PATIENT INFORMATION RECORD

NAME:_____ DOB:_____/_____/_____ AGE: _____

SSN:_____ MARITAL STATUS: S ___M ___D___ Other _____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

EMAIL:_____ PHONE:_____

EMERGENCY CONTACT NAME, ADDRESS AND PHONE NUMBER:

_____

_____

_____

PATIENT EMPLOYER/SCHOOL ADDRESS:

_____

PATIENT EMPLOYER/SCHOOL TELEPHONE: _____

PARENT/PARTNER: _____ DOB:___/___/___

PARENT/ PARTNER ADDRESS:

_____

PARENT/ PARTNER TELEPHONE: _____

PLEASE CIRCLE (YES OR NO)

MAY I LEAVE A MESSAGE FOR YOU VIA VOICEMAIL IN REGARDS TO APPOINTMENTS? Y N
MAY I EMAIL YOU IN REGARDS TO APPOINTMENTS? Y N
MAY I SEND TEXT MESSAGES TO YOUR TELEPHONE IN REGARDS TO APPOINTMENTS? Y N

I HEREBY AUTHORIZE EMMA J. WOOD, PSYD, TO PROVIDE TREATMENT FOR ME AND/OR MY DEPENDENTS.

SIGNATURE:_____ DATE: _____

PLEASE INITIAL UNDER EACH SECTION TO ACKNOWLEDGE PATIENT RIGHTS AND RESPONSIBILITIES:

Confidentiality: I understand that my information and things I discuss with Dr. Wood will be kept confidential. I understand that there are exceptions to confidentiality, and confidentiality may be broken under any of the following circumstances: 1. If a court of law orders my records. 2. If Dr. Wood believes I am a danger to myself or someone else. 3. If I disclose sexual misconduct by a mental health therapist. 4. If Dr. Wood suspects child abuse or abuse of the elderly or disabled. 5. I will be responsible for the confidentiality of the documentation/receipt from my appointment that contains information about my diagnosis and treatment. If you have any questions about the above information, or if you have questions about a specific situation, please feel free to discuss your questions with Dr. Wood.

**INITIALS: _____

Fees for services: Fees for services are as follows: Intake Session: $180 Therapy hour: $165.00 Late cancelation (less than 24 hours) fee: $100 No show fee is equivalent to the services scheduled to be rendered. All fees are due after each session. Fees are assessed for each 50-minute session. Additional fees for services such as additional therapy time, documentation letters, and phone calls will be assessed on a case by case basis. Formal assessments are charged at $180 per hour of work and face to face sessions.

**INITIALS: _____

Consent for a card on file: By initialing above for fees of service, I understand that if I do not come to my session, or if I cancel within 24 hours of my appointment, that I will still be charged for my appointment spot. I understand that Dr. Wood's office will use this card on file to receive payment. It is my responsibility to update my card information when necessary. Dr. Wood may also use this card information to charge me if I forget my payment method or choose for them to manually charge me instead of swipe my card or pay with cash or check.

Card Number: _____ Card Security Code: _____

Expiration Date:_____/_____ Billing Zip Code: _____

**INITIALS: _____

SuperBill: I understand that Dr. Wood does not take insurance, but a SuperBill may be created when I request one so that I may seek reimbursement from my insurance provider. Please initial and date:

_____ Yes, I would like to receive a SuperBill for my sessions.

_____ No, I do not want a SuperBill at this time.

I understand that I can change my mind at any point in time, but a new request for a SuperBill will begin after the date requested, and all prior sessions will not be included on the SuperBill.

**INITIALS: _____

Court: I understand that Dr. Wood does not testify in court as an expert witness. In rare and unusual situations where Dr. Wood might be required to testify in civil court, she will require payment of her standard fee of $165.00 per hour. Fees will be assessed for any time that Dr. Wood spends in court related activities. These include, but are not limited to, paperwork, consultation, travel, and time spent in court.

**INITIALS: _____

Crisis Intervention: I understand that Dr. Wood does not provide 24-hour crisis counseling. If I experience a crisis that requires immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance. If I need to be seen prior to my next scheduled appointment, I understand that I may contact Dr. Wood and ask for an earlier appointment. I understand that Dr. Wood will make an effort but does not guarantee to provide me with an earlier appointment. I understand that if Dr. Wood sees me in a crisis or a session that requires an additional level of care, a higher fee may be charged.

**INITIALS: _____

I acknowledge that I have read and understand the above information. I certify that the information I provided above is true and accurate, to the best of my knowledge. By signing below, I consent to receive psychological services from Dr. Wood. My signature also acknowledges that I have received a copy of Dr. Wood's Notice of Privacy Practices.

Printed Name _____

Signature Date _____

HIPAA CONSENT

Name:_____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "healthcare operations"). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise my Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time. You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or healthcare operations: however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked. I hereby consent to the use or disclosure of my protected Health Information as specified above.

Patient Signature_____Date_____

INTAKE FORM

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name:

_____

Preferred Method of Contact: (*Please Circle **and** Initial to indicate consent*)

Call Email Text

Briefly Describe Your Reason for Seeking Counseling:

_____

_____

_____

_____

_____

_____

_____

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ No ☐ Yes

(previous therapist/practitioner, approximate dates)

_____

_____

Are you currently taking any prescription medication? ☐ Yes ☐ No

Medications:_____

_____

_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

Please list and provide dates and provider:

_____

_____

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

_____

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

_____

5. Are you currently experiencing overwhelming sadness or depression?

☐ No ☐ Yes

If yes, for approximately how long?

_____

6. Are you currently experiencing anxiety or panic attacks? ☐ No ☐ Yes

If yes, when did you begin experiencing this?_____

7. Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe?_____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage recreational drug use? (please circle)

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your satisfaction with the relationship? _____

11. What, if any, significant life changes or stressful events have you experienced recently?

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition/Diagnosis	Family Member(s)
Alcohol/Substance Abuse	
Anxiety	
Depression	
Schizophrenia	
Obsessive-Compulsive Behavior	
Eating Disorders	
Bipolar Disorder	
Suspected Mental Illness (Unspecified)	
Domestic Violence	
Suicide Attempt(s) and/or Completion	

Anything else you would like to add:

_____

_____

_____

_____

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes

If yes, name and address of your employer:_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief:_____

_____

_____

3. What do you do to take care of yourself when under stress?

_____

_____

4. Who is in your support system?

_____

_____

_____

6. What current situation or symptom is the most distressing to you currently?

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

(please keep the following notice of privacy for your own records)

EMMA J. WOOD, PSYD, PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO ME. OUR LEGAL DUTY:

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices. My legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect May 1, 2016, and will remain in effect until I replace it. I reserve the right to change my privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that we maintain, including health information I created or received before I made the changes. Before I make a significant change in my privacy practices, I will change this Notice and make a new Notice available upon request. You may request a copy of our Notice at any time. For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION I use and disclose health information about you for treatment, payments, and other healthcare operations

> For example: Treatment: I may use or disclose your health information to a physician or other healthcare provider providing treatment for you. Payment: I may use and disclose your health information in a receipt so that you can obtain reimbursement from your insurance carrier. Healthcare Operations: I may use or disclose your healthcare information to provide quality assessment and improvement activities, to review the competence or qualifications of healthcare professionals, for evaluation of practitioner and provider performance, for conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to my use of your health information for treatment, payment or healthcare operations, you may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your health information for any reason except those described in the Notice.

PERSONS INVOLVED IN CARE: I may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such use or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. I will also use my professional judgment and my experience with common practice to make reasonable inferences of your best interest in allowing a person

to pick up health information.

Marketing Health-Related Services: I will not use your health information for marketing communications.

Required by Law: I may use or disclose your health information when I am required by law to do so or if a court of law orders your records.

TECHNOLOGY: NOTICE REGARDING USE OF TECHNOLOGY

1. E-mail Communications. Unencrypted email may not be confidential, and any information regarding PHI sent by email may not be confidential.

2. Skype, FaceTime, or Other Similar Video Conferencing Technology: Communication through Skype or FaceTime may not be confidential.

3. Internet Communications: Counseling or communication through the Internet may not be confidential.

4. Storage of Healthcare Information: Health care records and information maintained on a Cloud may not be confidential, depending on the number of servers involved.

5. Voicemail: Telephone messages left through voicemail may not be confidential, if they may be accessed by individuals other than the client. Please let me know if you do not want me to use voicemail in contacting you.

6. Facsimile Communication: The submission of healthcare information or records by fax may not be confidential, and may lead to a disclosure of confidential information to third parties if the wrong fax number is used to send the information.

7. Communication by U.S. Mail: Communication of information by U.S. mail may lead to disclosure of private information to third parties, depending on who may open the mail. Please let me know if you do not want me to send you correspondence, billing invoices, or other information through the U.S. mail.