

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 10 = Extreme Distress: _____

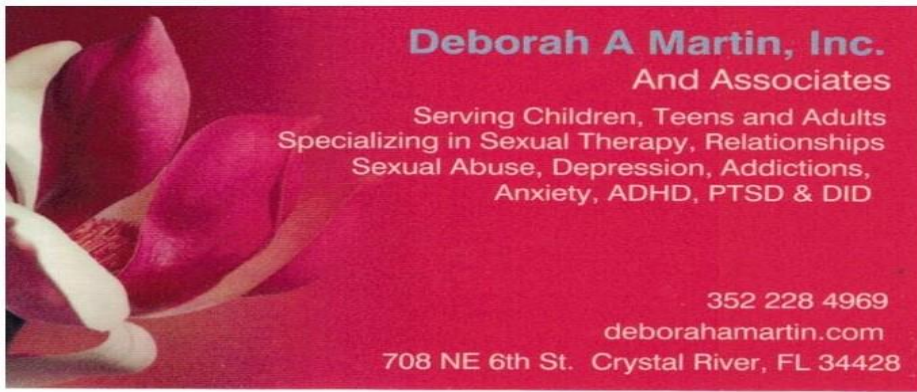
Are You Currently Experiencing Any Suicidal Thoughts: Yes No.
Have You Experienced Them in the Past: Yes No

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:

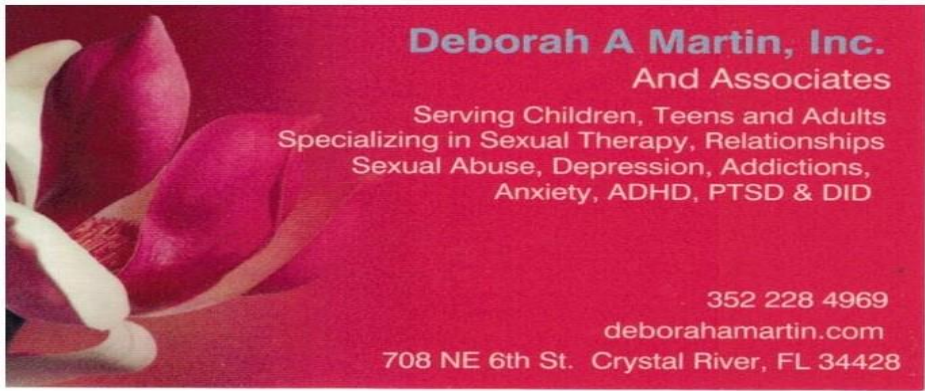
Date	Reason	Discharge Result

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:

- | | | |
|---|---|---|
| <input type="checkbox"/> feeling foolish | <input type="checkbox"/> own ability to do things | <input type="checkbox"/> something happening at bedtime |
| <input type="checkbox"/> getting harmed | <input type="checkbox"/> being teased | <input type="checkbox"/> caregivers will leave |
| <input type="checkbox"/> becoming sick | <input type="checkbox"/> making mistakes | <input type="checkbox"/> what others think about him/her |
| <input type="checkbox"/> family getting sick/harmed | <input type="checkbox"/> making right choices | <input type="checkbox"/> easily embarrassed |
| <input type="checkbox"/> the future | <input type="checkbox"/> needs reassurance | <input type="checkbox"/> clingy |
| <input type="checkbox"/> whines | <input type="checkbox"/> nervous | <input type="checkbox"/> refuses to leave caregivers |
| <input type="checkbox"/> Upsets easily | <input type="checkbox"/> difficult to calm down | <input type="checkbox"/> excessive worry most of the time |

ANGER:

- | | | |
|--|---|--|
| <input type="checkbox"/> tantrums | <input type="checkbox"/> takes things that are not his/hers | <input type="checkbox"/> directs anger at self |
| <input type="checkbox"/> throws things | <input type="checkbox"/> uses things without permission | <input type="checkbox"/> hurts others feelings |
| <input type="checkbox"/> breaks things | <input type="checkbox"/> gets into physical altercations | <input type="checkbox"/> wants revenge |
| <input type="checkbox"/> quickly becomes angry | <input type="checkbox"/> verbally aggressive | <input type="checkbox"/> regrets actions later |
| <input type="checkbox"/> argumentative | | |

SOMATIC SYMPTOMS (No medical diagnoses have been found):

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> stomachaches | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> aches/pains |
| <input type="checkbox"/> complains to not feel good | <input type="checkbox"/> bed wetting | <input type="checkbox"/> urination issues (wets self) |
| <input type="checkbox"/> bowel issues (soils self) | <input type="checkbox"/> other: _____ | |

SOCIAL SKILLS/SCHOOL:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bullied by others | <input type="checkbox"/> makes poor social choices | <input type="checkbox"/> procrastinates doing homework |
| <input type="checkbox"/> Bullies others | <input type="checkbox"/> aggressive to peers | <input type="checkbox"/> negative towards authority figures |
| <input type="checkbox"/> Issues with making/keeping friends | <input type="checkbox"/> refuses to go to school | <input type="checkbox"/> in-school suspensions |
| <input type="checkbox"/> Follower | <input type="checkbox"/> makes excuses to not go to school | <input type="checkbox"/> indifferent attitude |
| <input type="checkbox"/> Shy | <input type="checkbox"/> skips classes | <input type="checkbox"/> suspension/expelled |
| <input type="checkbox"/> Not listening/following directions | <input type="checkbox"/> failing grades | <input type="checkbox"/> other: _____ |

BEHAVIORAL ISSUES:

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> poor hygiene | <input type="checkbox"/> obsessive behaviors | <input type="checkbox"/> displays promiscuous behaviors |
| <input type="checkbox"/> hoarding | <input type="checkbox"/> compulsive behaviors | <input type="checkbox"/> poor boundaries with others |
| <input type="checkbox"/> stealing | <input type="checkbox"/> physically picks at body parts | <input type="checkbox"/> touching own private parts |

- | | | |
|--|---|--|
| <input type="checkbox"/> uses baby talk | <input type="checkbox"/> pulls/plays with hair setting | <input type="checkbox"/> touching others private parts |
| <input type="checkbox"/> regression | <input type="checkbox"/> blames others for own mistakes | <input type="checkbox"/> everything must be perfect |
| <input type="checkbox"/> sucks finger | <input type="checkbox"/> denies any wrong doing | <input type="checkbox"/> issues with lying |
| <input type="checkbox"/> displays rituals | <input type="checkbox"/> chews on clothing | <input type="checkbox"/> must be the best |
| <input type="checkbox"/> bites nails | <input type="checkbox"/> runs away | <input type="checkbox"/> sets fires |
| <input type="checkbox"/> extremely interested in sexual material | <input type="checkbox"/> law enforcement issues: _____ | |

ATTENTION SPAN/HYPERACTIVITY:

- | | | |
|--|--|--|
| <input type="checkbox"/> distracted | <input type="checkbox"/> cannot focus | <input type="checkbox"/> excessive noises |
| <input type="checkbox"/> easily frustrated | <input type="checkbox"/> cannot concentrate | <input type="checkbox"/> cannot complete work |
| <input type="checkbox"/> inattentive | <input type="checkbox"/> interrupts frequently | <input type="checkbox"/> forgetful |
| <input type="checkbox"/> impulsive actions | <input type="checkbox"/> ignores consequence | <input type="checkbox"/> requires frequent repetition |
| <input type="checkbox"/> unorganized | <input type="checkbox"/> careless | <input type="checkbox"/> fidgety |
| <input type="checkbox"/> cannot complete projects/homework/chores | <input type="checkbox"/> restless | <input type="checkbox"/> fast speech |
| <input type="checkbox"/> overexcited | <input type="checkbox"/> demanding | <input type="checkbox"/> instantly regrets choices/actions |
| <input type="checkbox"/> robotically driven (two switches on/off) | <input type="checkbox"/> loses control of physical self | |
| <input type="checkbox"/> not respect others privacy/personal space | <input type="checkbox"/> problems listening/following directions | |

NUTRITIONAL CONCERNS:

- | | | |
|--|---|--|
| <input type="checkbox"/> hoarding food | <input type="checkbox"/> diarrhea | <input type="checkbox"/> wears oversized clothes |
| <input type="checkbox"/> bingeing | <input type="checkbox"/> skipping meals | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> throwing up | <input type="checkbox"/> loss appetite | <input type="checkbox"/> chronic constipation |
| <input type="checkbox"/> body image issues | <input type="checkbox"/> excessive exercise | <input type="checkbox"/> 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 6 th 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

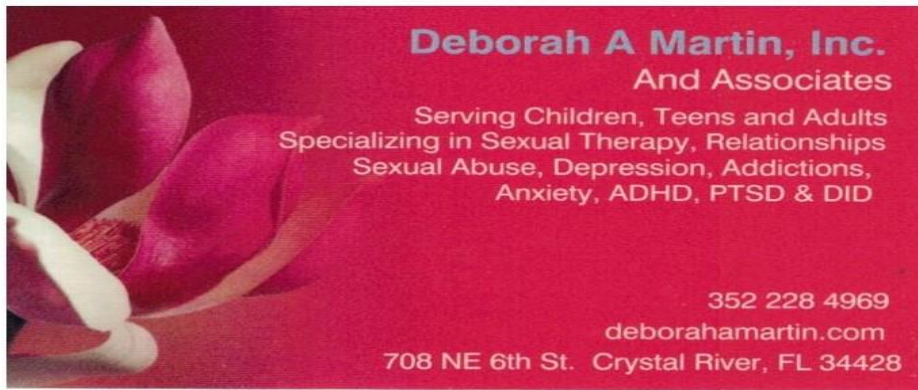
Financially able to make copayment (if any): __Yes __No Copay amount: _____

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.

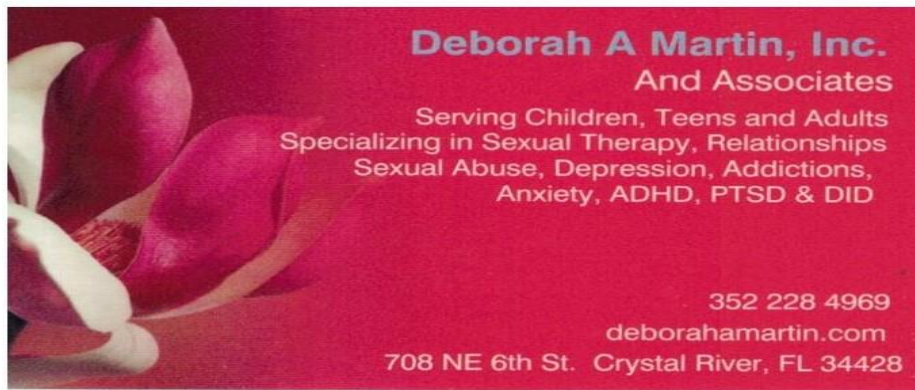
All information I authorize to be obtained from this agency will be strictly confidential and cannot be released by the recipient without my express written consent.

Signature of Client

Date

Signature of Therapist/Evaluator

Date



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

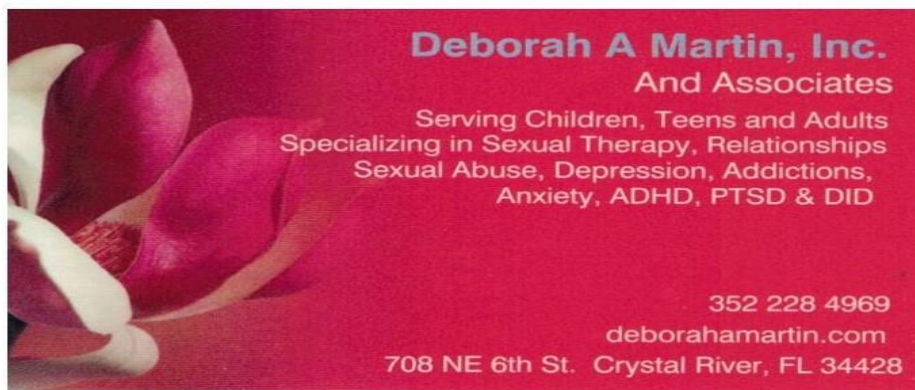
signature

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 one no show/no call, you will lose your standing appointment. After three 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.

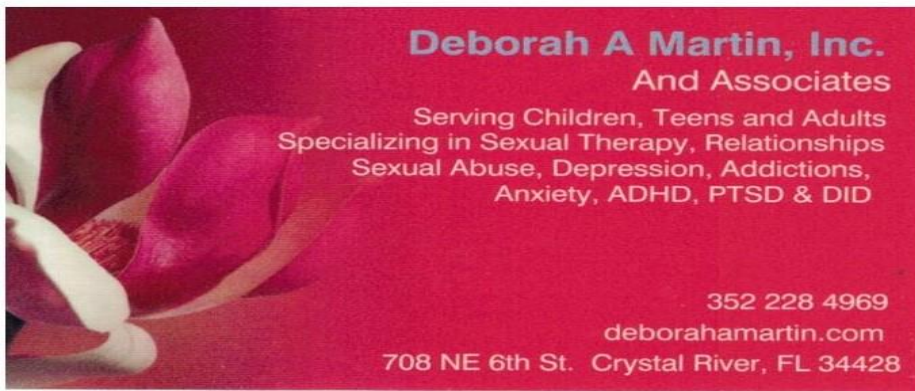
Enrollee Signature

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