~Jeffrey Noethe, Ph.D.~
Licensed Psychologist

2100 NE Broadway, Suite 329
Portland, OR 97232

Phone: (503) 730-1594

Web: www.DrNoethe.com

E-mail: Jeffrey@DrNoethe.com

Dear Potential Client,

First, let me thank you for choosing my professional services! I will do my best to provide you with a useful and meaningful therapeutic experience. To make our first meeting more efficient, I provide the following documents for you to read and fill out ahead of time:

(1) AGREEMENT AND INFORMED CONSENT FOR TREATMENT outlines my policies and the therapy agreement.

(2) NOTICE OF PRIVACY PRACTICES explains the federal regulations and my practices regarding the use and disclosure of your health information.

(3) PAYMENT CONTRACT FOR SERVICES explains my payment policies.

(4) NEW CLIENT INFORMATION SHEET helps me to better understand you and make our first few sessions more productive.

Please complete these documents and bring them to your first appointment, along with your health insurance card. If you have any questions, please feel free to contact me beforehand. We can also discuss your questions during our first meeting. I realize that this is a lot of information to digest, and I will do everything I can to make it clear.

Paperwork aside, it is common for new clients to feel nervous about starting therapy, and I understand how stressful it can be. Fortunately, most people begin to feel more comfortable with the process in just a few sessions. In the meantime, it might be helpful (for both of us) if you would take some time to think about what you want from therapy. You might even make some notes about your goals and what is most important to you, so that we can discuss these together during our first few sessions.

I look forward to meeting with you! If I can provide any additional information, please contact me.

Sincerely,

Jeffrey Noethe, Ph.D.

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AGREEMENT AND INFORMED CONSENT FOR TREATMENT

Treatment Agreement

Welcome to my practice! I greatly appreciate the opportunity to serve you as a psychologist. This document (the AGREEMENT) contains important information about my professional services and business policies, as well as summary information about the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA is the federal law that protects your privacy and rights related to health information. HIPAA regulations require that I provide you with a NOTICE OF PRIVACY PRACTICES (the NOTICE) regarding the use and disclosure of your health information. The law also requires that I obtain your signature acknowledging that I have provided you with this information at the start of treatment. Although these documents are long and sometimes complex, it is very important that you read them carefully before signing. If you have any questions or concerns, please let me know so that we can address them.

When you sign the AGREEMENT, it represents a formal agreement between us. You may revoke this agreement in writing at any time, and that revocation will be binding unless (1) I have already taken action in reliance upon it, (2) there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or (3) you have not satisfied financial obligations incurred by you.

Psychological Services

Psychotherapy has both benefits and risks. While I do expect that you will benefit from therapy, there is no guarantee that your condition will improve. Therapy can even cause disappointing, unexpected, or negative results or outcomes. During the therapy process, you may experience emotional discomfort, changes in your relationships, and/or a worsening of symptoms. These are normal parts of the process, and we will deal with them in therapy. On the other hand, psychotherapy has also been shown to have many benefits. Therapy can lead to better relationships, solutions for specific problems, and significant reductions in distress. To be effective, psychotherapy requires an active investment of time and energy, both during and between sessions.

Our first few sessions will serve as an initial evaluation of your concerns, history, goals, and needs. By the end of this evaluation, I will provide you with my impressions of how our work might proceed. You should consider this information along with your own impressions and your comfort level with me, so that we can decide together whether I am the best person to provide services to meet your treatment goals. Therapy can be a big commitment, so you should select a therapist carefully.

If we agree to enter into a therapy relationship, we will typically schedule one 50-minute session per week, although other arrangements are possible. Treatment duration is highly variable, depending on your presenting concerns, goals, and other factors. During our work together, we will periodically review your goals and progress. I may also request that you have a medical or psychiatric evaluation to aid in treatment. Remember, you always retain the right to request changes in treatment or to refuse treatment at any time and for any reason. However, it is my hope that you will discuss any concerns with me first. If your concerns cannot be resolved, I may be able to provide an appropriate referral to another mental health professional. Your input is always welcome, and I understand that other forms of therapy may be useful.

Legal Proceedings

Psychotherapy is for the improvement of your psychological functioning and is not intended to be used for the purpose of current or future legal proceedings (e.g., custody, divorce, or civil proceedings). If you are involved in or anticipate becoming involved in any legal proceeding, please notify me as soon as possible. It is important for me to understand how, if at all, your involvement in these proceedings might affect our work.

Office Policies

(A) Phone Contact and Emergencies: For your information, I use a cellular phone as my primary business line and therefore cannot guarantee absolute privacy. The same limitation applies to e-mail and text correspondence, so I offer the option of communicating through an encrypted messaging app called Signal. I am generally available by phone 24 hours a day, and I check my voice mail several times a day during business hours. Phone calls are returned as soon as possible, usually within 24 hours, except on weekends and holidays. I do not answer the phone when I am with clients, and my availability at other times cannot be guaranteed. You may leave a confidential voice mail for me at any time, but messages that are left after 5:00 pm may not be received until the following morning. Because voice mail technology is not error proof, if you have not heard back from me by the end of the next day, please feel free to call again since it is likely that I did not receive your original message. Please be sure to state if you are calling about an urgent matter. In the case of an emergency, if you cannot reach me, you should call the **Multnomah County Crisis Line (503-988-4888)**, dial **911**, or go to the nearest hospital emergency room.

(B) Social Media: For marketing purposes, I maintain a limited presence on social media, but it is not my practice to connect to or communicate with clients through these channels. My preferred client communication channels are telephone and the Signal app, but you can also reach me via email and text, as long as you understand the potential privacy risks.

(C) Billing & Fees: All payments are due in full at the time of service, unless we have agreed to other arrangements. Please have payments ready at the beginning of each session. I reserve the right to suspend or terminate treatment if there are unpaid balances on your account. My fees are based on services provided, and my standard and customary fees are as follows. An initial 55-minute evaluation/consultation is $250, and subsequent sessions (approximately 50 minutes) are $200. Fees may also be charged on a pro-rated basis for other professional activities necessary for good clinical care or for professional services you may need or request of me. These include, but are not limited to, time spent writing letters, reports, or treatment summaries on your behalf; telephone consultations initiated by you and lasting over 10 minutes; and consultations with others on your behalf. Clients experiencing financial hardship are invited to raise their financial concerns so that we can discuss payment options. There is a $20 charge for dishonored checks. All standard and customary fees may be reviewed and revised at any time, and I will notify clients of any upcoming changes. Additional payment information can be found in the PAYMENT CONTRACT FOR SERVICES.

NOTE: If you become involved in legal proceedings that require my participation, you agree to pay for all of my professional time, even if I am called to testify by another party. This includes, but is not limited to, time spent traveling, consulting with attorneys, attending depositions, reviewing materials in preparation for testimony, giving testimony, and waiting to be called to testify. Because of the difficulty of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding.

(D) Appointments and Cancellations: Appointments are made directly with me. If we establish a regular appointment time, I will assume that that time is yours each week, and you must clarify with me if you plan to miss or need to change an appointment. With sufficient notice, appointments can often be rescheduled. However, if an appointment is cancelled with less than 24 hours notice, I reserve the right to incur a late cancellation fee of $50. Appointments that are missed without any notice may incur a no-show fee of $75. It is important to note that insurance companies do not reimburse for cancelled or missed appointments, so you will be personally responsible for this fee. If you are late for your session and have not called me, I will keep your time free until 15 minutes after the scheduled start time.

(E) Drugs and Alcohol: A client who attends an appointment under the influence of drugs or alcohol may not be seen. Such an incident will be treated as a missed appointment, and the client may be billed.

Health Insurance

If you are using health insurance to pay for psychotherapy services, you need to be aware of what this means. Your health insurance plan requires cooperation between the client, provider, and insurance company to provide services as efficiently as possible. In many cases, I will be required to provide information about your treatment as well as a diagnosis. I may also be required to provide additional clinical information, such as treatment plans or summaries, or even copies of your entire Clinical Record. Released information will become part of the insurance company records, and while 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.

Health insurance companies may not cover all services or conditions, and they may only cover a limited number of sessions. Some insurance plans require pre-authorization or they will not cover your first meeting, and many require periodic reauthorizations for ongoing treatment. You are responsible for obtaining the initial pre-authorization, if necessary. It would also be very helpful if you would check the specifics of your insurance benefits, if any, prior to our first meeting. You remain responsible for your entire bill regardless of whether insurance covers treatment costs or whether you are the primary insured person.

You always have the choice to pay for my services out-of-pocket rather than utilize insurance. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. If you exhaust your benefits but wish to continue therapy with me, we will need to determine whether we can make this happen. If we cannot, I will attempt to help you find treatment that you can afford.

Confidentiality and the Limits on Confidentiality

Confidentiality is the obligation not to disclose any client information obtained during a professional relationship without permission. Confidentiality is a cornerstone of effective psychotherapy, and the law protects confidential communications between a client and a psychologist. Information is never released to anyone, including your spouse/partner or family, without your written consent, **except** as required by law or ethical guidelines. In the event that there are two or more clients in therapy at one time (e.g., couples or family therapy), written consent must be given by all participating clients before records are released.

I will make every effort to protect your confidentiality when I call you by phone. If you have special instructions for how I should leave messages, please let me know. Otherwise, I will generally state my name and leave a brief message. If we happen to meet outside of therapy, I will not reveal our therapy relationship, and unless otherwise arranged, I will not even acknowledge that I know you.

HIPAA allows me to use or disclose confidential information, including but not limited to your health information, for the purposes of treatment, payment, and health care operations, as long as I have your informed written consent, signified by signing this document. For purposes outside of treatment, payment, and health care operations, I can only release your information if you sign an AUTHORIZATION. However, you should be aware that there are some additional legal and ethical exceptions or limits to confidentiality and some situations in which I am permitted or required to disclose information without your consent or AUTHORIZATION. For more information, please consult the NOTICE OF PRIVACY PRACTICES. I will try to disclose only information that is necessary to meet the needs of the situation.

Clinical Record

As a psychologist, I maintain confidentiality in creating, storing, accessing, transferring, and disposing of records in any medium. Your Clinical Record includes your reasons for seeking therapy, how your life is being impacted, your diagnosis, the goals that we have set for treatment, your progress toward those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. By submitting a written request, you may examine and/or receive a copy of your Clinical Record, except in circumstances where disclosure would be injurious to you or would constitute an immediate and grave detriment to your treatment. In such circumstances, I may

provide you with an accurate and representative summary of your Clinical Record, if requested. Professional records can be very confusing and/or upsetting to an untrained reader. For this reason, I recommend that you review them in my presence or with another mental health professional. In most circumstances, I will charge a copying/printing fee of $15 plus 50¢ per page plus any postage. If you wish to review your Clinical Record, please address your request to me, so that we can discuss the best way to make this happen.

In addition to your Clinical Record, I may also keep a set of Psychotherapy Notes for my own use. Psychotherapy Notes vary from client to client, but they may include the contents of our conversations, as well as sensitive information that is not required to be included in your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written AUTHORIZATION. Insurance companies also cannot require such an AUTHORIZATION as a condition of coverage nor penalize you in any way for your refusal.

All records and notes are kept double-locked or password protected, and all records are retained for a minimum of seven years as required by law. In the event of your death, the privilege to access your record passes to your estate. In the event of my own incapacitation, withdrawal, or death, another licensed psychologist will assume responsibility for my records. Currently, my records custodian is Dr. Bret Fuller.

Minors & Parents

Minors 14 years or older have a right, without parental consent, to outpatient diagnosis and treatment for mental or emotional disorders. In this case, the law requires that the Psychologist shall have the parents involved by the end of treatment unless (1) the parents refuse to be involved, (2) the minor has been sexually abused by a parent, (3) the minor is emancipated or has been self-sustaining for 90 days, or (4) there are clear clinical indications that the parents should not be involved, in accordance with the best interest of the client. In addition, the psychologist can disclose to a parent without the minor's consent if disclosure is clinically appropriate and will serve the best interest of the client due to a deterioration of condition.

Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I may request that parents agree not to access the child's records, with the understanding that I will provide them with general information about the child's attendance and progress. I will also provide parents with either a verbal or written summary of their child's treatment when it is complete, if requested. Any other disclosures will require the child's permission, unless I feel that the child may be in danger or may be a danger to others, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Agreement and Consent to Treatment

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTOOD, AND AGREED TO THE TERMS OF THIS DOCUMENT.

_____	_____	_____
Client Name	Signature	Date
_____	_____	_____
Parent/Guardian Name (if minor)	Signature	Date

This form has been discussed and a copy given to the client.

	_____	_____
	Jeffrey Noethe, Ph.D.	Date

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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam, smartphone, or tablet during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

_____	_____	_____
Client Name	Signature	Date
_____	_____	_____
Psychologist Name	Signature	Date

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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.**

Your Rights **(see page 2 for details)**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask me to limit the information I share
- Get a list of those with whom I've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices **(see page 3 for details)**

You have some choices in the way that I use and share information as I:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory *(I do not create, manage, or link to any such directories.)*
- Provide mental health care
- Market my services and sell your information *(I never market or sell personal information.)*
- Raise funds *(I never use personal information for fundraising.)*

My Uses and Disclosures **(see pages 3 & 4 for details)**

I may use and share your information as I:

- Treat you
- Run my practice
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information I have about you.
- I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.

Ask me to correct your medical record

- You can ask me to correct health information about you that you think is incorrect or incomplete.
- I may say "no" to your request, but I'll tell you why in writing within 60 days.

Request confidential communications

- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- I will say "yes" to all reasonable requests.

Ask me to limit what I use or share

- You can ask me not to use or share certain health information for treatment, payment, or operations. I am not required to agree to your request, and I may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or my operations with your health insurer. I will say "yes" unless a law requires me to share that information.

Get a list of those with whom I've shared information

- You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why.
- I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). I'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.
- I will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- I will make sure the person has this authority and can act for you before I take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel I have violated your rights by contacting me using the info on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- I will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, talk to me. Tell me what you want me to do, and I will follow your instructions.

In these cases, you have both the right and choice to tell me to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory *(I do not create, manage, or link to any such directories.)*

If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if I believe it is in your best interest. I may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases I never share your information unless you give me written permission:

- Marketing purposes *(I never use personal information for marketing purposes.)*
- Sale of your information *(I never sell personal information.)*
- Most sharing of psychotherapy notes

In the case of fundraising:

- *I never use personal information for fundraising.*

My Uses and Disclosures

How do I typically use or share your health information?

I typically use or share your health information in the following ways.

Treat you

I can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run my practice

I can use and share your health information to run my practice, improve your care, and contact you when necessary.

Example: I use health information about you to manage your treatment and services.

Bill for your services

I can use and share your health information to bill and get payment from health plans or other entities.

Example: I give information about you to your health insurance plan so it will pay for your services.

How else can I use or share your health information?

I am allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. I have to meet many conditions in the law before I can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

I can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls

- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

I can use or share your information for health research.

Comply with the law

I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I am complying with federal privacy law.

Respond to organ and tissue donation requests

I can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

I can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

I can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

I can share health information about you in response to a court or administrative order, or in response to a subpoena.

My Responsibilities

- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me I can in writing. If you tell me I can, you may change your mind at any time. Let me know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request, in my office, and on my web site.

~Jeffrey Noethe, Ph.D.~
Licensed Psychologist

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ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES (the NOTICE) for Dr. Jeffrey Noethe, and I agree to the procedures and policies described therein. Specifically, I agree that my protected health information may be used and disclosed by Dr. Noethe to carry out treatment, payment, and health care operations as specified in the NOTICE. (For more information on uses and disclosures, please refer to the NOTICE.)

I understand that I have the right to review the NOTICE before signing this consent. I understand that I have the right to request restrictions on the uses and disclosures of my protected health information. I also understand that Dr. Noethe does not have to agree to my requested restrictions, but if he does agree, that agreement is binding. I understand that I can revoke consent in writing, but I cannot revoke consent retroactively.

_____	_____	_____
Client (or personal representative)	Signature	Date
_____	_____	_____
Client (or personal representative)	Signature	Date

_____
Relationship to Client (if a personal representative)

For Office Use Only

I, Dr. Jeffrey Noethe, have attempted to obtain written acknowledgment of receipt of the NOTICE OF PRIVACY PRACTICES from the client named above, but acknowledgment could not be obtained because:

- ☐ The client or personal representative refused to sign.
- ☐ Communications barriers prohibited obtaining the acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other (specify below):

_____

_____

_____	_____
Jeffrey Noethe, Ph.D.	Date

~Jeffrey Noethe, Ph.D.~
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PAYMENT CONTRACT FOR SERVICES

This document is intended to clarify the payment policies for services contracted with Dr. Jeffrey Noethe. The Person Responsible for Payment is required to sign this document before any services are provided.

Your insurance policy, if any, is a contract between you and the insurance company. I am not part of that contract, and you are responsible for knowing what your insurance covers. As a service to you, I am willing to assist with insurance issues and questions. I am also often willing to submit claims to insurance companies and other third-party payers. However, I cannot guarantee such benefits or the amounts covered, and I am not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may not consider certain services to be reasonable or necessary, may determine different standard and customary rates, or may determine that services are not covered at all. In such cases, the Person Responsible for Payment is responsible for the costs of all services not covered by insurance companies or other third-party payers. **The Person Responsible for Payment is also responsible for all costs not paid by insurance companies or third-party payers after 60 days.**

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere, this amount will be collected by me until the deductible payment is verified by the insurance company or third-party payers. All insurance benefits will be assigned to me by the insurance company or third-party payers unless the Person Responsible for Payment pays the entire balance each session.

Clients are responsible for payments at the time of service. The parent or guardian accompanying a minor is responsible for payments for the minor at the time of service. **Cancellations with less than 48 hours notice may incur a late cancellation fee of $25, and scheduled appointments that are missed without any notice may incur a no-show fee of $50.** Please note that insurance companies do not reimburse for cancelled or missed appointments, so you will be held responsible for this fee.

Payment methods include cash or check only, unless other arrangements have been made. For more information on Billing & Fees or on Health Insurance, please review the AGREEMENT AND INFORMED CONSENT FOR TREATMENT.

If you have any questions regarding this document, please be sure to ask me.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTOOD, AND AGREED TO THE TERMS OF THIS DOCUMENT.

_____	_____	
Client Name(s)		
_____	_____	_____
Person Responsible for Payment	Signature	Date
_____	_____	_____
Co-Responsible Person	Signature	Date

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CLIENT INFORMATION

Please provide the following information as honestly and completely as possible. If you do not feel comfortable answering a question, leave it blank and we will discuss it during the first session. If you need more space, feel free to use the margins or attach an additional page. All answers are strictly confidential in accordance with the NOTICE OF PRIVACY PRACTICES.

Today's Date: _____ Referred By: _____

Full Name of Client:		
Home Address:		Date of Birth: Age:
Home Phone:	May I leave messages at this number? ☐ Yes ☐ No	Gender:
Cell Phone:	May I leave messages at this number? ☐ Yes ☐ No	Marital/Relationship Status:
E-mail Address:		Ethnicity:
Work/School Address:		Nation of Origin: Military Veteran Status:
Work Position/Title:		Highest Educational Degree:
Work Phone:	May I leave messages at this number? ☐ Yes ☐ No	
Emergency Contact:		Relationship:
Emergency Contact Address:		Emergency Contact Phone #1: Emergency Contact Phone #2:
Parent/Guardian (if under 18):		Relationship (if guardian):
Parent/Guardian Address (if different):		Parent/Guardian Phone #1: Parent/Guardian Phone #2:

Family & Relationship History

1. **Family of Origin:** Please list the members of your family of origin (parents, brothers, sisters, etc.):

Name	Relationship	Age	Occupation/School	Lives with you?

2. Is there any family history of mental health or substance abuse issues?

3. Are there any special circumstances related to your childhood? (adoption, separation, divorce, etc.)

4. Were you raised with any particular religious or cultural beliefs?

5. What are your current relationships like with your family of origin?

6. **Current Family:** Please list the members of your current/immediate family (if different from above):

Name	Relationship	Age	Occupation/School	Lives with you?

7. How would you describe your social and relationship history? (active, isolated, etc.)

8. Who do you consider to be your primary social supports right now?

9. Are you currently in a romantic relationship? If so, for how long?

10. Have you ever been abused or witnessed abuse? (physical, sexual, emotional, etc.)

Physical & Mental Health History

11. Past Hospitalizations or Major Medical Problems:	
12. Current Medical Conditions or Allergies:	
13. Current Prescription Medications:	
14. Date of Last Complete Physical:	
15. Primary Physician:	16. Primary Physician Phone:
17. Current Non-Prescription Medications (vitamins, supplements, diet pills, etc.):	
18. Have you ever had a head injury?	
19. Do you experience any serious concentration or memory problems?	
20. Have you ever received mental health or substance abuse services? If so, when, where, and with whom?	
21. Do you have any history of suicidal thoughts or attempts? If so, when?	
22. Do you have any other history of self-harm? (cutting, burning, etc.)	
23. Do you have any history of harming others?	
24. Do you have any history of substance use problems? (excessive use, dependency, etc.)	
25. Is there anything else I should know about your physical or mental health?	

Other Relevant History

26. Describe any relevant work or school issues:

27. Describe any relevant legal history:

28. Is there anything else I should know about your history?

Symptom Checklist

29. Please check any of the symptoms that you are having or have had recently:

☐ Fatigue	☐ Hopelessness	☐ Dizziness	☐ Impulsiveness
☐ Stress	☐ Irritability	☐ Weight Change	☐ Feeling Worthless
☐ Sadness/Depression	☐ Poor Concentration	☐ Violent Behavior	☐ Excessive Sweating
☐ Anger	☐ Anxiety	☐ Loneliness/Isolation	☐ Body Image Concerns
☐ Worrying	☐ Sleep Difficulties	☐ Speech Difficulties	☐ Heart Palpitations
☐ Memory Difficulties	☐ Perfectionism	☐ Physical Pain	☐ Sick Often
☐ Low Energy	☐ Sexual Difficulties	☐ Work Difficulties	☐ Avoiding People
☐ Eating Behavior Issues	☐ Panic Attacks	☐ Poor Judgment	☐ Headaches
☐ Nervousness	☐ Hallucinations	☐ Obsessive/Compulsive	☐ Easily Distracted
☐ Social/Family Conflicts	☐ Suicidal Thoughts	☐ Chest Pain	☐ Disorganized Thoughts
☐ Mood Swings	☐ Muscle Tension	☐ Elevated Mood	☐ Trembling
☐ Low Self-Esteem	☐ Intrusive Thoughts	☐ Nightmares	☐ Thoughts of Harming Others

30. Please add any useful details about your checked items above:

I certify that the above information is accurate. I understand that this information will be included in my Clinical Record and will be used and disclosed only as described in the AGREEMENT AND INFORMED CONSENT FOR TREATMENT and the NOTICE OF PRIVACY PRACTICES.

Name _____ Signature _____ Date _____