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

Health Insurance/EAP/Private-Pay Form

Patient Name:_____DOB:_____

Address:_____City:_____ST:____ZIP:_____

Contact Phone(s) C:_____ 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:_____

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:_____

Check if using Private-Pay/No Insurance_____ ☐

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:_____

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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 HIPAA (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 private-pay fee of $100 per therapy session. If I choose to use insurance for payment, I agree to make my co-insurance/co-payment at the time of service and I agree I am responsible for any 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.

Email Restrictions: 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 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_____

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PERSONAL INFORMATION FORM – ADULT

Client'sName: _____DOB:_____

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)

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□ withdrawn	□ guilt	□ suicidal	□ overly distracted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

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

SLEEP PATTERNS: (check all that apply)

□ awaken early	□ insomnia	□ hard to get to sleep	□ sleep too much
□ excessive fatigue	□ night terrors	□ sleep walking	□ nightmares

# of hours of sleep per night: _____

ENERGY LEVEL:

□ tire easily □ average energy □ high energy

PRIMARY STRESSORS: (check major areas of stress)

□ Problems with family or friends	□ Not enough support people
□ Death or loss of loved one	□ Educational stressors
□ Occupational stressors	□ Housing problems
□ Economic/financial problems	□ Transportation problems
□ Legal Issues	□ Other: _____

TREATMENT HISTORY:

List any previous Psychiatric/Psychological Treatment or Counseling: □ None

_____

CHEMICAL USE HISTORY:

Do you use Nicotine? □ YES □ NO If yes, how many packs per day? _____
Do you use Caffeine? □ YES □ NO If yes, how much: _____
Do you use alcohol? □ YES □ NO If yes, what do you drink? □ Beer □ Wine □ Hard Liquor
How often do you drink alcohol? □ 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 CURRENLY 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: _____