

Client Information Form

This form is completely confidential

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ Social Security #: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

Referred by: _____

- May I have your permission to thank this person for the referral?
Yes No
- If referred by another clinician, would you like for us to communicate with one another?
Yes No

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

What are your goals for therapy? _____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

**The following information on this form will help guide your treatment.
Please try to fill out as much as you are comfortable disclosing.**

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons): _____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO

(Please list approximate dates and reasons): _____

Height _____ Weight (if applicable) _____ Age _____ Gender _____

Sexual Identity: Heterosexual__ Lesbian__ Gay__ Bisexual__ Transgender__ In Question__

FAMILY:

How would you describe your relationship with your mother? _____

How would you describe your relationship with your father? _____

Are your parents still married? _____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: ^{POOR} 1 2 3 4 5 6 7 ^{EXCELLENT}

Married/Life Partnered? ____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships _____

Do you have Children? ____ If YES, how many and what are their ages: _____

Describe any problems any of your children are having: _____

List the names and ages of those living in your household: _____

Please briefly describe any history of abuse, neglect and/or trauma: _____

Current level of satisfaction with your friends and social support: ^{POOR} 1 2 3 4 5 6 7 ^{EXCELLENT}

Please briefly describe your coping mechanisms and self-care: _____

Is spirituality important in your life and if so please explain: _____

Briefly describe your diet and exercise patterns: _____

EDUCATION & CAREER

High School/GED ____ College Degree ____ Graduate Degree(or Higher) ____ Vocational Degree ____

What is your current employment? _____
Employment Satisfaction: ^{POOR} 1 2 3 4 5 6 7 ^{EXCELLENT}

Any past career positions that you feel are relevant? _____

What do you think are your strengths? _____

PLEASE CHECK ALL THAT APPLY & **CIRCLE** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
Suicide			Learning Disabilities			“Nervous Breakdown”		

Any additional information you would like to include:

UPREACH INCORPORATED
COMPREHENSIVE PSYCHOLOGICAL SERVICES

P.O. Box 91250 * Atlanta, Georgia 30364
404-526-9304 * 470-237-2396 fax

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date as indicated below.

I, _____ (client), hereby authorize
_____ Dr. Richard R. Mouzon (therapist) and the following party or parties
to discuss my mental health treatment information and records obtained in the course of
psychotherapy treatment, including, but not limited to, therapist's diagnosis:

- (1) _____
- (2) _____
- (3) _____

Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.

Please indicate your preference regarding the information to be shared:

- The parties stated above may discuss my medical and/or mental health information without limitations.
- I would prefer to limit the information shared between the parties stated above. The limitations I would like to make are as follows:

Additionally, the above-named parties, therapist & person(s) or entity (entities) designated under (1) or (2), agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have the right to revoke this authorization at any time unless the therapist stated above has taken action in reliance upon it. Additionally, if you decide to revoke this authorization, such revocation must be in writing and received by the above named therapist at P.O. BOX 91250 , Atlanta, GA 30364 to be effective.

Client's Signature: _____ Date: _____

Parent's/Legal Guardian's Signature: _____ Date: _____

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Consent for Treatment

I have been fully informed of my rights as a client of this agency, the extent and limits of confidentiality in therapy, and the goals associated with the described intervention (i.e., therapy, psychological testing, etc.). With that knowledge, I request and consent to receive the described intervention from the qualified personnel of this agency.

I understand that the staff of this agency may not disclose information about treatment to anyone outside this agency without my written consent, except as required by law to comply with a Court Order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow staff of this agency to provide some information about my involvement to a referring agency and/or an insurance company or other payer, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed.

I understand that my clinician/therapist may work with me at this agency, or in other settings based on his/her professional judgment. I further understand that my treatment may involve my participation in individual, couple, family, and/or group counseling, and may involve homework assignments for me to do outside of therapy sessions. I agree to participate actively in my treatment, to cooperate with my clinician/therapist, and to complete required homework assignments or other activities included in my treatment.

I understand that if I participate in group counseling, a condition of my doing so is that I protect the privacy and confidentiality of other participants. I agree that if I participate in group counseling, I will not disclose information about the identity, words, or actions of other group counseling participants to anyone outside the therapy group.

I understand that my therapy may include my attendance at meetings of independent self-help, such as those involving Parent Support, Abuse Victims, Alcoholics Anonymous, Narcotics Anonymous, and/or other programs. I agree to participate in such programs if assigned and to abide by the practices of those programs regarding protecting the privacy and anonymity of other program participants.

Patient/Guardian Name: _____ Signature: _____ Date: ___ / ___ / ___

Clinician Name: _____ Signature: _____ Date: ___ / ___ / ___

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Patient Notice

HIPPA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organization is the Administration Simplification section of the Act, which requires healthcare organization to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transactions & codes set for transmitting data electronically
- Security regulations over protections of electronic health information
- Privacy regulations over disclosure and use of health information

I authorize _____ to leave mental health information pertaining to me or any child in my legal custody by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone	Yes _____ No _____	# _____
Answering Machine at Home	Yes _____ No _____	# _____
Work Telephone	Yes _____ No _____	# _____
Voice Mail at Work	Yes _____ No _____	# _____
Cell Phone/Voice Mail	Yes _____ No _____	# _____
Pager	Yes _____ No _____	# _____
Email	Yes _____ No _____	# _____

Please list the names of people we can discuss your mental health care with:

Spouse: _____ Yes _____ No _____

Parent: _____ Yes _____ No _____

Other: _____ Relationship _____

Signature of Patient/Parent/Guardian

Date: _____

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I Acknowledge by signing below that I have received and read the Notice of Privacy Practices and Notice of individual Rights.

Date: _____

Patient/Parent/Personal Representative

Patient/Parent refused to sign:

Name: _____ Date: _____

Office Representative: _____ Date: _____

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact [insert the name of contact, title, and phone number of the contact person or office responsible for handling complaints]. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

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Referral for Additional Services

Client Name: _____ Case #: _____ Date: _____

Referral Source/Contact: _____

Client Address: _____ Client/Sponsor ID# / SSN #: _____

_____ Agency Address: _____

Client Phone: (H) _____

(W) _____ Agency Phone: _____ Fax: _____

Parent/Guardian: _____ Agency Contact Person: _____

Emergency Contact Name/Phone: _____

Referred To: _____

Preferred Focus of Treatment: _____

Service(s)/Program(s) Requested:

- | | |
|---|---|
| <input type="checkbox"/> Individual counseling | <input type="checkbox"/> Case management |
| <input type="checkbox"/> Family counseling | <input type="checkbox"/> Developmental testing |
| <input type="checkbox"/> Group counseling | <input type="checkbox"/> Psychiatric assessment |
| <input type="checkbox"/> Substance abuse counseling | <input type="checkbox"/> Medication monitoring |
| <input type="checkbox"/> Medical examination _____ | |
| <input type="checkbox"/> Other: _____ | |
- _____
- _____

Appointment(s) Will Be Scheduled by:

Patient Clinician Customer service rep. Other: _____

Insurance Information:

Insurance Company: ___ Blue Cross/Blue Shield ___ CHAMPUS/TriCare ___ Medicare
___ Aetna ___ Cigna ___ Premier ___ Health Partners
___ Magellan ___ Cenpatico Other: _____

Policy/Account #: _____ Group Number: _____ Effective Date: ___/___/___

Signature of Clinician: _____ Date: _____/_____/____