BloomCounseling

Client Information

Name _____ **DOB**_____ **Date**_____

Address _____

Gender_____

Phone_____ May we leave a message? _____

Emergency Contact _____

Phone_____ Relationship_____

Do you have a psychiatrist? _____

- To best coordinate your care, may we contact your psychiatrist? _____
- To best coordinate your care, may we contact your primary care physician? _____

Have you worked or are you working with other mental health providers? _____

- Would you like us to contact them regarding your counseling at Bloom? _____

If you answered affirmatively above, please complete the Release of Information Form as well.

You have the right to request that we restrict how protected health information about you is used or disclosed. Most patients have family members and friends that occasionally become involved in their care. As such, please list any restrictions to the information you have regarding how we can communicate with those listed below and how. Examples include, "appointments only" or "financial only." If there are no restrictions, please write "no restrictions."

NAME	RELATIONSHIP	PHONE	RESTRICTIONS

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME. I REQUEST THAT MY CONFIDENTIAL INFORMATION BE HANDLED IN THE MANNER LISTED ABOVE AND AUTHORIZE BLOOM COUNSELING TO DISCLOSE INFORMATION ONLY TO THOSE LISTED ABOVE AND IN THE MANNER STATED FOR ORAL AND WRITTEN COMMUNICATIONS. ANY OTHER RELEASE OF INFORMATION WILL REQUIRE A SIGNED AUTHORIZATION FOR RELEASE OF INFORMATION.

_____ _____

Client/Legal Guardian Signature Date

What's the main reason you feel a need for counseling?

_____
_____
_____
_____

Have you engaged in prior psychotherapy? _____

- Provider Name_____
- Approximate Date_____

- Provider Name_____
- Approximate Date_____

Have you engaged in prior psychiatry or had inpatient treatment before? _____

- Provider/Facility _____
- Approximate Date_____
- Diagnosis_____

- Provider/Facility _____
- Approximate Date_____
- Diagnosis_____

MEDICAL/SURGICAL HISTORY:

☐ Seasonal Allergies	☐ Anemia	☐ Arthritis
☐ Asthma	☐ Chronic Back Pain	☐ BPH
☐ Cancer (type)_____	☐ COPD/Emphysema	☐ Diabetes Type 1 Type 2
☐ Disc Disease	☐ Fibromyalgia	☐ GERD/Gastritis
☐ Gout	☐ Hearing Loss	☐ Heart Disease
☐ Hepatitis	☐ Hernia	☐ High Cholesterol
☐ HIV	☐ Hypertension	☐ Hypotension
☐ Hyperthyroidism	☐ Hypothyroidism	☐ IBS
☐ Kidney Disease	☐ Kidney Stones	☐ Liver Disease
☐ Lupus	☐ Migraines	☐ Obesity
☐ Parkinson's	☐ Seizures (type) _____	☐ Sleep Apnea
☐ STD's	☐ Stroke/TIA History	☐ Low Testosterone
☐ Traumatic Brain Injury	☐ No Medical Issues	☐ Other _____

☐ Appendectomy	☐ Back	☐ Lumbar	☐ Cervical
☐ Cardiac Valve	☐ Bypass	☐ Ear/Nose/Throat	☐ Gall Bladder
☐ Gastric Bypass	☐ Hernia Repair	☐ Hip	☐ Hysterectomy

☐ Kidney Stones	☐ Kidney	☐ Knee	☐ Prostate
☐ Rotator Cuff	☐ Shoulder	☐ Tubal Ligation	☐ Wrist
☐ Stomach	☐ Liver	☐ Ulcers	☐ Other _____

HABITS:

☐ Do you drink alcohol?
How many drinks per day? _____
☐ Do you currently smoke cigarettes?
How many per day? _____
☐ Do you use dip or chewing tobacco?

STRESSORS:

☐ Economic/Financial	☐ Education/School	☐ Family	☐ Grief/Loss
☐ Legal	☐ Medical	☐ Work	☐ Domestic
☐ Social	☐ Substance Abuse	☐ Marital	☐ Injury
☐ Political	☐ Racial	☐ Gender	☐ Bullying

SYMPTOMS:

There is a more complete list later, but for now, please check any major issues:

☐ Anxiety	☐ Anger
☐ Eating Disorder	☐ Behavioral Issues
☐ Decreased Concentration	☐ Decreased Energy
☐ Decreased Pleasure or Interest in Things	☐ Depressed Mood
☐ Hopelessness or Worthlessness	☐ General Stress
☐ Grief/Loss	☐ Phobias/Type _____
☐ Chronic Pain	☐ Thoughts of Hurting Someone
☐ Hallucinations	☐ Falling Asleep During the Day
☐ Impulsiveness	☐ Insomnia
☐ Irritability	☐ Isolating (staying away from others)
☐ Mania	☐ Memory Impairment
☐ Nightmares	☐ Panic/Anxiety Attacks
☐ Sexual Dysfunction	☐ Rapid Weight Change

FAMILY:

FATHER:

- ☐ Living
- ☐ Deceased

Description: _____

MOTHER:

- ☐ Living
- ☐ Deceased

Description: _____

SIBLINGS:

- ☐ ____ Living
- ☐ ____ Deceased

What birth order are you in the family?

- ☐ Youngest
- ☐ Oldest
- ☐ Middle

How is your relationship with your siblings?

_____

What is your cultural background (Hispanic, Italian, African-American, Indian, Irish, etc.)?

_____

SUBSTANCE ABUSE:

Do you have a history of substance abuse? ☐ Yes ☐ No

TYPE INGESTED	AMOUNT USED	FREQUENCY AVERAGE

Have you experienced any of the following as a result of substance abuse?

☐ Arrests	☐ Overdosing	☐ Blackouts	☐ DUI
☐ Employment Issues	☐ Family Conflict	☐ Feeling Guilty	☐ Financial Issues
☐ Fighting	☐ Health Problems	☐ Higher Tolerance	☐ Fear
☐ Seizures	☐ Withdrawals	☐ Hallucinations	☐ Paranoia

Has anyone in your family been treated for mental health issues or drug abuse?

FAMILY MEMBER	ISSUE
☐ Mother	
☐ Father	
☐ Sister	
☐ Brother	
☐ Spouse	
☐ Son	
☐ Daughter	
☐ Maternal Grandmother	
☐ Maternal Grandfather	
☐ Paternal Grandmother	
☐ Paternal Grandfather	
☐ Aunt	
☐ Uncle	
☐ Cousin	

RESIDENTIAL STATUS

☐ Own	☐ Rent	☐ Live with Parents	☐ Foster Care
☐ Homeless	☐ Nursing Home	☐ Assisted Living	☐ Roommates

How are your housing conditions?

☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ Dangerous

NETWORK

What kind of socially supportive network do you have?

☐ Family	☐ Friends	☐ Church	☐ Co-workers
☐ Internet	☐ Social Services	☐ Sponsor	☐ Support Group

ORIENTATION

☐ Straight	☐ Gay	☐ Bi-sexual	☐ Transgendered
☐ Questioning	☐ Aromantic	☐ Gender Fluid	☐ Other

FAITH

Denomination:	☐ Participate	☐ Do not participate

How much of a role does your faith or belief currently play in your thoughts and emotions?

☐ Significant	☐ Somewhat	☐ Minimal	☐ None

EDUCATION

☐ Student in grade _____	☐ Less than High School	☐ Graduated from High School
☐ GED	☐ Highest Grade _____	☐ Associate's Degree
☐ College Degree	☐ Master's Degree	☐ Professional Degree
☐ Technical Degree	☐ Some College	☐ Certificate _____

EMPLOYMENT

☐ Full-time	☐ Part-time	☐ Contract	☐ Retired	☐ Disabled	☐ Homemaker

Employer: _____ Length of job: _____

Occupation: _____

MILITARY

☐ Never in Military	☐ Active Duty	☐ Parent is Active Duty
☐ Spouse is Active Duty	☐ Retired from Military	☐ Honorably Discharged
☐ Veteran	☐ Medically Discharged	☐ Dishonorably Discharged

Branch (Thank you for your service):

☐ Army	☐ Navy	☐ Air Force	☐ Marines
☐ National Guard	☐ Coast Guard	☐ Reserves	☐ Other

MARITAL STATUS

☐ Single	☐ Married	☐ Divorced
☐ Separated	☐ Widowed	☐ Partnership

How do you feel about this relationship?

☐ Happy	☐ Neutral	☐ Sad	☐ Frightened	☐ Angry

How many times have you been married? _____

How many children do you have? _____

How many live with you? _____

How many dependents live with you? _____

Please list dependents:

Name	Age	Relation

Patient Rights and Responsibilities

Bloom Counseling is committed to providing quality mental health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following patient rights and responsibilities.

You have the right to:

- A personal clinician who will see you on an on-going, regular basis
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or orientation.
- A second opinion from the clinician of your choice, at your expense.
- An easily understandable explanation of your condition, treatment and chances for stabilization.
- The personal review of your own records.

Legal Limits on Confidentiality

The law protects the privacy of all communications between a patient and a healthcare provider. In most situations, I can only release information about your treatment to others if you sign the written authorization form that meets certain legal requirements imposed by the Health Information Portability and Accountability Act (HIPPA). There are other situations that require only that you provide written, advance consent. However, there are some situations in which I am permitted or required to disclose information without either your consent or authorization.

- If you are a danger to yourself.
- If you are a danger to others.
- If there is a reasonable suspicion of child, elderly abuse or neglect.
- If a court order compels reporting.

If these situations arise, I will make every effort to discuss them with you before take any action. While this written summary of exceptions of confidentiality should prove helpful in informing you about potential problems, it is important that discuss any questions or concerns that you may have now or in the future.

Minors and Parents

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. The practitioner will provide parents with general information about the progress of the child's treatment, unless the child agrees otherwise. However, there are important exceptions to confidentiality if the practitioner has any reasonable suspicions about the child's safety. Bloom Counseling will work hard to ensure that parents are rapidly informed about any safety concerns that come to our attention.

HIPPA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protected Health Information (PHI). These rights include requesting that I amend your record: requesting restrictions on what information from the Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you sent, you have neither consented to, nor authorized; determining the locations to which PHI disclosures are sent; having any complaints or make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, and my privacy policies and procedures. We are happy to discuss any of these rights with you.

YOUR SIGNATURE BELOW INDICATES YOU HAVE READ THIS AGREEMENT, AGREE TO ITS TERMS, AND SERVES AS ACKNOWLEDGEMENT THAT YOU RECEIVED THE HIPPA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Patient/Legal Guardian Signature PRINTED Date

_____ _____

Patient/Legal Guardian Signature SIGNED Date

BloomCounseling

Notice of Privacy Practices
(Brief Version)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT.

OUR COMMITMENT TO YOUR PRIVACY:

We are dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the full, legally required notice of privacy practices. Please ask if you would like the full version of the notice.

How we use and disclose your protected health information with your consent:

We will use the information about you mainly to provide treatment, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

DISCLOSING YOUR HEALTH INFORMATION WITHOUT YOUR CONSENT:

Examples times when the laws require us to use or share your information:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When required by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs. There are some other rare situations described in the longer version of privacy practices.

Client Initials _____

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try to accommodate your wishes.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records for a copying fee. Please allow 14 business days to fulfill this request.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will provide you with the new version.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or my health information privacy policies, please let us know.

Client Initials _____

SIGNATURES INDICATES CLIENT HAS READ, DISCUSSED, UNDERSTOOD, AND AGREED TO ABIDE BY THE ABOVE.

_____ _____

Patient/Legal Guardian Signature PRINTED Date

_____ _____

Patient/Legal Guardian Signature SIGNED Date

Financial Agreement

PROFESSIONAL FEES:

Bloom Counseling is a private psychotherapy practice, accepting cash payments.

- Balances are due in full at time of service.
- Special financial arrangements must be discussed prior to appointment.
- Parents/Guardians are financially responsible for payment of services provided to minors, or other legal dependents.
- $50 processing fee will apply to returned checks.
- Additional fees may include charges for other professional services such as:
  - Psychological testing
  - Third-party report writing
  - Crisis-related telephone interventions
  - Consulting with other professionals
  - Legal proceedings requiring representation by the physician will be charged $1,000/first hour and $500/each subsequent hour, including preparation time and transportation. fees must be remitted prior to service.
  - Preparation of records or treatment summaries $25 for administrative processing. Attorney request for records: $50/first page, $20/each subsequent page. All fees must be remitted prior to service.
  - Disability & FMLA paperwork will be charge $125 for each form needed to be filled out.

PAYMENT FOR SERVICES:

As a client of Bloom Counseling, it is my responsibility to know what services are covered by my insurance plan. I have carefully reviewed the section in my insurance coverage that describes mental health services. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or denied by my insurance plan.

I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self-pay basis. I will present my insurance card at the time of my appointment. I will provide updated insurance information prior to my appointment in case of any changes.

I understand that I, not my insurance company, am responsible for full payment of fees. I understand insurance billing assistance is provided by my healthcare provider as a courtesy, but I remain the responsible party. I understand that, if after 90 days, my insurance company has not responded, I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

I understand that I am responsible for payment of any balances on my account. If my account is referred to a collection specialist, I will also be responsible for paying any applicable collection fees.

POLICY FOR MISSED APPOINTMENTS AND CANCELLATIONS:

As a client of Bloom Counseling, I acknowledge that appointment times are reserved exclusively for me; if I do not cancel my appointment in a timely manner, I will be charged the full amount of the scheduled time. To avoid any missed appointments or late cancellation fees, I will call 24 hours in advance to make any changes to my appointment.

I agree that I must give proper notification to cancel an appointment to avoid late cancellation or missed appointment fees. I agree to call at least 24 hours in advance to cancel or change my appointment.

Appointment no-shows will be charged a fee of $110. Appointments cancelled less than 24 hours for practitioners will be charged a fee of $75.

SIGNATURES INDICATES CLIENT HAS READ, DISCUSSED, UNDERSTOOD, AND AGREED TO ABIDE BY THE ABOVE.

_____ _____

Patient/Legal Guardian Signature PRINTED Date

_____ _____

Patient/Legal Guardian Signature SIGNED Date

Informed Consent

I will treat what you tell me with great care. My professional ethics and laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. Nevertheless, I cannot promise everything you tell me will never be revealed to someone else. There are some times when the law mandates information disclosure, so there are some limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret. So please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

1. WHEN YOU OR OTHERS ARE IN DANGER, THE LAW REQUIRES ME TO TELL OTHERS ABOUT IT.

- If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek emergency hospitalization for you or call on other emergency professionals who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
- If I believe you are threatening serious harm to another person, I may have to tell the person and the police, or perhaps try to have you admitted to a hospital for public safety.
- In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
- If I believe or suspect the abuse or potential abuse of a minor, an elderly person, or a disabled person I must file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics.
- If you disclose you were physically or sexually abused as a minor, even though you are now an adult, I am required to report this to a state agency *if* the perpetrator of the abuse is known to have continued access to minors.
- If you disclose past inappropriate sexual behavior towards you by a therapist/counselor in the state of Texas, I am required to report this to a state agency. Your identity may remain anonymous at your request.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not disclose everything you have discussed in sessions.

2. IN GENERAL, IF YOU BECOME INVOLVED IN A COURT CASE OR PROCEEDING, YOU CAN PREVENT ME FROM TESTIFYING IN COURT ABOUT WHAT YOU HAVE TOLD ME. THIS IS CALLED "PRIVILEGE," AND IT IS YOUR CHOICE TO PREVENT ME FROM TESTIFYING OR TO ALLOW ME TO DO SO. HOWEVER, THERE ARE SOME SITUATIONS WHERE A JUDGE OR COURT MAY REQUIRE ME TO TESTIFY:

- In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.
- In cases where your emotional or mental condition is important information for a court's decision.
- During a malpractice case or an investigation of me or another therapist by a professional group.

- In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
- When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.
- If you were sent to me for an evaluation by worker's compensation or Social Security disability, I will be sending my report to a representative of that agency and it can contain anything that you tell me.

3. THERE ARE A FEW OTHER THINGS TO KNOW ABOUT CONFIDENTIALITY AND YOUR TREATMENT:

- I may sometimes consult with another mental health professional about how to make your treatment the most therapeutically effective, without revealing your identity or any information that could identify you to others. This other person would also be required by ethical standards to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help you. In such an arrangement, I need to provide them with some of your information so they can help you if needed.
- I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. Please allow 14 business days to prepare your file for review.

4. HERE IS WHAT YOU NEED TO KNOW ABOUT CONFIDENTIALITY IN REGARD TO INSURANCE:

- If you use your health insurance to pay part of my fees, the insurance company, the managed care organization, or perhaps your employer's benefits office will require me to provide information about your functioning in many areas of your life, your social and psychological history, and your current symptoms. I will also be required to provide a treatment plan for your problems and information on how you are doing in therapy.
- Upon your request, copies of forms sent to your insurance company may be provided. That way, you can see what the company will know about our therapy. It is against the law for insurers to release information about our office visits to anyone without your written permission. However, we cannot control who sees this information once they receive it. You cannot be required to release more information just to get payments.
- If you have been sent by your employer's employee assistance program, the program's staff may require some information. Again, we cannot control who sees this information at their offices. If this is your situation, let us fully discuss your agreement with your employer or the program before we talk further.
- If your account is unpaid and we have not arranged a payment plan, we can use legal means to get paid. The only information we will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due.

5. CONFIDENTIALITY IN GROUP THERAPY PRESENTS A DIFFERENT CONFIDENTIALITY SITUATION:

In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws to which therapists must conform. However, they will be required to sign a group therapy confidentiality clause as part of their acceptance into a group. Nevertheless, I cannot guarantee they will never speak about what's been covered in group to another person outside the group.

6. FINALLY:

- WE WILL NOT RECORD THERAPY SESSIONS WITHOUT YOUR WRITTEN PERMISSION.
- IF YOU WANT US TO SEND INFORMATION ABOUT YOUR THERAPY TO SOMEONE ELSE, OR CONSULT WITH ANOTHER PROVIDER OVER THE TELEPHONE OR IN PERSON, YOU MUST SIGN THE RECORDS RELEASE FORM BELOW.

The laws and rules on confidentiality are complicated. Please bear in mind that we are not able to give you legal advice. If you have special or unusual concerns, and do need special advice, we suggest you consult an attorney to protect your interests.

SIGNATURES INDICATES CLIENT HAS READ, DISCUSSED, UNDERSTOOD, AND AGREED TO ABIDE BY THE ABOVE.

_____ _____

Patient/Legal Guardian Signature PRINTED Date

_____ _____

Patient/Legal Guardian Signature SIGNED Date

BloomCounseling

Consent to Treatment

This is a confidential patient medical record. Disclosure or transfer prohibited by law.

I acknowledge I have received, have read (or have had read to me), and understand:

- Informed Consent
- Notice of Privacy Practices (Brief Version)

I do hereby seek and consent to take part in psychotherapeutic treatment by Matthew Peterson, LPC. I agree to play an active role in this process.

I understand no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware I may stop treatment at any time. The only thing I will still be responsible for is paying for the services received. I understand I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know I am obligated to cancel an appointment at least 24 hours before the appointment. If I do not cancel and do not show up, I may be charged for that appointment.

I am aware an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that I may revoke this consent anytime by providing Bloom Counseling my revocation in writing.

SIGNATURES INDICATES CLIENT HAS READ, DISCUSSED, UNDERSTOOD, AND AGREED TO ABIDE BY THE ABOVE.

_____ _____

Patient/Legal Guardian Signature PRINTED Date

_____ _____

Patient/Legal Guardian Signature SIGNED Date

I, Matthew Peterson, have discussed the issues above with the client (and/or his or her parent, guardian, or another representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Therapist Signature: _____

Date: _____

❑ Copy accepted by client ❑ Copy kept by therapist

BloomCounseling

Authorization for Release of Mental Health Information

Name _____ **DOB**_____ **Date**_____

Address _____

THE ABOVE LISTED CLIENT DOES AUTHORIZE BLOOM COUNSELING TO MAKE A VERBAL OR WRITTEN RECORD DISCLOSURE TO A THIRD PARTY FOR VARIOUS REASONS.

Dates and Type of information to disclose:

- ☐ Records from all treatment
- ☐ 2 years prior from last date seen
- ☐ Specific Dates: _____
- ☐ Specific Information Only

The purpose of this disclosure release is:

- ☐ To Aid Quality of Treatment by Allowing Consultation between Providers
- ☐ Change of Insurance or Provider
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other____

RESTRICTIONS: Only records originated through Bloom Counseling will be copied unless otherwise requested. This authorization is valid only for the release of information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my counseling record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: _____

Address: _____

City, State, Zip: _____

Fax: _____ Phone: _____

- ☐ Please mail records
- ☐ Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Bloom Counseling. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____.

If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. **I need not sign this form in order to assure treatment.** I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I HAVE READ THE ABOVE FOREGOING AUTHORIZATION FOR RELEASE OF INFORMATION AND DO HEREBY ACKNOWLEDGE THAT I AM FAMILIAR WITH AND FULLY UNDERSTAND THE TERMS AND CONDITIONS OF THIS AUTHORIZATION.

_____ _____

Patient/Legal Guardian Signature PRINTED Date

_____ _____

Patient/Legal Guardian Signature SIGNED Date

BloomCounseling

Checklist of Concerns

Name _____ **DOB**_____ **Date**_____

This is a confidential patient medical record. Disclosure or transfer prohibited by law.

Please quickly scan and check any areas of concern and star the top three most pressing issues.

- ❑ No problem or concern brings me here
- ❑ Abuse, currently (physical, sexual, emotional, neglect) of children, animals, disabled or elderly
  - When did abuse occur? _____
- ❑ Abuse, childhood (physical, sexual, emotional, neglect)
  - When did abuse occur? _____
- ❑ Aggression, violence
  - Perpetrator of violence: _____
- ❑ Alcohol
  - Drinks per week: _____
- ❑ Anger, hostility, arguing, irritability
- ❑ Anhedonia (not enjoying anything)
- ❑ Anxiety, persistent, intrusive & debilitating
- ❑ Attention, concentration, distractibility
- ❑ Body image issues such as anorexia, bulimia or binge eating
- ❑ Career concerns
- ❑ Childhood issues
- ❑ Codependence
- ❑ Concern about welfare/well-being of others
  - Is someone's health is imminent danger? _____
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making

❑ Delusions (false ideas)

❑ Depression, low mood, sadness, crying

❑ Divorce, separation

❑ Drug abuse—prescription, over-the-counter, illicit drugs

How often abuse occurs per week: _____

❑ Eating issues

❑ Emptiness

❑ Failure

❑ Fatigue

❑ Fears, phobias

Specific phobias/fears: _____

❑ Financial issues

❑ Friendships

❑ Gambling

❑ Grief

Cause(s) of grief: _____

❑ Guilt

Cause(s) of guilt: _____

❑ Hallucinations (auditory or visual)

Nature of hallucinations: _____

❑ Health, illness, medical concerns, physical problems

❑ Helplessness

❑ Hopelessness

❑ Housework—quality, schedules, sharing duties

❑ Identity exploration, confusion, definition

❑ Inferiority issues

❑ Internet overuse or addiction

❑ Interpersonal conflicts

❑ Impulsiveness

❑ Irresponsibility

❑ Judgment issues, risky behavior

❑ Labile affect (rapid shifts in outward emotional expression)

❑ Lack of direction or purpose

❑ Legal matters

Criminal or civil issues? _____

❑ Life transition (career change, becoming a parent, divorce/dating, retirement, empty-nest)

❑ Loneliness

❑ Marital issues/deteriorated relationship

❑ Marital issues/mental, emotional, physical abuse related to power and control

Is anyone involved in imminent danger? _____

❑ Memory issues

❑ Menstrual issues, PMS, menopause

❑ Mood swings

❑ Motivation, laziness

❑Narcissism (feeling you are always right, lack of empathy, etc).

❑ Nervousness, tension

❑ Obsessions, compulsions, ruminations (repeated thoughts or actions)

❑ Overdependence on others

❑ Oversensitivity to rejection

❑ Pain/chronic

❑ Panic or anxiety attacks

How many attacks per week? _____

❑ Parenting, child management, single parenthood

❑ Perfectionism

❑ Pessimism

❑ Phobias

❑ Pornography

❑ PTSD issues such as re-experiencing events, paranoia, and insomnia

❑ School issues

❑ Self-centeredness

❑ Self-esteem issues

❑ Self-injury

❑ Self-neglect, poor self-care

❑ Sexual identity issues

❑ Sexual issues with others

❑ Shame

Is someone making you feel ashamed? _____

Has someone made you feel ashamed in the past? _____

❑ Shyness

❑ Sleep issues

❑ Smoking and tobacco addiction

Packs per week: _____

❑ Somatic issues (body aches and pains from mental distress)

❑ Spiritual, religious, moral, ethical issues

❑ Stress

❑ Suspiciousness, paranoia

❑ Suicidal ideations

Do ideations also include plans, mean and intent? _____

❑ Temper

Has temper resulted in the injury of others? _____

Has temper resulted in the destruction of property? _____

Has temper resulted in emotional/mental distress of others? _____

❑ Thought disorganization and confusion

Has confusion endangered others in the past? _____

Does confusion endanger others in the present? _____

❑ Threats, violence perpetrated by others against you

❑ Trauma (current or historical including physical, sexual, or emotional abuse/life-threatening events)

Are you currently in danger? _____

❑ Underachieving, not living up to perceived potential or where you "should" be at this point

❑ Weight

❑ Withdrawal, isolating tendencies, agoraphobia, dissociation (feeling separated)

❑ Work issues, workaholism, job churn, dissatisfaction

❑ Other concerns or issues:

_____

_____

Thank you!