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Copy of Standard Intake Questionnaire 1

Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms

(check all that apply)

- [ ] Anxiety
- [ ] Appetite Issues
- [ ] Avoidance
- [ ] Crying Spells
- [ ] Depression
- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Guilt
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes
- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

- [ ] Alcohol
- [ ] Tobacco
- [ ] Marijuana
- [ ] Hallucinogens (LSD)

- [ ] Heroin
- [ ] Methamphetamines
- [ ] Cocaine
- [ ] Stimulants (Pills)
- [ ] Ecstasy
- [ ] Methadone
- [ ] Tranquilizers
- [ ] Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want the doctor to know?:

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Telehealth Treatment Consent

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.

Client Consent

Client Name:

☐ I hereby give my informed consent for the use of telemental health in my care.

Client Initials:

Date of Birth:

Email:

Phone Number:

Client Signature:

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Release of Information: HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date:

I. The Patient

This form is for use when such authorization is required and complies with the Health Insurance Portability Act of 1996 (HIPPA) Privacy Standards.

Client Full Name:

Client Date Of Birth:

Client ID Number:

SSN:

II. Authorization

I authorize [Agency/Provider Name] to use or disclose the following: (check one)

- ☐ All of my medical-related information
- ☐ My medical information ONLY related to a specific diagnosis. (complete sentence below)

My medical information only related to:

- ☐ My medical-related information in a specified date range. (enter date range below)

Enter date range:

- ☐ Other (please explain below)

Please explain other:

III. Disclosure

The Authorized Party has my authorization to disclose Medical Records to: (check one)

- ☐ Any party that is approved by the Authorized Party.
- ☐ Only the following party (enter details below)

Name:

Address:

Phone Number:

Fax Number:

Email Address:

IV. Purpose

The reason for this authorization is: (check one)

- [ ] General Purpose at my request (general)
- [ ] To receive payment. To allow the authorized party to communicate with me for marketing purposes when they receive payment from a third party.
- [ ] To sell my medical records. To allow the Authorized Party to sell my medical records. I understand that the Authorized Party will receive compensation for the disclosure of my medical records and will stop any future sales if I revoke this authorization.
- [ ] Other (please explain below)

Explain other:

V. Termination

The authorization will terminate: (check one)

- [ ] Upon sending a written revocation to the Authorized Party
- [ ] On the following date: (enter below)

Date:

- [ ] Other (please explain below)

Explain Other:

VI. Additional Consent for Certain Conditions

Sensitive information. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

Check One

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

VII. Acknowledgement of Rights

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient (if filling out electronically, type your name, you will have the opportunity to sign at the end):

Client Full Name:

If the patient is unable to sign use the signature area below

The patient is unable to sign due to (check one)

☐ Being a Minor (complete the statement below)

The Patient is _____ years old and considered a minor under state law:

☐ Being Incapacitated (please explain below)

Patient is incapacitated due to:

☐ Other (please explain below)

Signature of Representative (if filling out electronically, type your name, there will be an option to sign at the end):

Date:

Printed Name of Representative:

Relationship to Patient (check one)

- [ ] Parent
- [ ] Guardian
- [ ] Spouse
- [ ] Other (please explain below)

Explain other:

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Good Faith Estimate

Good Faith Estimate for Health Care Items and Services

Patient Information

Client Full Name:

Client Date Of Birth:

Client ID Number:

Client Address:

Client Email:

Client Mobile Phone Number:

Patient's Contact Preference:

Patient Diagnosis

Primary Service or Item Requested/Scheduled:

Client Diagnosis:

If scheduled, list the date(s) the Primary Service or Item will be provided:

☐ Check this box if the service or item is not yet scheduled.

Date of Good Faith Estimate:

Provider Name:

Estimated Total Cost:

The following is a detailed list of expected charges for the Service or Item listed above scheduled for the above date. The estimated costs are valid for 90 days from the date of the Good Faith Estimate.

Service/Treatment Estimate

Provider/Facility Name:

Provider/Facility Type:

Street Address:

City:

State:

Zip Code:

Phone Number:

NPI:

TIN:

Details of Services and Items

Service/Item:

Address where service/item will be provided:

Diagnosis Code:

Service Code:

Quantity:

Expected Cost:

Additional Health Care Provider/Facility Notes:

Total Estimated Cost for All Services and Items:

Disclaimer:
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute

(appeal) the bill. This estimate does not take into consideration the client's insurance deductible, co-payment, or coinsurance amounts.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to
www.cms.gov/nosurprises/consumers or call 1-800-985-3059.
For questions or more information about your right to a Good Faith Estimate
or the dispute process, visit www.cms.gov/nosurprises/consumers or call
1-800-985-3059.

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Credit / Debit Card Payment Consent

Client name:

(Card holder) Name on card if different than client:

Card Type:

Last 4 digits of card number:

Expiration Date :

I authorize The Coffey Table Counseling to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that Camille Coffey will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature:

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Copy of Informed Consent for Psychotherapy 1

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:
1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

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Copy of PHQ-9 Questionnaire 1

The Patient Health Questionnaire 9 (PHQ-9)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:

2. Feeling down, depressed or hopeless:

3. Trouble falling asleep, staying asleep, or sleeping too much:

4. Feeling tired or having little energy:

5. Poor appetite or overeating:

6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down:

7. Trouble concentrating on things, such as reading the newspaper or watching television:

8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual:

9. Thoughts that you would be better off dead or of hurting yourself in some way:

Questionnaire Score

Add up all the numbers for answers 1-9 above.

Total Score:

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?: