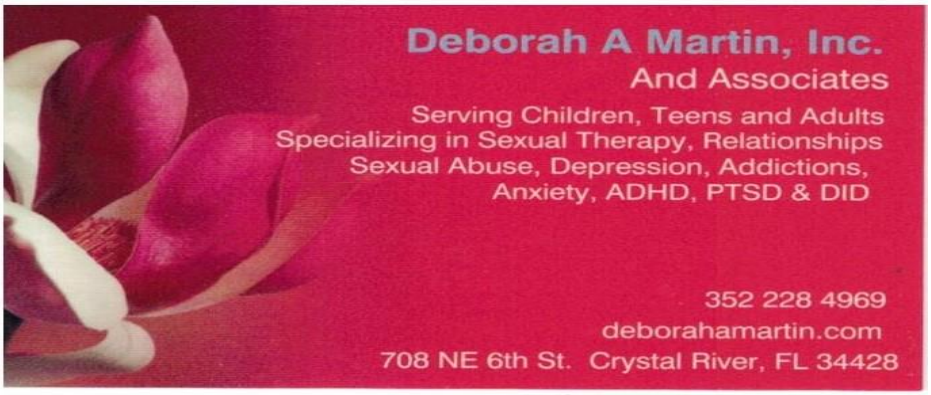
Client Sign in Sheet

DX	Name	Copayment
Date of Service	Signature	Amount



GENERAL INFORMATION

Date:_____

Full Name _____

Name You Prefer: _____

SS #: _____

Date of Birth : _____

Sex: Male Female

Home Phone: (_____)_____

Mobile Phone: (_____)_____

Email Address:_____

Home Address:_____

RELATIONAL INFORMATION

Current Relational Status: Single Dating Engaged Married Separated Divorced Widowed

Partner's Name (if applicable): Mr. Mrs. Ms. Miss _____.

CHILDREN: List Your Children & ages: _____

MEDICAL INFORMATION

Primary Physician: _____

Phone: (_____) _____

Specialty , if applicable (e.g. Psychiatrist, O B/G Y N, Internal Medicine) : _____

Are You Currently Receiving Medical Treatment: Yes No. If Yes, Pease Specify: _____

_____

MEDICATIONS: List All Current Medications & dosage you are taking, including those you take only as needed (Use Back If Necessary) : _____

_____

LEVEL OF DISTRESS Indicate How Distressed You Are by Using the Scale of 1 = Very Little Distress to 1 0 = Extreme Distress: _____

Are You Currently Experiencing Any Suicidal Thoughts: Yes No.

Have You Experienced Them in the Past: Yes No

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling Now (i.e., What Are Your Issues, Problems, concerns)?_____

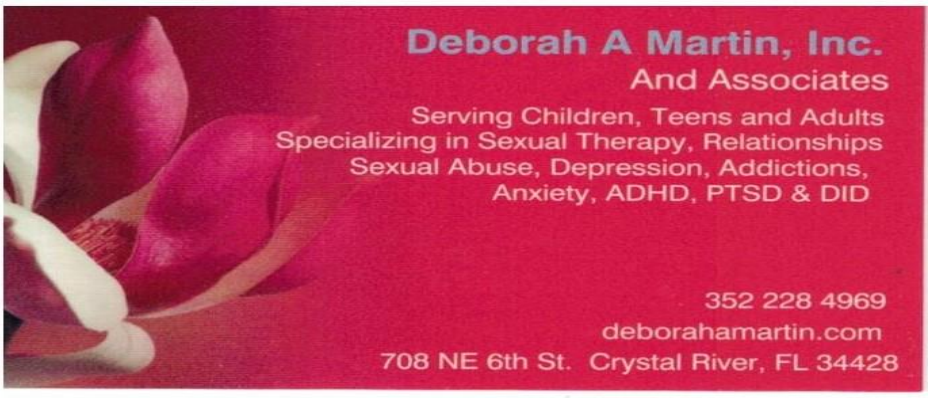
What Do You Hope to Gain or Change by Coming for Counseling?

_____

_____

PREVIOUS COUNSELING: List any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back If Necessary)

Therapist: _____ Location: _____



Client Name:_____ Date:_____

Age:____ Race:____ Weight:____ Height:____ Hair Color:____ Eye Color:_____

Medication Allergies:_____

Food Allergies:_____

Other Allergies:_____

Current Medications (includes over the counter medications):

Name of Medication	Reasons for Medication	Length of Time on Medication

History of Hospitalizations

Date	Reason	Discharge Result

History of Baker Acts/Residential Treatment Facilities:

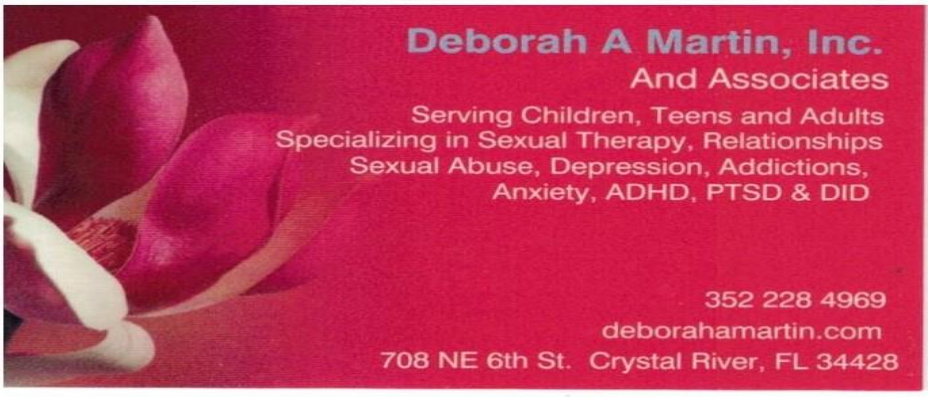
Date	Reason	Discharge Result

Any Nutritional Problems: _____

Any Current Physical Pain Issues: _____

Primary Medical Physician: _____

Last Date of Physical Exam: _____



Client Name:_____ Date:_____

Directions: Please check any symptoms present within the last six months. If parent/caregiver, please check any symptoms present within the last six months for your child/adolescent.

MOOD:

__feeling sad __ Mood swings __negative attitude __ feels worthless

__useless __lack of interest __fatigue __withdrawn

__Hypersensitive __irritable __feels alone with others around __lethargic

__says no good __decrease in activity level __talks about wishing to be dead __ frequently cries

__lonely __easily annoyed __complains no one loves her __feels helpless and or hopeless

__talks about self-harm __ has attempted self-harm __how many times? __number of Baker Acts__

TRAUMA WITNESSED/EXPERIENCED:

___loss of family member __substance abuse/alcohol abuse __kidnapping

__loss of animal __domestic violence __custody dispute

__an accident __neglect __ murder

__natural disaster __sexual abuse __divorce

__physical abuse __sexual assault __removal from caretakers

__violent acts __Medical trauma (amputation) __human trafficking

FEARS:

__being alone __ghosts __crowded places

__someone will harm him/her __nightmares __new conditions

__taking medicine __being trapped __caregivers will leave

__dirt/germs __thunder and lightning __animals

__flashbacks of trauma __trouble sleeping __the dark

__fire __wont sleep alone __people

ANXIETY:

__feeling foolish
__own ability to do things
__something happening at bedtime
__getting harmed
__being teased
__caregivers will leave
__becoming sick
__making mistakes
__what others think about him/her
__family getting sick/harmed
__making right choices
__easily embarrassed
__the future
__needs reassurance
__clingy
__whines
__nervous
__refuses to leave caregivers
__Upsets easily
__difficult to calm down
__excessive worry most of the time

ANGER:

__tantrums
__takes things that are not his/hers
__directs anger at self
__throws things
__uses things without permission
__hurts others feelings
__ breaks things
__gets into physical altercations
__wants revenge
__quickly becomes angry
__verbally aggressive
__regrets actions later
__argumentative

SOMATIC SYMPTOMS (No medical diagnoses have been found):

__Headaches
__stomachaches
__vomiting
__Constipation
__diarrhea
__aches/pains
__ complains to not feel good
__bed wetting
__urination issues (wets self)
__bowel issues (soils self)
__other:_____

SOCIAL SKILLS/SCHOOL:

__Bullied by others
__makes poor social choices
__procrastinates doing homework
__Bullies others
__aggressive to peers
__negative towards authority figures
__Issues with making/keeping friends
__refuses to go to school
__in-school suspensions
__Follower
__makes excuses to not go to school
__indifferent attitude
__Shy
__skips classes
__suspension/expelled
__Not listening/following directions
__failing grades
__other:_____

BEHAVIORAL ISSUES:

__poor hygiene
__obsessive behaviors
__displays promiscuous behaviors
__hoarding
__compulsive behaviors
__poor boundaries with others
__stealing
__physically picks at body parts
__touching own private parts

__uses baby talk
__pulls/plays with hair setting
__touching others private parts
__regression
__blames others for own mistakes
__everything must be perfect
__sucks finger
__denies any wrong doing
__issues with lying
__displays rituals
__chews on clothing
__must be the best
__bites nails
__runs away
__sets fires
__extremely interested in sexual material
__law enforcement issues:_____

ATTENTION SPAN/HYPERACTIVITY:

__distracted
__cannot focus
__excessive noises
__easily frustrated
__cannot concentrate
__cannot complete work
__inattentive
__interrupts frequently
__forgetful
__impulsive actions
__ignores consequence
__requires frequent repetition
__unorganized
__careless
__fidgety
__cannot complete projects/homework/chores
__restless
__fast speech
__overexcited
__demanding
__instantly regrets choices/actions
__robotically driven (two switches on/off)
__loses control of physical self
__not respect others privacy/personal space
__problems listening/following directions

NUTRITIONAL CONCERNS:

__hoarding food
__diarrhea
__wears oversized clothes
__binging
__skipping meals
__weight loss
__throwing up
__loss appetite
__chronic constipation
__body image issues
__excessive exercise
__weight gain

OTHER EMOTIONAL/BEHAVIORAL PROBLEMS: (please explain)

_____

_____

X_____ date: _____ client signature (if minor, Parent/legal guardian/caregiver signature)X_____ date: _____
Therapist signature

Deborah A. Martin, Inc.

Phone: 352-228-4969
Fax: 352-228-8901

THERAPIST NAME	Deborah A Martin	CODE SERVICE FEE
ADDRESS	708 NE 6th Street	__90791
CITY, STATE, ZIP	Crystal River, FL 34428	__90837
OFFICE PHONE #	352-228-4969	__90834
STATE LICENSE #	SW8375	__90832
TAX ID #	800768212	__H2019HR ___ units
PERSONAL NPI#	1083891626	__H0031 HO __H2000 HO
NPI # (ORG)	1629340260	__H0031 HN
Provider:		__H0032

Auth.# _____

CLIENT NAME _____DOB: _____COPAY_____

ADDRESS: _____

Tel#_____SS# _____

INS NAME_____

INS ID# _____

INS ADDRESS _____

INSUREDS NAME AND DOB_____

DOS_____

POS _____11_____

DX: _____

DX: _____

DX: _____

PT SIGNATURE_____ON FILE_____

Deborah Martin, Inc.
Financial Form

Client Name: _____

Facility: _____

Marital Status: _____

Date of Birth: _____

Gender:_____

Primary Insurance **Secondary Insurance**

_____ _____

Name of Company Name of Company (if BC/BS – Which State)

_____ _____

Policy number (including suffix) Policy number

Information given was retrieved from your insurance company, but that information is not a guaranty of payment. Provider of services accepts assignment. **The client will be responsible for any amount not covered by insurance. Initial _____**

Client understands his/her responsibility: __Yes __No

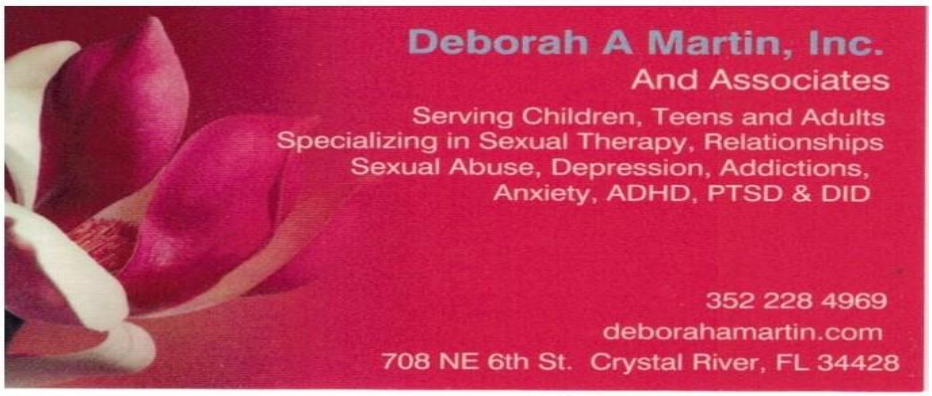
Financially able to make copayment (if any): __Yes __No Copay amount:_____

_____ _____

Clinician's Signature Date

_____ _____

Client's Signature Date



AUTHORIZATION TO DISCLOSE/REQUEST CLIENT INFORMATION

Client Name: _____
SS#:_____ DOB: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone #:_____

I hereby request and authorize: Deborah A. Martin, LCSW

Fax #: _____

To obtain from or release to: _____

_____ (Name, Address, phone #).

The following information from my records: _____

_____

For the purpose of: _____

Form in which information may be released:

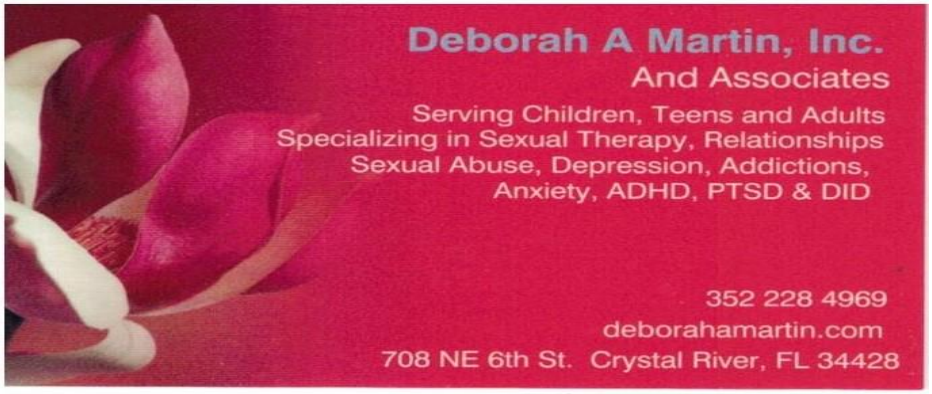
__ Written __Verbal __Audio __Video __Electronic __Photographic

Valid Authorization Dates or Expiration Event/Condition: 1 YEAR FROM SIGNATURE DATE BELOW.

All information I authorize to be obtained from this agency will be strictly confidential and cannot be released by the recipient without my express written consent.

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist/Evaluator Date



GENERAL AUTHORIZATION FOR TREATMENT EXCEPT PSYCHOTROPIC MEDICATIONS

CLIENT'S NAME:_____

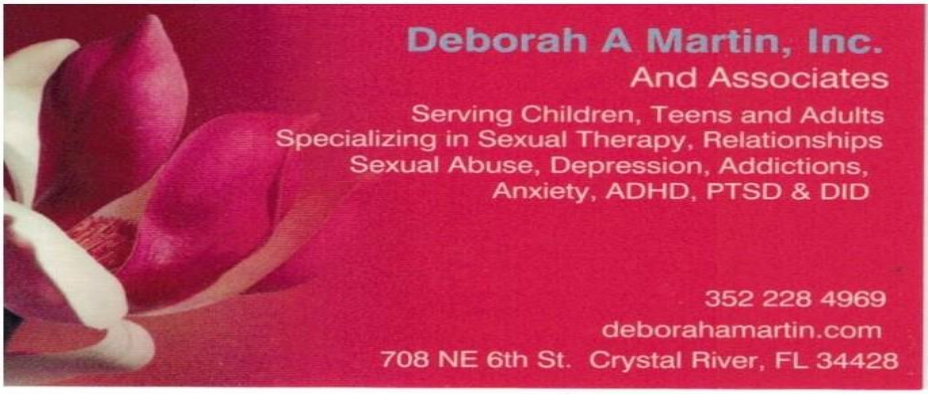
The undersigned a □ client, a □ parent, a □ legal guardian, a □ guardian advocate, or a □ health care surrogate/proxy herby authorize the professional staff of this agency to administer assessments and treatment specified below.

□ Routine medical care_____.
□ Psychiatric assessment_____.
□ School based therapy_____.
□ Individual therapy _____.
□ Video feedback _____.
□ Assessments_____
□ Therapeutic placement_____
□ Family therapy_____
□ Group therapy _____
□ Other (specify & initial) _____
□ Psychiatric evaluation and consultation_____
□ Prescribing of medication (if deemed necessary. Specific authorization for psychotropic medication and informed consent signature page must be completed and signed also). _____
□ Random drug screening (if deemed necessary) _____
□ Initial of patient or authorized decision maker confirms authorization and consent for each treatment.

I understand that more information will be provided to me before my informed consent will be requested for the administration of any psychotropic medications.
I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.
I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment.

_____ _____
Signature of Competent Patient* Date

_____ _____
Signature of Witness Date



Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance use, and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this notice of our legal of our legal duties and privacy practices with respect to that information
(2) We are required to abide by the terms of this notice currently in effect
(3) We reserve the right to change the terms of this notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this notice will be prominently displayed and available at our office

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received a notice of privacy practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or healthcare operations requires you to sign an authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your acknowledgement or authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed acknowledgement that you received this notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

TREATMENT: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may be necessary to share your health information with another healthcare provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

PAYMENT: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health care plan pre-certification and pre-authorization of services, or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

There are certain circumstances under which we may use or disclose your health information without first obtaining your acknowledgement or authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases, or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you

OTHERS INVOLVED IN YOUR HEALTHCARE: Unless you object we may disclose to a member of your family, a close friend, or any other person you identify, your protected health information that directly relates to that persons involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or disclose protected health information to notify or assist in notifying a family member, person representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare

COMMUNICATION BARRIERS AND EMERGENCIES: We may use or disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as responsibly practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to contain your consent, we may still use or disclose your protected health information to treat you

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific authorization which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain rights regarding your health record information, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to your care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for those in a civil, criminal, or administrative action or proceeding to which your access is restricted by law. We will charge a responsible fee for providing a copy of your health records, or a summary of your records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of information

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this notice, must be made in writing and addressed to the privacy officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve month period; however, we will charge you a responsible fee for each subsequent request for an accounting within the same twelve month period.

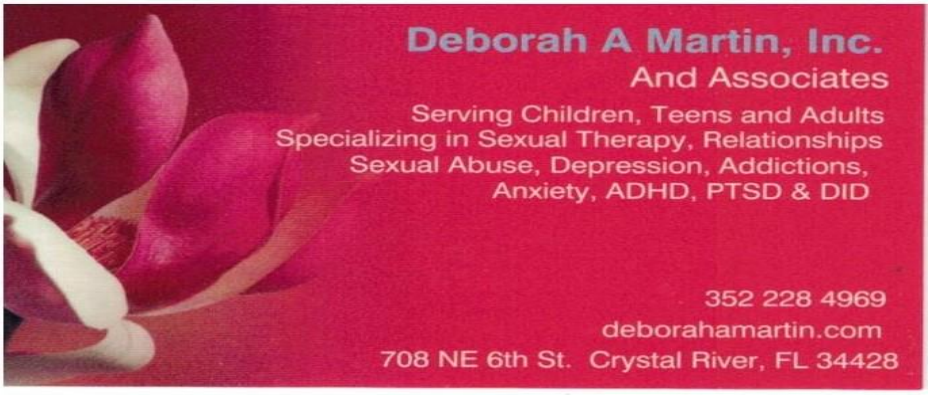
(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish

You may file a written complaint to us or to the secretary of health and human services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the privacy officer (in the case of complaints to us) your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's website, http://www.hhs.gov/ocr/hipaa.

_____

Printed name signature date

Witness signature date



ENROLLEE RIGHTS AND RESPONSIBILITIES STATEMENT

YOU HAVE THE RIGHT TO:

- Be treated with courtesy, respect, and dignity. You have the right to privacy.
- Prompt and fair answers to questions.
- Know who is providing services and who is in charge of your care.
- Know what support services are available and if there are interpreters if you do not speak English.
- Know what rules and regulations apply to how you act.
- Be told what problem you may have, what care is planned, what other kind of care is available, risks and outcomes.
- Refuse care, unless the law says care must be given.
- Tell us if you are not satisfied with anything we have done or said we will not do. These types of concerns or complaints are called Grievances.
- Information and counseling on how to pay for your care, if asked.
- Know before any care is given if the provider or facility takes Medicaid.
- Get an estimate of how much it will cost before care is given, if asked.
- Get a clear and easy to understand bill and have the bill explained to you, if you ask.
- Get help regardless of your race, ethnicity, religion, disability, or how you can pay.
- Help with any emergency problem that will get worse if help is not given.
- Be informed when treatment is for experimental research.
- Opt in or out of the experimental research.
- Get easy to follow information on the care options and what other kinds of care there are for you.
- Take part in decisions about your care. You have the Right to decline care.
- Understand that methods such as seclusion and restraint are not used to make you do something you do not want to do.

YOU ARE RESPONSIBLE FOR:

- Telling your provider, to the best of your ability, everything you know about your problem to include what sicknesses you had in the past, if you have you been in the hospital before, what medication you have taken and/or are taking, and other things about your health.
- Telling your provider about any changes in how you feel.
- Letting your provider know you understand what care you are going to get and that you understand what you are supposed to do to help yourself.
- Making sure you follow your care plan.
- **Not missing appointments and calling 24 hours in advance if you need to reschedule the appointment. After <u>one</u> no show/no call, you will lose your standing appointment. After <u>three</u> no shows/no calls, you will be discharged from this facility. You are responsible for a $25 fee for each missed appointment.**
- What happens if you refuse help or do not follow the care plan.
- Following all rules on patient/client care and conduct.

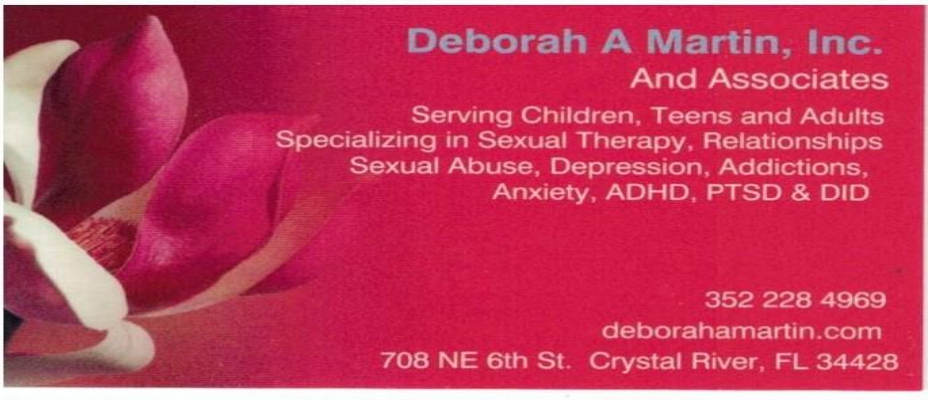
My signature below shows that I have been informed and understand my rights and responsibilities.

_____

Enrollee Signature *Date*

The signature below shows that I have explained this statement to the enrollee and have provided the enrollee a copy of this statement.

_____*Provider Signature* *Date*



INFORMED CONSENT CONTRACT

Confidentiality: Please understand that all records, written information, or any electronic data are marked CONFIDENTIAL and are kept under lock and key.

I am required by law to report:
--threats of harm to another or oneself
--domestic violence
--child or elder abuse, neglect or exploitation

Permission to treat: I acknowledge that it is my choice to participate in psychotherapy services
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient and the particular problems you are experiencing. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part, in order for the therapy to be most successful. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant parts of your life, you may temporarily experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.
Our first few sessions will involve an evaluation of your needs and requests. 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. You have the right to participate in your treatment plan and review or revise it at any time.

Therapy sometimes involves a large commitment of time, money and energy so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. You may withdraw consent at any time simply by informing me.

Before you sign below, please ask any questions you may have of this document. **Your signature acknowledges agreement and understanding:**

_____ _____

Signature of client **Date**

_____ _____

Signature of Therapist/Evaluator **Date**