Date: ______________

PSI Client Information Form

Client Name: ________________________________ Sex: M F Date of Birth: ________________

Client Address: ____
Street City State Zip Code

May we correspond by email? Y N Email address: ______________________________________

Client Home Phone:______________Daytime Phone:_______________Cell Phone:______________

Marital Status: Single Married Divorced Domestic Partner Widowed

Client SSN: __________________________

Person filling out form, if not client: ___________________________ Relationship to client: ________

Primary Care Physician: ___________________________________ Phone: ____________________

Emergency Contact: ______________________________________ Phone: ____________________

Please fill out all of the following information even if a copy of your insurance card is attached:

Primary Insurance: _____________________________________ Phone: ____________________

Authorization #: _______________________ Policy Holder SSN: _____________________________

Insurance Billing Address: ____
Name of Policy Holder Exactly as It
Appears on the Card: ___________________________________ Date of Birth: _________________

Policy Holder I.D. #: _____________Group #: _____________ Group Name: ___________________

Policy Holder Mailing Address (if different from client's): ___________________________________

Policy Holder Phone: ____________________________ Relationship to Client: __________________

Cash Pay: Yes No **EAP**: _________________________ EAP Authorization #: _______________

Are you involved in any legal proceedings (e.g. Worker's Compensation Claim, child custody dispute, etc) which may involve your therapist? Yes No If yes, please describe:
____

____

How did you hear about PsychStrategies, or who referred you to us? _____________________________
I authorize my insurance carrier to pay PsychStrategies (please sign):

____

For Clinician use Only *(please print)*

Clinician Name: ____________________________ # _____ Dx: _______ Copay due/session: ________

PsychStrategies

Client History, Concerns and Goals

Name of Client:____ Date: ________________________

(If you have come for Couples Therapy, please fill out one form for each partner.)

Filled out by: _____________________________ Relationship to Client: ________________________

Please fill in the following information as completely as possible. All information is covered by our confidentiality policy (see attached office policies). **Use the back of form as necessary.**

1) Describe what has happened recently that led you to seek counseling now. ___________________________

____

____

____

2) Describe current concerns and symptoms. ____

____

____

3) Check the one response which best applies:

(A) My current concerns and symptoms are:

- ☐ the continuation of a long-standing condition
- ☐ a recent worsening of an on-going condition
- ☐ the reoccurrence of a previous condition
- ☐ significantly different from any previous condition
- ☐ my first occurrence of any condition

(B) My current symptoms developed:

- ☐ suddenly (less than four weeks)
- ☐ gradually (one to several months)
- ☐ very gradually (one to several years)

4) **Medical History.** Please list major injuries, illnesses or surgeries.

Condition	Dates	Treatment

5) Are you currently on any medication? ☐ yes ☐ no

Medication	Dosage	Prescribing Physician	Date Started

Allergies/Sensitivities to medications ____

6) Any psychiatric medications you have taken in the past (and are not currently taking):

Medication	Dosage	Prescribing Physician	Date Started

7) Please indicate any significant prenatal events and developmental history. ____________________________

____

8) Please list other substances that you use. *Include amount and frequency.*

Alcohol ______________________ Heroin ______________________
Marijuana ______________________ Psychedelics______________________
Caffeine ______________________ Methamphetamine ______________________
Tobacco (cigarettes, etc.) ______________________ Other ______________________

9) Have you been in psychotherapy or been hospitalized in a psychiatric facility? (Please list names of past therapists and hospitalizations, dates, and reason for treatment.) ______________________

____

____

10) Has anyone in your immediate or extended family had a psychiatric illness? Please list relationship and nature of illness. ______________________

____

11) Spouse/Significant Other: ______________________ Age: ______________________
Children (Please list names and ages): ______________________
Parents (Please list names and ages): ______________________
Describe your current family situation and relationship history.

____

____

12) Education: ______________________

13) Current employment and work history (summary). ______________________

____

____

14) Describe your relationship within your family of origin. Include parental substance abuse issues as well as other relevant life events. ______________________

____

____

15) Briefly describe your current support system (family, friends, organizations, self). ______________________

____

____

____

16) Briefly describe your strengths and weaknesses.

____

____

17) Please describe your goals for therapy.

A. ______________________
B. ______________________
C. ______________________

18) Do you have thoughts about hurting yourself or others?☐ yes ☐ no
Please describe. ______________________

____

PSYCHSTRATEGIES, INC.
Office Policies

Legal and Ethical Policies

Without pressure or coercion, I, the client/guardian, consent to treatment for myself and/or my legal dependent. All information disclosed in sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my, the client/guardian's, written permission, except where disclosure is required by law.

The reporting of information disclosed in session is *required by law* under the following circumstances:

- If a client presents an imminent danger to self or others or is gravely disabled (severely disoriented or in danger due to a psychiatric condition) authorities must be notified.
- If a client expresses a serious threat of harm to an identifiable person, that person must be warned and the police must be notified.
- If there is *reasonable suspicion* of child, dependent, or elder abuse or neglect, authorities must be notified.

The reporting of information disclosed in session *may be required*:

- If the client's mental status is placed at issue in litigation initiated by me, the client/guardian.
- In the event of a court order or subpoena. Information, records, or testimony about the client may have to be produced.

I, the client/guardian, have the right to review and/or receive a copy of the client's protected health information. If the treating clinician deems that releasing such information might be harmful in any way, the clinician will either deny my request or provide the records to an appropriate and licensed mental health professional of the client/guardian's choice.

I, the client/guardian, may end treatment at any time by notifying the therapist in person or by telephone.

Financial Policies

I, the client/guardian, assume primary financial responsibility for all professional services rendered and understand that any balance due will be billed to me on a monthly basis. I, the client/guardian, am responsible for the standard fee of **$_______ per session.** Payment is due at the time that services are provided. An additional charge may be added for payments received after the date of service.

Insurance co-payment per session is $___________.

Cancellation Policy

If the client misses an appointment or cancels an appointment without giving 24 hours notice I, the client/guardian, will be charged $_________for the missed session. Missed appointments and late cancellations are not covered by insurance.

Services provided outside of the client's usual scheduled session (i.e., telephone consultations, site visits, travel time, longer sessions, etc.) may be charged to me, the client/guardian, at the clinician's standard fee unless otherwise agreed upon.

If payment of the client's account is over 120 days late, or if it goes to collection, all fees including collection and attorney fees will be my, the client/guardian's, responsibility.

Insurance Policies

Yes ___ No___ I, the client/guardian, consent to have claims submitted to the client's insurance company.

I, the client/guardian, am ultimately responsible for charges incurred even though services will be billed to the client's insurance. PsychStrategies, Inc. will bill the client's primary insurance only. PsychStrategies, Inc. will not bill a secondary insurance (except when MediCare is the primary insurance). A receipt for services can be provided upon request. I, the client/guardian, understand that not all issues/conditions/problems that may be the focus of treatment are reimbursed by insurance companies.

I understand that the client's insurance benefit may only provide for crisis intervention, and that, therefore, a brief therapy model with solution-focused therapy or problem-solving techniques may be used by the clinician.

I, the client/guardian, consent to have PsychStrategies, Inc. release the client's protected health information to the client's insurance company in order to receive payment for claims. I understand that the client's protected health information will include diagnostic information, dates of service, and other information as requested by the client's insurance company for payment. I, the client/guardian, understand that PsychStrategies, Inc. has no control over or knowledge of what insurance companies do with the submitted information or who has access to this information after it is released.

It is my, the client/guardian's, responsibility to verify the specifics of the client's insurance coverage and be aware of and inform PsychStrategies, Inc. of any changes that may occur to the client's insurance coverage. It is my, the client/guardian's, responsibility to be aware of the amount of the client's insurance co-payment and any changes to the amount of the client's co-payment.

General PsychStrategies, Inc. Policies

I, the client/guardian, consent to release the client's protected health information to all PsychStrategies, Inc. clinicians who participate in the client's treatment.

EMERGENCY PROCEDURES

- *Urgent/non-emergency:* To contact my clinician between sessions, I, the client/guardian, can leave a message on the voice mail number provided. Clinicians check messages regularly during the week.
- *Emergency:* If I am unable to reach my clinician by phone about an *urgent* situation, I, the client/guardian, may call 526-8300 (ext. 4) between 5PM and 9AM and on weekends and holidays. The PsychStrategies on-call clinician returns calls within one hour.
- *If the client is a danger to him/herself or others:* I, the client/guardian, will call **Psychiatric Emergency Services**, the 24-hour crisis line for Sonoma County, at **707-576-8181** or the Police at **911**.

Appeals and Grievances

If the client's insurance company denies additional sessions, I, the client/guardian, may appeal for additional sessions.

If I, the client/guardian, am dissatisfied with any action taken by PsychStrategies, Inc., I must notify PsychStrategies, Inc. in writing within ten (10) business days. The letter should be addressed to:

PsychStrategies, Inc.
659 Cherry Street
Santa Rosa, CA 95404

Appeals to decisions made by PsychStrategies, Inc. may be made directly to my insurance company.

I, the client/guardian, may submit a grievance to the client's insurance company to register a complaint about services. Grievances regarding your insurance company can be made to the Department of Corporations at 800-400-0815.

Yes___ No___ I, the client/guardian, request a copy of this form.

*If requested, a copy of this form was provided to the client/guardian. Date:*__________ *Staff Initials:*_____

I have read the above statements, understand them, and agree to comply with them:

____
Client/Legal Dependent Name (Print) Date Signature

____
Client/Legal Guardian Name (Print) Date Signature

____
Clinician Name (Print) Date Signature

PsychStrategies, Inc

Authorization to Share Information with the Primary Care Provider

This is intended to facilitate communication and coordination of care between you, your PSI clinician, and your primary care provider. Coordination of care is encouraged by your insurance company and PSI.

I request that <u>no</u> mental health information be provided to my primary care provider.

I request that my mental health information be provided to my primary care provider.

This authorization will expire 1 year from the date of signature, or ________________.

________________________________ __________

Client Signature Date

____

Client Name – Printed

Clinician use only:

Primary Care Provider Name: ______________________

I am currently providing mental health services for the client named above. If you wish to receive information regarding this client's mental health diagnosis, symptoms, or treatment plan, please sign and return this Request for Mental Health Information to: PsychStrategies, 659 Cherry St, Santa Rosa, CA 95404; or fax it to: 707.526.8310.

________________________________ __________

Clinician Signature Date

____

Clinician Name – Printed

Primary Care Providers use only:

To protect patients from broad disclosure of personal information, I am requesting only the following limited information about the above referenced person:

1. The specific information to be released includes: <u>current symptoms</u>, <u>diagnosis</u>, and <u>treatment plan</u>.
2. I intend to use this information for <u>coordination of care</u>.
3. The information that PsychStrategies supplies will not be used for any purpose other than coordination of care.

________________________________ __________

Primary Care Provider Signature Date

PSYCHSTRATEGIES, INC.

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that PsychStrategies, Inc. has given you. The *Notice of Privacy Practices* provides information about how PsychStrategies, Inc. may use and disclose your protected health information. You are encouraged to read it in full.

The *Notice of Privacy Practices* is subject to change. If PsychStrategies, Inc. changes its *Notice of Privacy Practices*, you may obtain a copy of the revised form from your clinician, from our web site at www.PsychStrategies.com or by contacting our main office at (707) 526-8300.

Please discuss any questions about the *Notice of Privacy Practices* of PsychStrategies, Inc. with your clinician.

I acknowledge receipt of the Notice of Privacy Practices of PsychStrategies, Inc.

____ __________________________

Signature of Client/Guardian Date

Inability to Obtain Acknowledgment of Receipt of Notice of Privacy Practices

I made good faith attempts to obtain my client's acknowledgment of his/her receipt of the *Notice of Privacy Practices* of PsychStrategies, Inc., including ____________________________________
(describe good faith attempts)

____.

However, because of ____
(reason(s) why acknowledgment was not obtained)

____ I was unable to obtain my client's acknowledgement.

______________________________ __________________________

Signature of Clinician Date