



CLIENT REGISTRATION INFORMATION

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Email Address _____

Social Security # _____ Age _____ Date of Birth _____

If minor (under age 18) please write name of legal guardian _____

Male _____ Female _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Preferred method of contact: ___ Home ___ Work ___ Mobile

Relationship to insured: ___ Self ___ Spouse ___ Child ___ Other

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Other

Employment Status: ___ Employed ___ Full-time Student ___ Part-time Student

Children _____ Ages _____

Emergency Contact Name _____ Phone _____

PARENT/GUARDIAN'S INFORMATION (if different from above)

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Social Security# _____

Employer/School _____

Home Phone _____ Work Phone _____

Caseworker's Name _____ Phone _____

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
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Witness	signature	date
---------	-----------	------

Client Name _____ Date _____

Age ___ Race ___ Wt ___ Ht ___ Hair Color _____ Eye Color _____

Medication Allergies _____

Food 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

Primary Physician _____ Phone _____

Are you currently/or have ever seen a Psychiatrist ___ No ___ Yes – Date _____ Reason for visit _____.

LEVEL OF DISTRESS Indicate How Distressed You Are by Using the Scale of 1 = Very Little Distress 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)? _____

Client Name _____ Date _____

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: _____

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:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> feeling sad | <input type="checkbox"/> Mood swings | <input type="checkbox"/> negative attitude | <input type="checkbox"/> feels worthless |
| <input type="checkbox"/> useless | <input type="checkbox"/> lack of interest | <input type="checkbox"/> fatigue | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> Hypersensitive | <input type="checkbox"/> irritable | <input type="checkbox"/> feels alone with others around | <input type="checkbox"/> lethargic |
| <input type="checkbox"/> says no good | <input type="checkbox"/> decrease in activity level | <input type="checkbox"/> talks about wishing to be dead | <input type="checkbox"/> frequently cries |
| <input type="checkbox"/> lonely | <input type="checkbox"/> easily annoyed | <input type="checkbox"/> complains no one loves her | <input type="checkbox"/> feels helpless and or hopeless |
| <input type="checkbox"/> talks about self-harm | <input type="checkbox"/> has attempted self-harm | <input type="checkbox"/> how many times? | <input type="checkbox"/> number of Baker Acts |

TRAUMA WITNESSED/EXPERIENCED:

- | | | |
|--|--|--|
| <input type="checkbox"/> loss of family member | <input type="checkbox"/> substance abuse/alcohol abuse | <input type="checkbox"/> kidnapping |
| <input type="checkbox"/> loss of animal | <input type="checkbox"/> domestic violence | <input type="checkbox"/> custody dispute |
| <input type="checkbox"/> an accident | <input type="checkbox"/> neglect | <input type="checkbox"/> murder |
| <input type="checkbox"/> natural disaster | <input type="checkbox"/> sexual abuse | <input type="checkbox"/> divorce |
| <input type="checkbox"/> physical abuse | <input type="checkbox"/> sexual assault | <input type="checkbox"/> removal from caretakers |
| <input type="checkbox"/> violent acts | <input type="checkbox"/> Medical trauma (amputation) | <input type="checkbox"/> human trafficking |

FEARS:

- | | | |
|--|--|--|
| <input type="checkbox"/> being alone | <input type="checkbox"/> ghosts | <input type="checkbox"/> crowded places |
| <input type="checkbox"/> someone will harm him/her | <input type="checkbox"/> nightmares | <input type="checkbox"/> new conditions |
| <input type="checkbox"/> taking medicine | <input type="checkbox"/> being trapped | <input type="checkbox"/> caregivers will leave |
| <input type="checkbox"/> dirt/germs | <input type="checkbox"/> thunder and lightning | <input type="checkbox"/> animals |
| <input type="checkbox"/> flashbacks of trauma | <input type="checkbox"/> trouble sleeping | <input type="checkbox"/> the dark |
| <input type="checkbox"/> fire | <input type="checkbox"/> wont sleep alone | <input type="checkbox"/> people |

Deborah A Martin, Inc. 708 NE 6th St, Crystal River, Fl. 34428, Phone: (352) 228-4969 Fax: (352) 228-8901

Client Name _____ Date _____

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: _____ |

Client Name _____ Date _____

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 | |

Client Name _____ Date _____

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 _____

Signature (if minor, legal guardian)

X _____ Date _____

Signature of Provider

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. If you cancel or reschedule more than (3) appointments, it is as the discretion of your therapist to discharge you for lack of commitment to treatment. 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.

Client Signature

Date

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

Provider Signature

Date

Deborah A Martin, Inc.

708 NE 6th Street

Crystal River, Fl. 34428

Phone: (352) 228-4969

Fax: (352) 228-8901

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

FINANCIAL/INSURANCE AGREEMENT

AGENCY/INSURANCE INFORMATION (if applicable)

Primary Insurance Carrier Name _____ Insured's Policy# _____

Subscriber Name _____ Subscriber Date of Birth _____

Co-Pay amount _____ Authorization# _____ Number of Visits _____ Date _____

Secondary Insurance ___ No ___ Yes

Secondary Insurance Carrier Name (if applicable) _____ Insured's Policy# _____

Subscriber Name _____ Subscriber Date of Birth _____

*****A copy of your insurance card(s) are needed at the time of service. Please read following carefully and sign below.***

Assignment of Benefits and Release of Information

I give permission to Deborah A Martin, Inc. and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will be responsible for any unpaid balances including copayments, deductibles, and non-covered services. **I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed \$25.00. I understand that my insurance or EAP does not cover the cost of missed visits.**

Information given was retrieved from your insurance company, that information is NOT a guarantee 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: _____

Signature of Responsible Party

Date

Witness

Date

