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.

Parent/Guardian Signature_____Date_____

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PERSONAL INFORMATION FORM -ADOLESCENT

Today's Date:_____ Client Name: _____

Contact Phone:_____ DOB:_____ Age:_____ Gender: _____

Race:_____

Referred by: _____

Name of Primary Care Physician: _____

PARENT OR GUARDIAN INFORMATION

(If parent address info is same, record one and write word "same" for the other)

Who Has Legal Custody of Child? _____

PARENT/GUARDIAN

Name: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Email: _____

PARENT/GUARDIAN

Name: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Email: _____

SCHOOL INFORMATION

Name of School: _____ Grade Level: _____ School District: _____

Special Services: (check all that apply) □ SBH □ LD □ DH □ Home Schooled □ Gifted □ Other: _____

PEOPLE CURRENTLY LIVING IN CHILD'S HOME

NAME	RELATIONSHIP TO CLIENT	AGE	SEX

Please answer the following questions about your child/adolescent.

What are your child's most serious problems?

1. _____

2. _____

What have you tried to solve these problems?

1. _____

2. _____

Check any changes or stressors that might have brought on or added to the above problems:

□ New brother/sister
□ Job changes
□ School changes
□ Marriage/New relationship
□ Alcohol use
□ Deaths
□ Family financial pressures
□ School pressures
□ Divorce/Separation
□ Loss/Change of friends
□ Addiction issues
□ Health problems
□ Traumatic experience
□ Moves
□ Activity/sports pressures
□ Family medical problems
□ Family mental illness
□ Other: _____

PAST OR CURRENT MENTAL HEALTH SERVICES OR SUBSTANCE ABUSE TREATMENT

PROVIDER	DATES	TYPE OF TREATMENT

DEVELOPMENTAL INFORMATION (circle or check appropriate response)

ADOPTION Is this child adopted? □ NO □ YES Age at Adoption: _____

AGES 0 TO 12 MONTHS

During this time period, was the child:

□ Unusually fussy, very hard to soothe
□ Hard to cuddle (stiff or floppy)
□ Slow to smile or sit or crawl
□ Unusually quiet, not responding much to attention
□ Bothered with feeding problems
□ Not interested in looking at people

AGES 1 TO 5 YEARS

During this time period, was the child:

□ Late walking
□ Said to be slow, delayed or retarded
□ Hard to leave with a baby-sitter
□ Late talking
□ Difficult to toilet train
□ Bothered by unusual fears
□ Hard to understand
□ Hard to control in public places
□ Setting fires
□ Needing much supervision to prevent dangerous behavior
□ Having sleep problems
□ Having severe or frequent tantrums
□ Lack of imaginative play
□ Unusually upset by changes or new situations
□ Very demanding, wanting things right away
□ Having sleep problems
□ Often fighting, biting, scratching over little frustrations
□ Having sleep problems
□ Having trouble sharing or taking turns
□ Unable to get along will in pre-school or Kindergarten
□ Showing unusual behaviors, body movements, tics, or nervous habits

AGES 6 TO 12 YEARS

During this time period, was the child:

□ Hard to get along with at home
□ Uninterested in being with other children
□ Having trouble with behavior in school
□ Often "down" or depressed
□ Having sleep problems
□ Having other problems or behavior difficulties
□ Having trouble making or keeping friends
□ Having trouble learning
□ Having trouble controlling frustration or anger
□ Very shy or nervous
□ Having many physical problems or complaints
□ Evidence of substance use/abuse

AGES 12 TO 18 YEARS

During this time period, was the adolescent:

□ Having trouble getting along with parents
□ Having trouble making or keeping friends
□ Having trouble with behavior or attendance at school
□ Often hurting others or threatening to kill
□ Often "down" or depressed or threatening suicide
□ Having sleep problems
□ Having other problems or behavior difficulties
□ Having trouble getting along with brothers or sisters
□ Having trouble achieving at school
□ Uninterested in being with other adolescents
□ Often destructive of property
□ Very anxious or nervous
□ Having many physical problems or complaints
□ Evidence of substance use/abuse

Use the following space to further describe any developmental issues needing further clarification:

MEDICAL HISTORY

HOSPITALIZATIONS □ NONE

AGE	HOSPITAL	ILLNESS/INJURY/SURGERY

SERIOUS OR CHRONIC HEALTH PROBLEMS □ NONE

AGE AT DIAGNOSIS	PROBLEM

Medication Allergies: _____

Other Allergies: _____

MEDICATIONS NOW BEING TAKEN □ NONE

MEDICATION	DOSE	REASON TAKEN	PRESCRIBED BY

FAMILY HEALTH HISTORY

Check the item if there is a family member with the problem and indicate the relationship to the child.

	Relationship		Relationship
□ Alcoholism	_____	□ Depression	_____
□ Heavy drinking	_____	□ Suicide attempt	_____
□ Other Addictive Disorders	_____	□ Intentional self-harm	_____
□ Drug abuse	_____	□ Suicide	_____
□ In trouble with the law	_____	□ Tics or Tourette's	_____
□ Attention problem	_____	□ "ADD" Hyperactivity	_____
□ Learning problems	_____	□ Severe anxiety	_____
□ Dyslexia	_____	□ Panic Attacks	_____
□ Special classes in school	_____	□ Mental Retardation	_____
□ Obsessive Compulsive Disorder	_____	□ Schizophrenia	_____
□ Extreme fears or phobias	_____	□ Eating Disorder	_____
□ Manic depression or Bipolar	_____	□ Victim of sexual abuse	_____
□ Victim of physical abuse	_____	□ Rape Victim	_____
□ Jail Sentence	_____	□ Other:	_____