Client Information

Date: _____

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Referred by: _____

Primary Physician: _____ Current Medication: _____

Allergies to Medication: _____

Emergency Contact: _____

Relationship to Client: _____ Phone No.: _____

Responsible Party: ( ) Self ( ) Spouse ( ) Parent

Name: _____ Address: _____

Social Security Number of Responsible Party: _____

His/Her Employer: _____ Address: _____

His/Her Job Title: _____ Work Phone: _____

Health Insurance: _____ Group No: _____

Please list each professional, program, or hospital that has provided behavioral health services to you or your family. If you don't have their current addresses, please bring this information to the next appointment.

Professional/Program or Hospital Address/Location Dates

Close Family Members (Parents, Siblings, Spouse, Children, etc.)

Name Relationship Age Any Mental Health, Drug/Alcohol Problems

_____

_____

_____

_____

Client Name: _____ Date: _____

Client Information

Reason for seeking help. Current problems experienced by the Client. Please circle any relevant problems.

Sadness Anxiety Drug Abuse Parenting Spouse Stress Limited Communications Behavior problems Sexual behavior Anger control Work conflicts Lonely Nightmares Lack of energy Confused thinking Sexual dysfunction Marriage problems Family conflicts Stealing Sibling conflicts Physical abuse Criminal/delinquent behavior Assertiveness Co-dependency Panic attacks Fears Compulsive behavior Underachievement Hyperactivity Short Attention Eating disorder Stuttering Apathy Job Stress Learning disability Financial problems Physical disability Death/loss Spirituality Weight/appearance Legal problems

My Goals for Treatment:

_____
_____
_____
_____
_____
_____
_____
_____

PATIENT LETTER OF AGREEMENT

INSURANCE BILLING AND PAYMENT POLICY

PLEASE INITIAL EACH ITEM BELOW

_____ I request Dr. Daniel J. Christiano, Ph.D to submit billing on my behalf directly to my Insurance Carrier.

_____ I acknowledge that payment for services will be forwarded directly to your provider.

_____ I authorize the release of any information necessary to process the claim for payment.

_____ Payment liability for Non-insured patients and for charges of DENIED services rests with the patient, or responsible party, who is the beneficiary of those services.

_____ I agree to be personally responsible for payment of those services, as well as, any legal fees, court costs, collection fees, and late fees connected with collection of payment.

_____ I agree to pay a **$25.00** fee for any personal checks returned for insufficient funds.

_____ I agree that the person who brought the child in to see the doctor, is responsible for all the fees associated with the visit.

APPOINTMENT POLICY

_____ The cooperation of each patient is necessary to assure that everyone's needs are met. Frequently, patients are placed on a "waiting list" for appointment cancellations. It is therefore necessary that every consideration be given to avoid missed appointments that could be used by someone else.

_____ Each patient is responsible for keeping appointments with his or her provider. If it becomes necessary to break an appointment, it is EXPECTED that a patient contact this office 24 hours in ADVANCE of scheduled appointment.

_____ If a patient misses his or her scheduled appointment or fails to provide **24 hours advance notice**, there will be a charge of **$50.00**. This charge will not and cannot be billed to your insurance company. You are personally responsible for this charge. **In the event my account is turned over for collection. I understand that I will be responsible for all collection costs.**

SIGNATURE OF AGREEMENT

_____

DATE _____

WITNESSED BY:

_____

DATE _____

INFORMED CONSENT FOR TREATMENT

I, _____ DOB_____ SSN_____

1. I have been informed of my rights and responsibilities as a patient of Dr. Daniel J. Christiano, Ph.D.

2. I have been informed about the limits of confidentiality of my records.

3. I have been informed of the cost of services from Dr. Daniel Christiano. I understand that I am responsible to pay a co-pay and that it is payable each time I come for treatment.

4. I have been informed about Dr. Daniel J. Christiano's qualifications.

5. I understand that I may address any concerns or grievances with my therapist/doctor at any time. I understand that I may also contact the licensing board which regulates therapists/doctors professional practice.

6. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment t any time. However, I agree to let Dr. Christiano know before stopping treatment.

7. I agree that, if at any time, I feel that I may be a threat to myself or others, I will call 9-1-1.

8. I give my authorization and consent to receive outpatient diagnostic and treatment services from Dr. Daniel J. Christiano. I understand that my therapist/doctor believes that this treatment will help me and there is no guarantee as to the result. I also understand that on occasion there are negative consequences to treatment, and I agree to inform Dr. Daniel Christiano if there are unexpected changes in my condition.

_____ _____

Signature of patient or legal consenter Date

_____ _____

Signature of staff providing the information Date

Dr. Daniel Christiano, Ph.D

ADULT HISTORY FORM

(Confidential)

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these as fully questions and accurately as you can, you will facilitate your therapeutic program. You benefit by completing these routine questions in your own time instead of using your actual consulting time. Case records are strictly confidential. No outsider is permitted to see your case record without your written permission. If you do not desire to answer any question, merely write: "Do not care to answer."

Insurance: _____

Date: _____

GENERAL

Name

Address _____

Home Phone _____ Work Phone _____

Age _____ Date of Birth and Place _____

Occupation_____ Employer_____

Do you live in a house, hotel room, apartment, etc.? _____

MARITAL HISTORY

Marital Status (Circle): Single Married Separated Widowed Divorced

How many times have you been married, including marriage above? _____Length of present marriage_____

How long did you know your marriage partner before engagement? _____

For how long were you engaged? _____ Husband's/Wife's age? _____

Husband's/Wife's occupation? _____ Employed now? _____

How many hours per week? _____

Describe his or her personality in your own words: _____

_____

In what areas is there compatibility? _____

In what areas is there incompatibility? _____

How do you get along with your in-laws? (This includes brothers and sisters-in-law) _____

_____

_____

How many children do you have? (List names, ages, sex, and personality). Note any from previous marriage. List marriages if any. _____

_____

Give any details of any previous marriage(s): _____

INDIVIDUAL PAST HISTORY

Are you adopted? ____ If yes: When _____ Where_____

What age _____ By Whom _____

What age did you find out _____ What was your reaction _____

When you were born, were there any medical or emotional complications for you or your mother? _____

If yes, explain: _____

List all serious diseases or illnesses you had as a child or teenager. (Include age) _____

_____

List all serious operations or accidents that you had as a child and what age you were _____

_____

Please describe any fearful or distressing experiences you've had which have not been previously mentioned.

_____

_____

Underline any of the following that applied during your childhood. Problems with:

Sleep-walking, thumb-sucking, nail-biting, stammering, fears, night terrors, shyness, tantrums, tics, day-dreaming, overweight, imaginary playmates, repeated fighting, dreams, slow development, special classes, excessive masturbation, bowel problems, nightmares, bed-wetting.

Do you remember your childhood as being happy or unhappy? _____

Games and interest during childhood (including make-believe) _____

Interests and hobbies during adolescence (teens) _____

Athletic or other accomplishments _____

Have you ever bullied or given a nickname which hurt your feelings? _____

Present interests, hobbies, activities _____

Relationship with brothers and sisters: _____

Past: _____

Present:_____

Give a description of your father's personality and his attitudes towards you. (Past and present) _____

_____

Give a description of your mother's personality and her attitudes towards you. (Past and present) _____

_____

In what ways did your parents punish you as a child? _____

Describe the home atmosphere in which you grew up, any family problems, and the status of compatibility between parents and between parents and children: _____

_____

At what age were parents divorced? _____

How did you react to divorce? _____

If you were not reared by your parents, who reared you and between what years? _____

_____

Who are the most important people in your life? _____

Are there any other members of the family about whom information regarding illness, etc. is relevant?

_____

SCHOOL HISTORY

Age Started _____ _____Last grade and age completed _____

Number of grammar schools attended _____Were you often truant _____

Were you ever in special classes? Yes/No Which classes? _____

Problems in going to school because of fears or of repeated illnesses _____

Did you have difficulties or problems in school not listed? If yes, explain:_____

_____

Have you had any trade/technical training in addition to formal schooling? If yes, describe: _____

_____

OCCUPATIONAL HISTORY

Current Job? _____ Previous jobs? _____

Ever fired? _____ If yes, why? _____

Are you satisfied with your current job? _____

What ambitions do you have for your future? _____

Do you have any financial problems? _____

Any problems relating to your supervisors or co-workers? _____

RELIGION

Your religion _____

Have you or your spouse changed religion? Yes/No If yes, why? _____

Do you attend services? _____

Your church? _____

HOBBIES

List your interests and hobbies _____

_____

Have there been any changes in your interest or involvement in these activities? _____

If yes, explain: _____

LEGAL ISSUES/LAW VIOLATIONS

Have you ever been arrested, imprisoned, or appeared before a Youth Service Board?_____ If yes, explain: _____

MILITARY/SERVICE HISTORY

Were you in the services? _____Years _____ Branch _____

Date and type of discharge _____

Rank at discharge _____

SEXUAL HISTORY (General)

What is your sexual orientation? _____

If married or in a relationship, is sex life with spouse/partner satisfactory? Yes/No

Have you ever had any unusual, unpleasant, or frightening sexual experiences? Yes/No

If yes, explain: _____

SEXUAL HISTORY (Women)

Age of onset of periods? _____ Do you experience any menstrual pain or irregularity? Yes/No

Do periods affect your mood? Yes/No If yes, explain: _____

Have you been pregnant? Yes/No Any complications during pregancies? _____

Have you ever had a miscarriage? Yes/No If yes, when and what was your emotional reaction? _____

_____

Have you undergone or are you going through menopause? Yes/No If yes, how has it affected you? _____

_____

MEDICAL

List all serious illnesses, operations, injuries, and hospitalizations not previously mentioned (Give dates, doctor, hospital, and treatment) _____

_____

_____

List all current medications and doses and reasons for taking _____

_____

_____

Are there any hereditary diseases in your family? Yes/No If yes, explain: _____

_____

Any recent weight changes? Yes/No If yes, explain: _____

Last physical checkup _____Why? _____

Results_____

Current medical problems for which you are receiving treatment for _____

_____

Any problems with pain? _____ Any other physical symptoms? _____

ALCOHOL AND DRUG HISTORY

Present use: _____

_____

Past use:_____

_____

How have alcohol and drugs affected your life? (e.g, legal issues, relationship problems, employment, health):

_____

_____

Have you experienced any physical or emotional reactions to your discontinuing use of drug or alcohol? _____

_____

CURRENT PROBLEMS

Underline any of the following that apply to you:

Delay in falling asleep, intermittent awakening, early morning awakening, oversleeping, mood swings, low energy level, changes in appetite, recent weight loss or gain, agitation, wishing to be dead, strange or fearful thoughts, excessive guilt, crying, decreased effectiveness at work or inability to concentrate headaches, dizziness, fainting spells, palpitations, stomach trouble, bowel disturbances, nightmares, take sedatives, alcoholism, feel tense, feel panicky, tremors, depressed, suicidal ideas, drugs, unable to relax, sexual problems, unable to have a good time, don't like weekends and vacations, over-ambitious, shy with people, can't make friends, feel lonely, can't make decisions, can't keep a job, inferiority feelings, home conditions bad, financial problems, hearing problems, vision problems, guilty, hearing voices

Explain the most important items underlined _____

_____

My main reason for seeking help is:_____

Since they started, my problems have: Stayed the same _____ Improved _____Worsened _____

I feel the cause of my problems are: _____

_____

My problems would be improved if: _____

How strongly do you want treatment for your problem? **Circle your answer**

Very much Much Moderately Could do without if necessary

Have you had suicidal ideas? Yes/No Ever attempted suicide? Yes/No Do you think you would? Yes/No

List suicide attempts you have made:

Date or Age Method of Attempt Hospitalized? How Long?

_____

_____

Previous Mental Health Counseling or Psychiatric Treatment (List type of counseling/therapy, when it occurred, frequency, duration, name and location of therapist, results.)

_____

_____

_____

Prior Psychiatric Hospitalizations (List Date, Hospital name and address, length of stay, voluntary or involuntary)

_____

_____

Please list family members names and ages: _____

_____

FAMILY MEDICAL HISTORY

Please list family members who have had mental health issues and/or substance abuse issues:

_____

_____

_____

With whom do you live at present? (List name, age, sex, relationship to you) _____

_____

SOCIAL CONTACTS

Other important persons: Please list those persons with whom you have a strong current and continuing relationship.

_____

_____

Have you or do you take medications for medical problems and/or psychiatric problems? Yes/No If yes, please list below

Name Daily Dose Reason/Results

_____

_____

_____

Please summarize below the most important aspect of your life and would help our therapist understand you better.

_____

_____

_____

_____

_____

DANIEL J CHRISTIANO, PHD
1630 E White Mountain Boulevard, Suite B
Pinetop, AZ 85935
480.577.6367 F 928.358.5015 djchere@aol.com www.drchristiano.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of Daniel J Christiano, PhD, Notice of Privacy Practices. This notice describes how Daniel J Christiano, PhD may use ad disclose my protected health information, certain restrictions on the use of my healthcare information and rights I may have regarding my protected health information.

_____ _____

Signature of patient or personal representative Date

_____

Relationship to patient

DANIEL J CHRISTIANO, PHD
1630 E White Mountain Boulevard, Suite B
Pinetop, AZ 85935
480.577.6367 F 928.358.5015 djchere@aol.com www.drchristiano.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This notice tell you about the ways in which Daniel J. Christiano, Ph.D. may collect, use, and disclose your protected health information and your rights concerning your protected health information. "Protected Health Information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by Federal and State laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice, while it is in effect. Some of the uses and disclosures described in this Notice may be limited to certain cases by applicable state laws that are more stringent than the federal standards. The HIPAA Privacy Rule for the first time creates national standards to protect individuals' medical records and other personal health information.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

PAYMENT: We use and disclose your protected health information to your insurance company in order to receive payment for your covered health expenses.

HEALTH CARE: We may use and disclose your protected health information to other health care providers (physicians, healthcare professionals, laboratories, or hospitals) to better assist in your diagnosis and treatment.

MEDICAL RECORDS REQUEST: We will disclose your protected health information if we receive a request from another physician who is treating you or will be treating you, with a signed request from you. We will disclose your protected health information to another physician if we refer you to that physician. We will disclose your protected health information to an insurance company if we have filed a claim on your behalf. We will disclose your protected health information, with your authorization, to a life insurance underwriter or health insurance company if you are seeking life or health insurance coverage and have requested a company to contact us for your medical history.

MARKETING: If our office ever decides to use a patient's protected health information for marketing purposes, a patient's prior written authorization to use this patient's information will be required. Daniel J. Christiano, Ph.D. will never sell lists of patients' names/information to any third party.

OTHER PERMITTED OR REQUIRED DISCLOSURES

AS REQUIRED BY LAW: We must disclose protected health information about you when required to do so by law.

PARENTS AND MINORS: State law governs disclosures to parents.

PATIENTS 18-22: who are financially dependent on their parents, yet legally are adults: Without prior authorization, we cannot disclose an adult patient health status to anyone including parents (and in some cases, we cannot disclose a minor's individual health data).

CHILDREN UNDER 18: It is our office policy that any child under the age of 18 must be accompanied by a parent or legal guardian on their first visit to our office. The parent or representative may then sign an authorization for treatment of the child when they are not with them.

GENERAL PUBLIC HEALTH ACTIVITIES: We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.

VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE: We may disclose protected health information to government agencies about abuse, neglect or domestic violence.

HEALTH OVERSIGHT ACTIVITIES: We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process, and disclose records to legal counsel for the purpose of seeking legal advice.

LAW ENFORCEMENT: We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

CORONERS, FUNERAL DIRECTORS, ORGAN DONATIONS: We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.

RESEARCH: Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

SPECIAL GOVERNMENT FUNCTIONS: We may disclose protected health information as required by military authorities or to authorized federal officials for national security and intelligence activities.

WORKERS' COMPENTSATION: We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, effective with the date of the letter of revocation.

YOUR RIGHTS REGARDING OUR PROTECTED HEALTH INFORAMTION

You have certain rights regarding protected health information that our office maintains about you.

RIGHT TO ACCESS YOUR PROTECTED HEALTH INFORMATON: You have the right to review or obtain copies of your protected health information records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying, mailing our requested information, but we will tell you the cost in advance.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATON: If you feel that the protected health information maintained by our office is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, for example, you may ask us to amend something in your record that was not created by our office, as is often the case when the information may come to us from another physician, health care professional, laboratory, or hospital. We may deny your request if you ask us to amend a record that is already accurate and complete.

RIGHT TO AN ACCOUNTING OF DISCLOSURES BY THE PLAN: You have the right to request an accounting of disclosures we have made of your protected health information. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before September 21, 2009. Your request should indicate in what form you want the list (example: on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists, we reserve the right to charge for the cost of providing the list.

RIGHT TO REQUEST RESTRICTIONS ON THE USE AND DISCLOSURE OF YOUR PROTETED HEALTH INFORMATON: You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment, or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

FOR INFORMATION REGARDING EXERCISING YOUR RIGHTS: You may exercise any of the rights described above by contacting. Daniel J. Christiano, Ph.D. See the end of this Notice for the contact information.

HEATH INFORMATION SECURITY

Daniel J. Christiano, Ph.D. requires its employees and associates to follow the office security policy and procedures that limit access to health information about patients to those employees and associates who need it to perform their job responsibilities. In addition, Daniel J. Christiano, Ph.D. maintains administrative, and technical security measures to safeguard your protected health information.

CHANGES TO THIS POLICY

Daniel J. Christiano, Ph.D. reserves the right to change the terms of the Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in the Notice.

COMPLAINTS

If you believe that your privacy rights have been violate, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing and sent to the Office listed at the end of this Notice. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

RIGHT TO REVOKE HEALTH CARE AUTHORIZATION

You have the right to revoke the **HEALTH CARE AUTHORIZATION FORM,** in writing, at any time. However, your written request to revoke your **AUTHORIZATION** is not effective to the extent that we have provided services or taken action in reliance on our authorization. You may revoke your **AUTHORIZATION** by mailing or hand delivering a written notice to our office at the address listed at the end of the Notice. The revocation is not effective until it is received by our office.

The written notice must contain the following information:

Our name, Social Security Number and date of birth
A clear statement of your intent to revoke your **AUTHORIZATION**
The date of your request, and
Your signature

The **AUTHORIZATION** is requested by Daniel J. Christiano, Ph.D. for its own use/disclosure of your protected health care information (Minimum necessary standards apply.)

You have the right to refuse to sign this **AUTHORIZATION.** If you refuse to sign this **AUTHORIZATION,** Daniel J. Christiano, Ph.D. reserves the right to refuse service. A copy of the signed **AUTHORIZATION** will be provided to you at your request.

MISSED APPOINTMENTS: Unlike some other medical or paramedical professionals who operate on more flexible or inexact schedules, our counselor commits a specific time period, usually 45-55-minute sessions, to each patient. It is important that you appreciate the fact that this block of time has been set aside for you. Our schedules are usually crowded. Your canceling or rescheduling your appointment without sufficient notice often means the loss of an hour of therapy, and it is difficult to reassign the hour to someone else on short notice. A charge may be made for an appointment not canceled 24-hours in advance.

PAYING YOUR BILL: We accept insurance payments, but you are responsible for any balance on the account. Cash accounts or insurance co-payments are due at the time of service. If we are to submit for reimbursement for your insurance carrier, it is your responsibility to provide us with the proper forms and necessary signatures. New claim forms may be needed at the beginning of each calendar year.

OFFICE HOURS: Are by appointment, during regular business hours. If you telephone the office at a time when the therapist is in session or out of the office, voicemail will record your message and your call will be returned as quickly as possible. Should you have a life-threatening emergency, please call 9-1-1.

CONTACTING DANIEL J. CHRISTIANO, Ph.D. If you have any questions or complaints about this Notice or you want to submit a written request to our office in any of the previous sections of the Notice, please call 480.577.6367 or write:

Daniel J. Christiano, Ph.D.
1630 E White Mountain Blvd., Suite B
Pinetop, Arizona 85935