

Client Information

To make our first meeting more productive, please provide complete and accurate responses to the following. All information will be treated confidentially. If you have a question about an area, put a check mark by it and your counselor will discuss it with you during the session.

Date: _____ Client's Full Name _____ Sex _____

Nickname _____ Age _____ Birthdate _____

Home Phone: () _____ Other Phone (cell, pager, etc.): () _____

Address _____ City/Zip _____

Parents'/Guardian's Names (if under 18) _____

Employer _____ How long? _____ Type of work _____

Work phone: () _____ Ext. _____ OK to call at work? _____

Circle last year of school completed: 6 7 8 9 10 11 12 GED College: 1 2 3 4 Other: _____

Person not living with you to contact in case of emergency: Name: _____

Phone: () _____ Relationship: _____

Marital Status: (circle current status)

Never married Engaged Living with someone Separated Divorced Widow(er) Married

How long in current status? _____

Spouse/partner name _____ Age _____ Occupation _____

How long married or living with this partner? _____ Are you happy in this relationship? _____

Number of prior marriages for you _____ For your partner _____

Household Members Names	Relationship to You	Age

If you have minor children from a previous relationship not living with you, give first names, ages, location: _____

Does anyone else in your household have any major medical or emotional problems? _____ If yes explain: _____

Describe your general health: Excellent _____ Good _____ Average _____ Poor _____

List all doctors that you see: _____

List any ongoing medical conditions (high blood pressure, diabetes, etc.): _____

List any medications you are currently taking (include dosage and purpose): _____

Have you ever been hospitalized in a mental health or substance abuse treatment facility? _____ If so, give reason, dates, and name of facility: _____

If you have been to counseling before, list reason, dates, and name of counselor: _____

If you are currently involved in any type of counseling or support groups, please specify: _____

Circle your current use of alcoholic beverages: Never _____ Occasionally _____ Once per week _____ Several times per week _____ Daily _____
Describe any other current drug use: _____

Circle any losses you have experienced within the last 18 months:
Death of: Spouse Child Parent Sibling Grandparent Friend Pet
Divorce Separation Broken engagement Change of school Suicide of loved one Miscarriage Abortion
Infertility Bankruptcy Homelessness Career or job loss Other _____

Circle any of the following that you have experienced:
Child abuse: physical, sexual, emotional. Spouse abuse: physical, sexual, emotional. Abandonment Rape Robbery
Assault Suicide attempt Major accident Major surgery Other _____

Circle any of the following that concern you now:
Relationship with: Spouse Boyfriend/Girlfriend Children Parents In-laws Co-workers Friends Teachers
Alcohol Drugs Eating habits Shopping Overwork Weight Procrastination Sleep Sex Anger Depression
Grief Anxiety Loneliness Low self-esteem Stress Fear Mood swings Spirituality Suicidal thoughts
Other _____

Client signature Date

SUSANNE GRAHAM, LMHC

**HIPAA PATIENT CONSENT
FOR
NOTICE OF PRIVACY PRACTICES**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my **protected health information (PHI)** to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of this practice.

You have the right to:

- Request restrictions on the disclosure of your PHI as provided by law, however, the practice is not obligated to agree to any requested restrictions. If there is agreement, the practice is then obligated to abide by the agreed restrictions.
- Inspect a copy of your PHI. Your PHI does not include the therapist's "psychotherapy notes". "Psychotherapy notes" means notes recorded by the therapist during a private counseling session and that are separated from the rest of the individual's medical record.
- Amend your PHI in our practice records.
- Receive confidential communications of your PHI from the practice by alternative means or at alternative locations.

PLEASE NOTE: The practice asks if you wish to exercise any of the rights enumerated above that you put your request in writing and deliver it to the practice location. If you have any questions about this information, please contact the Compliance Office, Susanne Graham, and she will entertain your request.

I have also been informed of, and given the right to review and secure a copy of Susanne Graham's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Relationship to Patient: _____

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CONSENT FOR SERVICES

I the undersigned client AND/OR I a parent or guardian of the client hereby authorize Susanne Graham, LMHC to administer mental health and/or substance abuse treatment to the below named client.

I understand that this consent can be revoked orally or in writing prior to or during the treatment period at which point treatment would cease and an appropriate referral would be provided to me. I acknowledge that no guarantees or assurances as to the results of treatment are made or implied.

I understand that I am personally responsible for the costs of all therapy services rendered and the costs of treatment will be discussed with me. I also understand that payment for services is expected at the time services are rendered.

I have read and/or fully understand the above consent for service

Date of Consent _____

Client Name _____ Client Signature _____

Parent/Guardian Signature (for minors) _____

Please answer the following to help us serve you better:

How did you learn about our center or who referred you here: _____

Briefly explain why you are pursuing counseling: _____

What do you want to gain from counseling? _____

SUSANNE GRAHAM, LMHC

Important Information for Clients

As a client, you have the right to be treated with respect and dignity, to be treated by qualified professionals and to be treated in privacy. You have the right to have answers to your questions and to know about the treatment process. You have the right to have your written records and all information about you known by your therapist held in strictest confidence. However, your therapist may reveal confidential information about you under any of the following conditions:

- a. If you sign a Release of Information Form, information can be shared with the person or agency that is designated on the form.
- b. Even without a release, a court may order your therapist to reveal information about you.
- c. By law, all suspected cases of the abuse and neglect of a child, elderly person or handicapped person must be reported to the Department of Children and Families.
- d. If you threaten to harm yourself or another person, your therapist may reveal information as necessary to protect you or the other person.
- e. Your therapist will gladly discuss their background and qualification with you. Furthermore, all therapists licensed in Florida are under the supervision of the Department of Health. To verify their licensure or register a complaint which you cannot resolve with your therapist, you may contact:

Florida Department of Health

Board of Clinical Social Work, Marriage and Family Therapy,
and Mental Health Counseling

4052 Bald Cypress Way, Bin #C08

Tallahassee, Florida 32399-3258 Phone: (850) 245-4474

As a Client, you will be expected to:

- a. Arrive on time for your scheduled appointments. If you arrive late, your session may still need to end at the appointed time so others can begin their time. In that case, you would still be responsible for the cost of your entire session. Therapy sessions are usually 50 to 60 minutes.
- b. To provide at least 24 notice if you need to cancel or reschedule. There will be a \$25.00 no show fee if you miss your appointment unless indicated by your therapist.
- c. Call and stay home if you are ill or have a cold or fever or are in quarantine.
- d. To pay for services at the end of each session. If we are billing your insurance company, you still are expected to pay co-pays. You are responsible for any fees the insurance company doesn't pay.
- e. All paperwork is to be filled out as required by the therapist. If you refuse to do so, the therapist has the right to not accept you as a client.
- f. Pay your co-pay over the phone by credit card if you have a Virtual Appointment scheduled.

I understand and have read the above:

Client Signature

Date:

Parent/Guardian

INSURANCE CONSENT

I understand that I am personally responsible for the costs of services not covered by my insurance including but not limited to unmet deductibles, co-payments, and any fees or portions of fees not paid by my insurance carrier. I understand that these fees are due at the time of service.

I hereby choose to have my insurance company billed for these services. Benefits due to me under the below policy are hereby assigned to Sue Graham, LMHC. I understand that specific diagnostic and treatment information will be required by my insurance company. I consent to the release of all requested confidential information to billing services and insurance companies for the purpose of processing my claims. I understand that Sue Graham, LMHC cannot be responsible for confidential information once it is released to others.

Client Name _____

Client Signature _____ Date _____

Signature of person responsible if other than client _____

Insurance Co. _____ Phone (____) _____

Policy # _____ Group # _____

Please allow the office manager to make a copy of your insurance card

Many managed care insurance companies request that we inform your primary care physician (PCP) about your treatment here. We will not release this confidential information without your consent. Please let us know of your preference by checking 1 or 2 and signing below.

1. I choose to have confidential information released to my PCP. My PCP's name and address are: _____

2. I choose not to have confidential information released to my PCP because: (check all that apply)

I do not have a PCP or do not see him regularly

I do not want my PCP informed about my treatment here

I am concerned about the security of information released to my doctor's office

I would rather have my treatment information released to another doctor (e.g. my psychiatrist)

instead of my PCP. The doctor's name and address are: _____

Client Signature _____ Date _____

Signature of person responsible if other than client _____

SUSANNE GRAHAM, LMHC