

# Psychotherapy Practice of Deborah S. Green-Lauber, LISW-S

## Health Insurance/EAP Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Contact Ph-Cell: \_\_\_\_\_ H: \_\_\_\_\_ Gender: \_\_\_\_\_

### Primary Insurance

Ins. Co.: \_\_\_\_\_ Employer: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Payor ID#: \_\_\_\_\_

### Insured's Information: (if different than patient)

Name: \_\_\_\_\_ Relationship to Pt: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

### EAP Benefit Information

EAP Co. : \_\_\_\_\_ Employer: \_\_\_\_\_

EAP Employee Name: \_\_\_\_\_ Relationship to Pt: \_\_\_\_\_ DOB: \_\_\_\_\_

Address(if different than pt) \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

EAP ID#: \_\_\_\_\_ Total # of Sessions Authorized: \_\_\_\_\_

EAP Authorization #: \_\_\_\_\_ Dates of Auth: \_\_\_\_\_ to \_\_\_\_\_

### Secondary Insurance

Secondary Insurance Co.: \_\_\_\_\_ Employer: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group#: \_\_\_\_\_ Payor#: \_\_\_\_\_

### Secondary Insured's Information: (if different than patient)

Name: \_\_\_\_\_ Relationship to Pt: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Deborah S. Green-Lauber, LISW-S will bill the above insurance company/EAP company directly for all services. Your signature indicates liability for any balance due. The patient's, or responsible person's, signature below authorizes release of any necessary medical or other information requested by the insurance company to process the claim. Your signature requests and assigns direct payment to Deborah S. Green-Lauber, LISW-S all proceeds payable under the terms and provisions of your insurance policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# **Psychotherapy Practice of Deborah S. Green-Lauber, LISW-S**

## **Consent for Treatment**

I, \_\_\_\_\_ give permission and consent to Deborah S. Green-Lauber, LISW-S to provide mental health assessment/treatment to me.

I understand that information disclosed in clinical sessions is confidential and may not be released to anyone without my written permission. This therapist adheres to professional, legal, and ethical guidelines established by state law. Legal and ethical exceptions to confidentiality include:

1. When there is clear and present danger or harm to you or others.
2. When there is knowledge or suspicion of abuse or neglect of children or elderly persons.
3. When a court subpoenas clinical records.
4. When an individual cites his/her treatment/clinical record in a legal proceeding.

I have also reviewed the information provided by this therapist regarding use of protected health information (PHI) per HIPPA (Health Insurance Portability and Accountability Act). A written copy of the Notice of Privacy Practices will be given upon request.

**My rights:** I understand I have to right to competent and professional service. I have the right to be treated with respect and courtesy. I have a right to a therapeutic relationship free of abuse or exploitation. I have the right to file a complaint. I have the right to review my clinical record and make a written request to have it released to a competent professional.

**My responsibilities:** I am responsible to be an active, collaborative participant in my therapy process.

**Payment:** I understand that I am financially responsible for this treatment at a fee of \$100 per therapy session. I agree to make a payment/co-payment at the time of service. If I choose to use insurance, I am responsible for the balance not paid by my insurance company.

**Missed appointments:** I understand I will be charged a late cancel/no show fee of \$50, if I fail to give 24 hrs notice to cancel or reschedule an appointment.

**Electronic Media:** I understand that I may want to use email to schedule and/or cancel appointments. If I use email for purposes other than appointment requests, I understand and waive my right to complete confidentiality, as there are limits to what can be kept private over the internet. I understand therapeutic advice/ consultation will not be conducted via email due to these confidentiality restrictions. I agree to the use of text message reminders for upcoming appointments.

I have read the above information and have had the opportunity to discuss this consent with my therapist. I give full voluntary consent to clinical services rendered by Deborah S. Green-Lauber, LISW-S. I understand that I may terminate clinical services and this consent at any time. My signature signifies understanding and agreement to these policies.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

# Psychotherapy Practice of Deborah S. Green-Lauber, LISW-S

## PERSONAL INFORMATION FORM – ADULT

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Education Completed: \_\_\_\_\_

Who Referred You to Deborah: \_\_\_\_\_

### SYMPTOM CHECK LIST: (check all that apply; use blank space to add items not listed)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> agitated               | <input type="checkbox"/> restless          | <input type="checkbox"/> anxious                 | <input type="checkbox"/> racing thoughts   |
| <input type="checkbox"/> fearful                | <input type="checkbox"/> worry a lot       | <input type="checkbox"/> depressed               | <input type="checkbox"/> appetite increase |
| <input type="checkbox"/> cry often              | <input type="checkbox"/> don't fit in      | <input type="checkbox"/> confused                | <input type="checkbox"/> appetite decrease |
| <input type="checkbox"/> hopeless               | <input type="checkbox"/> helpless          | <input type="checkbox"/> sad                     | <input type="checkbox"/> no appetite       |
| <input type="checkbox"/> withdrawn              | <input type="checkbox"/> guilt             | <input type="checkbox"/> suicidal                | <input type="checkbox"/> overly distracted |
| <input type="checkbox"/> feeling out of control | <input type="checkbox"/> hear voices       | <input type="checkbox"/> personality changes     | <input type="checkbox"/> mood swings       |
| <input type="checkbox"/> suspicious             | <input type="checkbox"/> can't concentrate | <input type="checkbox"/> overactive/rapid speech | <input type="checkbox"/> homicidal         |
| <input type="checkbox"/> angry                  | <input type="checkbox"/> irritable         | <input type="checkbox"/> passive                 |  |

How long have these symptoms been present?  less than a month  several months  several years  since childhood

### SLEEP PATTERNS: (check all that apply)

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> awaken early      | <input type="checkbox"/> insomnia      | <input type="checkbox"/> hard to get to sleep | <input type="checkbox"/> sleep too much |
| <input type="checkbox"/> excessive fatigue | <input type="checkbox"/> night terrors | <input type="checkbox"/> sleep walking        | <input type="checkbox"/> nightmares     |
- # of hours of sleep per night: \_\_\_\_\_

### ENERGY LEVEL:

- |                                      |   |                                      |
|--------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> tire easily | <input type="checkbox"/> average energy | <input type="checkbox"/> high energy |
|--------------------------------------|---|--------------------------------------|

### PRIMARY STRESSORS: (check major areas of stress)

- |  |  |
|--|--|
| <input type="checkbox"/> Problems with family or friends | <input type="checkbox"/> Not enough support people |
| <input type="checkbox"/> Death or loss of loved one      | <input type="checkbox"/> Educational stressors     |
| <input type="checkbox"/> Occupational stressors          | <input type="checkbox"/> Housing problems          |
| <input type="checkbox"/> Economic/financial problems     | <input type="checkbox"/> Transportation problems   |
| <input type="checkbox"/> Legal Issues                    | <input type="checkbox"/> Other: _____              |

### TREATMENT HISTORY:

List any previous Psychiatric/Psychological Treatment or Counseling: \_\_\_\_\_  None

### CHEMICAL USE HISTORY:

Do you use Nicotine?  YES  NO

Do you use Caffeine?  YES  NO

Do you use alcohol?  YES  NO

How often do you drink alcohol?

If yes, how many packs per day? \_\_\_\_\_

If yes, how much: \_\_\_\_\_

If yes, what do you drink?  Beer  Wine  Hard Liquor

Daily  3-5 times/week  1-2 times/week  Less frequently

Do you use drugs?  YES  NO

If yes, what do you use? \_\_\_\_\_ How often? \_\_\_\_\_

Do you or any family members have a problem with alcohol or drugs? \_\_\_\_\_

**FAMILY HISTORY**

Spouse/Partner's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Years together: \_\_\_\_\_

Client's # of Children: \_\_\_\_\_ Client's # of Siblings: \_\_\_\_\_

Number of Persons in Your Household: \_\_\_\_\_ List Names, Ages, and Relationships of Persons Living in Your Household:

Have any Family Members Been in Mental Health Treatment?  YES  NO

If yes, please specify: \_\_\_\_\_

Have you ever been exposed to abusive behavior(s)?  YES  NO

If yes, specify if you choose: \_\_\_\_\_

Is there anything else you would like your Provider to know? \_\_\_\_\_

**MEDICAL HISTORY**

Primary Care Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICATIONS CURRENTLY BEING USED:** (prescribed and/or over-the-counter)  None

Medication	Dosage	Frequency	Last Used	Prescribed by

VISUAL  No Problem  Wears Glasses  Blindness  Glaucoma  Blurred Vision  Other Visual Disturbances

HEARING  No Problem  Dizziness  Ringing in ears  Deafness  Other Hearing Problems  Hard of Hearing

RESPIRATORY  No Problem  Asthma  Hay Fever  Congestion  Short of Breath  Emphysema  Tuberculosis

CARDIOVASCULAR  No Problem  High BP  Low BP  Chest pain  Prior stroke  Prior heart attack

EXCRETORY  No problem  Urinary problems  Bladder problems  Other: \_\_\_\_\_

NEUROLOGICAL  No problem  Seizures  Frequent Headaches  Migraines  
 Memory problems  History of head injury

SEXUAL/REPRODUCTIVE Sexual Orientation:  
 Heterosexual  Gay  Bisexual  Other: \_\_\_\_\_  
 Sexual worries  Birth control issues  PMS  Menopause  Other Issues: \_\_\_\_\_

ENDOCRINE  No problem  Diabetes  Hypoglycemia  Thyroid Problem

GASTROINTESTINAL  No problem  Frequent nausea/vomiting  Diarrhea  Ulcers  Constipation  
 Appetite:  poor  ravenous

MUSCULOSKELETAL  No problem  Muscle impairment/tenderness  Joint pain  Restricted motion  Back pain

CANCER  None  Type: \_\_\_\_\_ Year of Discovery: \_\_\_\_\_

OTHER Medical Conditions /Surgeries: \_\_\_\_\_

Serious Injuries: \_\_\_\_\_