TALLAHASSEE COUNSELING CENTER

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Client Information

All information given on this form is 100% confidential

Name: _____ Date of Birth: ____/____/_____Today's Date: ____/____/_____

Gender (circle): Male Female Other: _____

Marital Status: Single Married Divorced Separated Other: _____

Primary Care Physician: _____ Psychiatrist: _____

E-mail Address: _____ Social Security #:_____-_____-_____

Phone Numbers: (cell) _____-_____-_____ (work) _____-_____-_____ (home) _____-_____-_____

Preferred Contact: ( ) Cell Phone ( ) Work ( ) Home ( ) E-mail

Address: _____ City: _____ Zip: _____

Employer: _____ School (if applicable): _____

Insurance Information:

Primary Insurance Coverage

Ins. Company Name: _____ Member ID #: _____

Ins. Company Address: _____ Group #: _____

Primary Insured Name: _____ Primary's DOB: _____/_____/_____

Primary's Address: _____ City: _____ Zip: _____

Primary Insured Place of Employment: _____ Primary's Cell: _____-_____-_____

Secondary Insurance Coverage

Ins. Company Name: _____ Member ID #: _____

Ins. Company Address: _____ Group #: _____

Primary Insured Name: _____ Primary's DOB: _____/_____/_____

Primary's Address: _____ City: _____ Zip: _____

Primary Insured Place of Employment: _____ Primary's Cell: _____-_____-_____

Please initial the following items after reading:

____ All co-payments / payments are due at the time services are rendered.

_____ I acknowledge that I have been given access to Tallahassee Counseling Center Notice Of Privacy Policies and that I *may request* to keep a paper copy of this Notice of Privacy Policies

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

List your goals for treatment:

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Increased irritability
( ) Change in Libido
( ) Social Anxiety
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Hallucinations
( ) Decrease need for sleep
( ) Excessive energy
( ) Fatigue
( ) Headaches
( ) _____
( ) Excessive worry
( ) Anxiety/Panic attacks
( ) Avoidance
( ) Stress
( ) Suspiciousness
( ) Excessive guilt
( ) Crying spells
( ) Financial Problems
( ) _____

List ALL current prescriptions:

Medication Name:	Daily Dosage:	Estimated Start Date:	Prescribed by:

1._____

2. _____

3. _____

4. _____

5. _____

6. _____

How many days per week do you drink alcohol? _____

How many drinks will you typically have in a day? _____

Do you think you have a problem with alcohol consumption or drug use? ( ) Yes ( ) No

Do you use recreational drugs? ( ) Yes ( ) No. If yes, please list.

_____

How many caffeinated beverages do you drink per day? Coffee _____ Sodas _____ Tea _____

Do you exercise regularly? ( ) Yes ( ) No ( ) Occasionally

Have you ever had thoughts of suicide or self harm? ( ) Yes ( ) No

Do you *currently* feel that you don't want to live? ( ) Yes ( ) No

History

Were you adopted? ( ) Yes ( ) No

Who would you consider was your primary caregiver(s)? _____

Place of Birth: _____ Where did you grow up? _____

Did your parents get divorced? ( ) Yes ( ) No If yes, how old were you when they divorced? _____

Has there been a significant death in your family? Briefly describe.

_____

_____

Have you ever been abused emotionally, sexually, physically, verbally or by neglect? ( ) Yes ( ) No

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, which substance(s)? _____

Is there a history of mental illness in your family? If yes, list family member(s) and the illness(es):

_____

_____

_____

Have you ever been hospitalized for psychiatric reasons? If yes, explain. ( ) Yes ( ) No

_____

_____

What was the highest level of education you completed? _____

Is religion/spirituality important to you? ( ) Yes ( ) No If yes, briefly describe: _____

Would incorporating religion/spirituality be helpful to your treatment? ( ) Yes ( ) No

Treatment Needs

Briefly describe any previous therapy experience.

_____

_____

Have you ever had a negative experience with therapy? ( ) Yes ( ) No.

What are activities or situations that make you feel calm/relaxed? _____

_____

Circle the personal attributes that you feel you exhibit:

Adventurous	Achiever	Artistic	Aggressive	Anxious
Close-minded	Complainer	Cynical	Confident	Communicative
Caring	Determined	Fearful	Focused	Greedy
Helpful	Inspired	Intelligent	Impatient	Impulsive
Insensitive	Irresponsible	Lazy	Motivated	Moody
Negative	Open-Minded	Outgoing	Organized	Positive
Reckless	Responsible	Short-tempered	Strategic	Sociable

Please list any additional strengths or weaknesses that are not listed:

_____

_____

_____

Is there is anything else you'd like your therapist to know?

_____

_____

_____

_____

_____

_____

Consent for Treatment, Uses, and Disclosures

During the course of providing treatment to you, there may be times when it will be necessary to use or disclose your protected health information (PHI) to carry out treatment, obtain/receive payment, or perform other health care operations on your behalf. This consent signifies your permission for us to use your PHI for these purposes. Some examples of these uses of your information include:

- Billing/ receiving payment from insurance companies for services provided to you
- Obtaining pre-authorizations for treatment or determining your coverage under a health plan
- Sharing information between practitioners here at the office to provide you with optimum mental health treatment

The Health Insurance Portability and Accountability Act of 1996 defines your protected health information (PHI) as health information, including personal information, that is created or received by us concerning you and that relates to your past, present, or future physical or mental health condition, or payment for health care, and that identifies or can be used to identify you. The terms use or disclosure, refer to the release, transfer, provision of access to, or divulging of information outside of this office. A full description of instances involving disclosure and of other terms used in this consent can be found in our Notice of Privacy Practices, which is posted here in the office. You can obtain a written copy for your review. We reserve the right to change the terms of this Notice of Privacy Practices at any time and will provide you with a copy of the revised Notice upon your request. You have the right to review our Notice of Privacy Practices, before signing this consent.

Under this same Act, there are a number of rights to which you are entitled concerning your protected health information. You have the right to restrict how your protected health information is disclosed including having it be disclosed by alternative means other than those we would normally use. We are not required to agree with your restrictions, but will consider your requests as binding in the event that we should agree to them.

You also have the right to revoke this consent at any time, but must do so in writing. We are not responsible for actions or disclosures taken during the effective time of this consent and any service costs incurred while this consent is active, are subject to payment. Additionally, we may refuse treatment to you, if you do not agree to this consent, and in the event that you revoke this consent, we have the right to discontinue further treatment.

Our policies concerning the protection of your health information have always been to take every safeguard possible in protecting your health information. We consider your information as private and take every necessary precaution to see that it is protected.

Your signature below indicates that you have given permission to receive therapeutic treatment from Tallahassee Counseling Center and you understand the information provided above.

Signature: _____ Date: _____

No Show & Late Cancellation Policy

You may request a copy of this policy for your records.

When appointments are scheduled for you, we offer you an appointment card/print-out of upcoming appointments (if you are in the office) and provide you with the opportunity to participate in our courtesy appointment reminder service. After you have scheduled an appointment, it is your responsibility to remember the appointment.

Our office operates on a pre-determined appointment schedule. When a patient does not show up for their scheduled visit, or does not provide adequate notice (preferably 24 hours, but no later than 2:00 PM on the business day prior to a scheduled appointment) of a cancellation of their scheduled appointment, they are depriving another patient of the opportunity to be seen by our office. Furthermore, we cannot bill insurance for appointments not kept.

If you need to cancel an appointment, please contact our office immediately. Failure to call the business day before your appointment, or failure to show up to your appointment will result in the following fee:

- **Late Cancellation & No Show Fee $50.00**

Depending on your Late Cancellation and No Show history with our office, you may be asked to pay all outstanding balances/fees prior to our office rescheduling your missed appointment. We also reserve the right to terminate treatment with you, should your history of late cancellations and no shows become excessive.

I, _____, have read and understand the above policy. Furthermore, I agree to act in accordance with this policy and accept financial responsibility in the event I do not adhere to the guidelines outlined above.

Signature: _____ Date: _____

Medical Disclosure/Release of Information Authorization

Clients that provide us with permission to contact their primary care physician will have a form sent to their doctor indicating that contact has been made at our office. Diagnosis information may also be released to the physician. By signing below, you give us permission to inform your doctor of your mental health.

I, _____, authorize Tallahassee Counseling Center to discuss treatment and release confidential medical information, including psychiatric records to the following parties:

- Primary Care Physician (PCP): _____
- Other: _____

This authorization will remain active unless revoked in writing by me. I understand that once our protected health information is disclosed, it is no longer considered protected and parties to whom this information is released may choose to further disclose this information. I agree that Tallahassee Counseling Center is not responsible for disclosures made pursuant to this authorization.

Signature: _____ Date: _____

Courtesy Appointment Reminder Service

In order to serve you better, Tallahassee Counseling Center offers a free courtesy appointment reminder service. This means that the business day prior to your appointment, you will receive a phone call, text, or e-mail reminding you of your scheduled appointment.

If you want to keep your appointment, you do not have to call/text/e-mail us back. If we do not hear from you, we assume you are keeping your appointment. However, it is imperative that you respond accordingly if you need to cancel or reschedule the appointment to avoid the Late Cancel/No Show fees.

You may call our office at 850-385-9046 at any time, if you have questions regarding your scheduled appointments or if you believe you have an appointment and do not receive a reminder call/text/e-mail.

Please remember that this service is provided free of charge, however, you are still held responsible for the appointments you schedule. Failure to receive a courtesy reminder call, text, or e-mail due to technical issues does not excuse you from fees associated with any missed appointments.

Patient's Name: _____

I prefer my appointment reminders via (please only select ONE):

___ Text Number: (____) _____-_____

___ Phone Number: (____) _____-_____ Select: ___ cell ___ home *Please do not leave a work number*

___ E-mail: _____

___ I choose to OPT OUT of appointment reminders & I will not receive a reminder call/e-mail

By signing below, I acknowledge that I am responsible for keeping track of my appointments. Reminders are provided as a courtesy to me. Any fees associated with any missed appointments are my responsibility.

Signature: _____ Date: _____