MADISON AVENUE PSYCHOLOGICAL SERVICES

CLIENT INFORMATION SHEET

Date: _____/_____/_____ MAPS CASE #: _____

CLIENT NAME: _____ M / F Date of Birth: _____/_____/_____

Home Address: _____
(Street) (City) (State) (Zip)

Marital Status: M S D W Soc. Sec. #: _____ Home Phone: _____

E-mail Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Emergency Contact:_____ Cell Phone: _____
Name Relationship

Home or Work Phone: _____

POLICY HOLDER INFORMATION (If you are not the policy holder)

Name: _____ Soc. Sec. #: _____ D.O.B. _____

Relationship to client: _____ Home Phone: _____

Address: _____
(Street) (City) (State) (Zip)

E-mail Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

RESPONSIBLE PARTY INFORMATION (Guardian, Custodial Parent)

Name: _____ Soc. Sec. #: _____ D.O.B.: _____

Relationship to client: _____ Home Phone: _____

Address: _____
(Street) (City) (State) (Zip)

E-mail Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

~~~~~~~~~~~~~~~~~~~~ INSURANCE INFORMATION - FOR OFFICE USE ONLY ~~~~~~~~~~~~~~~~~~

Company: _____ Certificate #: _____ Group #: _____

Authorization #: _____ # Visits: ____ CPT: _____ Expires: _____

Authorization #: _____ # Visits: ____ CPT: _____ Expires: _____

Copayment amount: _____ Deductible: _____ Deductible met? Yes No N/A

Axis I _____ Axis I _____ Axis II _____

PLEASE COMPLETE FOR CHILDREN AND ADOLESCENTS

Did mother use drugs, smoke or consume alcohol during pregnancy: _____

Problems during pregnancy or delivery: _____

Birth defects? (If yes, specify): _____

Ages at which child: Sat up _____ Crawled _____ Stood alone _____ Walked _____ First words _____

Age at which potty trained _____ Length of time to train _____ Once potty trained did your child ever revert

to soiling or wetting themselves? ❑ Yes ❑ No If yes, describe how and when: _____

_____

Current soiling or bedwetting? ❑ Yes ❑ No If yes, how long: _____

Cruelty toward animals ❑ Yes ❑ No Fire setting ❑ Yes ❑ No Stealing ❑ Yes ❑ No

List any history of seizures, prolonged high fevers, head injuries, poisoning, serious illness or injury:

_____

List any prolonged separations from mother or traumatic events in childhood: _____

_____

School: _____ Grade _____ Academic performance/grades: _____

_____

Problems / special services from school: _____

_____

Does your child show an unusual interest in sex for their age? ❑ Yes ❑ No
Are you concerned about sexual behavior on your child's part? ❑ Yes ❑ No
Do you have any reason to suspect that your child has been physically or sexually abused? ❑ Yes ❑ No

How would you rate your child's social adjustment (e.g., Poor, Fair, Good, Excellent):

_____

~~~ If the child is 12 years or older, please complete the following additional information~~~

Is your child sexually active? Yes ❑ No ❑ Do not know ❑
If yes, do they know about safe sex? Yes ❑ No ❑ Do not know ❑

Does your child smoke or use tobacco in any form? Yes ❑ No ❑ Do not know ❑
If yes, how much: _____ Cigarettes _____ Snuff _____ Chewing tobacco

Do you suspect that your child is abusing drugs or alcohol? Yes ❑ No ❑ Do not know ❑

CLIENT REPORT OF PROBLEM

Name:_____ Today's Date:_____ Case Number:_____

Client/parent statement of problem:

Briefly describe your reason(s) for seeking help:

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

History of treatment for emotional problems and family history:

Outpatient counseling (Therapist name, dates, did it help):

Inpatient treatment (Where, when, and for how long):

Family history of emotional problems (Who and their relationship to you):

Check any of the following items that apply:

____ Thoughts of suicide or death
____ History of attempts to kill yourself
____ Cutting or otherwise hurting yourself
____ Depressed mood
____ Feelings of hopelessness
____ Large weight gain or loss
____ Trouble getting to sleep
____ Waking during the night
____ Waking early every day
____ Inability to make decisions
____ Excessive guilt
____ Frequent crying
____ Loss of energy
____ Feeling worthless
____ Mood swings

____ Nervousness/anxiety
____ Trouble concentrating
____ Phobias
____ Panic attacks
____ Irritability
____ Feeling overwhelmed
____ Loss of appetite
____ Tingling or numbness
____ Forgetfulness
____ Excessive worrying
____ Feeling tense
____ Reliving traumatic events
____ Intrusive distressing thoughts you can't control
____ Seeing things others don't
____ Problems with drugs or Alcohol

____ Thoughts of harming others
____ Trouble controlling your temper
____ Violence toward others
____ Hearing voices
____ Feeling empty
____ Memory problems
____ Financial problems
____ Problems at work
____ Legal problems
____ Health problems
____ Family problems
____ History of sexual abuse
____ History of physical abuse
____ Racing thoughts

For Children:

____ Problems with attention
____ Problems at school
____ Hyperactivity
____ Behavior problems
____ Impulsiveness
____ Excessive fears
____ Problems with peers
____ Sad/unhappy
____ Oppositional or defiant
____ Anxious - Worried
____ Withdrawn
____ Irritable
____ Aggressive
____ Complains of aches and pains

Please complete the other side of this form

Client name:_____ Case #:_____

Health status

List any medical problems or physical problems and when they were diagnosed:

1.
2.
3.

List any major (where you were put to sleep) surgeries you have had and date:

1.
2.
3.

List any serious illness or injuries especially anything involving the head:

1.
2.
3.

List any allergies to foods or drugs:

Date of last physical examination:_____ Date of last physician visit:_____

Drug and alcohol information: List **all** of the **prescription(RX)** and **over-the-counter(OTC)** drugs you are taking

Check substances that you use in any amount at all:

	Age first used	How much do you use per: Weekday	Weekend	Month	Last used
❑Beer	_____	_____	_____	_____	_____
❑Liquor	_____	_____	_____	_____	_____
❑Wine	_____	_____	_____	_____	_____
❑Marijuana	_____	_____	_____	_____	_____
❑Cocaine/Crack	_____	_____	_____	_____	_____
❑Methamphetamine/Crystal	_____	_____	_____	_____	_____
❑Heroin	_____	_____	_____	_____	_____
❑Barbiturates (downers)	_____	_____	_____	_____	_____
❑PCP, LSD, (Hallucinogens)	_____	_____	_____	_____	_____
❑Tobacco in any form	_____	_____	_____	_____	_____
❑Other_____	_____	_____	_____	_____	_____

To be completed by adults (18 yr.s and older)

Have you ever felt like you should cut down on your drug or alcohol use? ❑Yes❑No
Has a friend or relative expressed concerns about your use? ❑Yes❑No
Have you ever felt guilty about your drinking or drug use? ❑Yes❑No
Have you ever had to take a drink or use a drug the next day to steady your nerves? ❑Yes❑No
Are you a recovering alcoholic or a recovering drug addict? ❑Yes❑No
Is there a history of problems with drug or alcohol use in your family? ❑Yes❑No

To be completed by adolescents (12 yr.s to 17 yr.s)

Have you ever used alcohol or drugs before or during school? ❑Yes❑No
Have you ever missed school (or been truant) because of use or just to use? ❑Yes❑No
Have you ever avoided non-users? ❑Yes❑No
How often do you get drunk/high? ❑Yes❑No
About how often do you use more than one drug when you get high? ❑Yes❑No
Is there a history of problems with drug or alcohol use in your family? ❑Yes❑No

Therapist Date Client/parent/guardian signature Date

CLIENT TREATMENT AGREEMENT AND CONSENT TO TREAT

Welcome to Madison Avenue Psychological Services. Please read this document which contains important information about our professional services and business policies. A Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI) is also posted in the reception area.

The law requires that I obtain your signature acknowledging that I have provided you with this information and that you have agreed to its terms. When you sign this document, it will represent a contract between us. You may revoke this contract in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or monies owed in connection with treatment.

I work with a group of independent mental health professionals, under the name of Madison Avenue Psychological Services. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While the members share a name and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained, and no member of the group can have access to them without your permission.

Payment of Services
Payment is required at the time of each visit and I accept cash, check, credit, debit, FSA and HSA cards as forms of payment. There will be up to a $25.00 charge for any returned check. You will be responsible for the fees that are charged in connection with your treatment. Our fee is $150.00 per hour or our contracted rate with your insurance provider. I will submit claims directly to insurance companies, their mediators and Employee Assistance Programs (EAP), for which I am a contracted provider.

I cannot guarantee payment by your insurance company. If your claim is not paid it will be your responsibility. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon in advance, I have the option of using legal means to secure the payment. This may involve employing the services of a lawyer or agency for collection purposes. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of the services and the amount due or other PHI allowed by HIPAA (Health Insurance Portability and Accountability Act).

Insurance companies may require access to your PHI. By signing this form, you will be authorizing me to release information about you that is required by your insurance company or EAP for payment of services.

Fees for other services not included in your insurance/EAP
Your insurance company or EAP does not typically reimburse for activities that are not a part of direct individual, family or group counseling. The following is a list of some activities where an additional fee is required to be paid in advance (time spent based on $150/hour).

1. Copying your clinical record. (rate based on the prevailing community standard)
2. Completion of any disability or other form at your request. (time spent based on $150/hour)
3. Preparation of a letter or report at your request. (time spent based on $150/hour)
4. Time spent away from the office to testify in court. (time spent based on $150/hour)
5. Consultation with other entities, including but not limited to attorney, school, disability insurers, workmen's compensation. (time spent based on $150/hour)
6. There will be a $10 service charge if I have to send you a bill for services rendered.

_____ (initials)

Professional Records
The laws and standards of my profession required that I keep Protected Health Information (PHI) about you in your clinical record. Your records will be maintained properly and consistent with HIPAA regulations, state law and the requirements of your insurance plan.

Confidentiality
The law protects the privacy of all communications between client and counselor, psychologist, social worker or psychiatrist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. Your signature on this agreement provides consent for release of information consistent with HIPAA and state law. A summary of the circumstances in which I may disclose PHI without your consent follows on page 2 of this document.

HIPAA (Health Insurance Portability and Accountability Act) Confidentiality
Confidential treatment of your clinical record. The following are cases where your information may be disclosed without your consent.

1. If there is a situation that is potentially life threatening.
2. When child abuse is known or suspected. (Reporting required by state law)
3. When the abuse of an elderly or dependent person is known or suspected. (Reporting required by state law)
4. I you commit a crime against a staff member or another person on the premises.
5. If you bring charges against, or sue, your clinician.
6. When ordered by the court.
7. In some cases, details of your treatment may be discussed with another clinician for the purpose of consultation. When this is done, no identifying information will be included (ie, the client is anonymous).
8. In some cases your records may be audited by the quality improvement activity of your insurance company or EAP. When this is done, no identifying information is included (ie, the client is anonymous).
9. If it becomes necessary to refer your account to a collection service. Only information necessary to pursue collection will be released.

Minors and Parents

Clients 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. Parents will need to sign a permission to treat form for services provided to a minor. In divorce families, clients under 18 need the consent of the custodial parent(s). A copy of the divorce decree may be requested prior to initiating evaluation and treatment.
I verify that I do have legal custody of this child _____ (initials)

Information Regarding Psychotherapy

1. Psychotherapy may involve remembering unpleasant events and can arouse intense emotions.
2. Psychotherapy is not always effective and may, in some cases, result in deterioration rather than improvement of a clients psychological functioning.
3. There are numerous forms of psychotherapy which vary not only in underlying theory and methods employed but also in terms of time commitment and cost. We will attempt to provide treatment plans that are realistic in both areas. In addition, we will discuss other possible treatment interventions.
4. Unless it is part of your treatment plan, your treatment will be terminated if you have not contacted your therapist in more than 60 days.

Appointments, Scheduling and Cancellation of Appointments

Individual appointments for counseling and psychotherapy services are typically scheduled for no more than 45 – 50 minutes. Scheduling and cancellation of appointments is done through your therapist directly. If you find it necessary to cancel a scheduled appointment, we require advance notice of at least 24 hours. You will be charged $75.00 for the missed appointment if it is not cancelled at least 24 hours prior to the scheduled appointment time. Please schedule or cancel your appointments with me directly by calling my voicemail at 816-753-3333 ex.____. Your calls to me are recorded with a time and date stamp.
_____ (initials)

Our clients have the right to:

1. Be treated by a licensed mental health professional and with respect for their individual needs, preferences, feelings and requirements;
2. Confidential treatment of their treatment records. Information from those records will not be released without their prior written consent, except in an emergency, as required by law or as noted (page 2);
3. Have an individualized treatment plan and participate with their therapist in treatment planning decisions;
4. Be given the information necessary to give informed consent prior to the start of any treatment or procedure;
5. Refuse treatment and to be informed of the consequences of refusal;
6. Continuity of care. Should transfer or discharge become necessary, clients will be given the reasons and plan, as well as reasonable advance notice;
7. Participate in the formulation of a discharge plan when the termination of treatment is therapeutically indicated;
8. View their treatment and financial records.

Our clients have the responsibility to:

1. Provide to the extent possible, information that their therapist needs to provide appropriate care;
2. Participate in the development of treatment plan goals;
3. Communicate openly and honestly with their therapist;
4. Ask questions so that they understand the care and instructions given;
5. Actively participate in his or her own treatment and to carry out therapeutic homework assignments;
6. Take medications prescribed as part of their treatment plan and as instructed;
7. Keep their appointments or call at least 24 hours in advance to cancel visits;
8. Inform their therapist of any changes or updates in insurance or EAP coverage;
9. Pay their co-payments, deductibles, other fees and/or bills for services rendered in a timely manner.

Client Consent to exchange Information with my Primary Care Physician / Psychiatrist

HIPAA policy allows collaboration between health care providers regarding your care. A space for this information is provided. You have the right to withhold this information. By my initials below I either authorize or withhold exchange of information with my/my child's primary care Physician, Psychiatrist or other relevant healthcare provider. I place no limits on dates, history of illness, diagnostic and therapeutic information, including treatment for alcohol and/or drug abuse.

_____

Physician Name Address Phone # Fax#

Initials: Authorize_____ Withhold_____

_____

Psychiatrist Name Address Phone # Fax #

Initials: Authorize_____ Withhold_____

If any of these policies or procedures cause problems or seem confusing, please speak with me, so that I may clarify them for you. I make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. I have no control over what they do with the information once it is in their hands. In some cases, they may share the information with a national medical information databank. By signing this Agreement, you agree that I can provide the necessary information to your insurance carrier, employee assistance program and other designated third-party payers such as Medicare or Medicaid, to process claims and for quality assurance activities.

AGREEMENT

By signing this 4 (four)-page agreement below I am acknowledging that I have reviewed:

1) Client Agreement and Consent to Treat Policies

2) Practices to Protect the Privacy of Your Health Information displayed in the office and you may obtain a copy for yourself on request

3) Notice of Client Rights and Responsibilities (page 3)

I have read these policy statements and having been informed to my satisfaction, I give consent to treatment and/or evaluation by _____ and Madison Avenue Psychological Services. I understand that by signing this agreement I am acknowledging that I understand the content on this form and agree to comply with all aspects of it.

_____ _____

Signature of client/parent/guardian Date **Print Client Name**

_____ _____

Relationship of above to client **Witness Date**