Health Provider (Member's Signature) Date

_____ _____
I Do Not Authorize Communication between My PCP and Mental Health Provider (Member's Signature) Date

_____ _____
Signature of parent or guardian (if member is a minor) Date

_____ _____
Witness Date

Provider Information (Please Print)

_____
Practitioner Name(s) Facility Name Address City
State Telephone Number _____
(Therapist and Psychiatrist if applicable)
DSM IV Diagnosis code &
name_____
Treatment Plan: Type_____Frequency_____Est length of
Tx_____
(I.e. ind, family, group, meds) (i.e. weekly, etc)

Mental Health Provider/
Primary Care Physician Communication Form (2)

Medication(s)
Prescribed:_____
_____
_____

Comments:_____
_____
_____

For urgent or emergency situation, please call the primary care physician in addition to sending form

□ Conclusion of mental health/substance treatment
□ Date of last session _____ Treatment completed? Yes___ No___
□ Notification of prescription or change in medications (see comments)
□
Other:_____

_____	_____	_____
Print Clinician Name	**Signature/Credentials**	**Telephone Number**

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGINAL IN THE MEMBER'S CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATION THAT FAX WAS SENT

_____	_____	**Please Check Method**
DATE SENT	**SENT BY (CLINICIAN PLEASE INITIAL)**	**Fax □ Mail □**

Client Name (please print)_____
Date of Birth_____

Please complete the following information regarding the person listed on the reverse and forward to the Mental Health Provider.

Provider Information (to be completed by Primary Care Physician) - Please Print

_____

Physician Name(s)	Address	City/State	Telephone #

Medical History:

_____

_____

_____

_____

_____

_____

Medication(s) Prescribed:

_____

_____

_____

Comments:

_____

_____

_____

_____ _____

Signature/Credentials **Date**

Please Check Method

DATE SENT SENT BY (PCP OFFICE STAFF PLEASE INITIAL) Fax Mail

SEND A COPY OF THIS FORM TO THE MENTAL HEALTH PROVIDER, RETAINING THE ORIGINAL IN THE PATIENT'S CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATION THAT FAX WAS SENT.

CONSENT TO RELEASE & EXCHANGE PATIENT INFORMATION

This form when completed and signed by you, authorizes W Mack Bartels, PysD, to exchange protected information from your clinical record to the person you designate.

Patient Name _____Birth Date _____

I authorize W Mack Bartels, PsyD to exchange:
__ Psychological/Diagnostic Evaluation __Educational Assessment __ School Records
__ Progress Update __Medical History __ Developmental History
Other (specify):_____

This Information should only be exchanged with:
Name/Agency_____
Address _____
Phone_____

Purpose of Release: I am requesting my psychologist to exchange this information for the following reasons: ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

__ Continuity of Care __Educational __Other ____ At the request of the individual

This authorization shall remain in effect until _____(fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.

_____ _____ _____ _____
Signature of Parent/Guardian Date Relationship