Dr. Ruthie Norman LICSW LLC
Trauma Treatment & Recovery Psychological Services

Hello and welcome to the practice of Dr. Ruthie Norman, LICSW LLC. Our sessions together will be approximately 50-60 minutes unless additional time is needed and planned for. Your first visit to a new therapist is very important- the following information may help you to understand some of the questions you may have.

My office is located at 1029 North Road Suite 24 Westfield, MA 01085.
(*Located in the Hampton Ponds Plaza/ directly across from Hampton Ponds State Park)*
When you enter the plaza, my office sits farthest to the right side on corner. You will see:(***Office Suites)*** above the door entrance. When you arrive, you may sit in the waiting area in the main entrance or, you will also see a sign with an arrow pointing you to the left where an additional waiting area is that sits at the end of the hall. I will look for you at either of these waiting areas at our scheduled time. Should you need to reach me, please feel free to do so!
Office Phone: 413-668-2282 Office Fax: 413-315-9684

Print, Complete & Bring to Your First Session:

→ **NEW CLIENT INTAKE:** Prior to our first session, please complete and bring it to our first appointment. This will help you share important details with me while also saving time in reviewing and obtaining your signature on the various documents included during our first meeting.

→ **ATTACHED FILE:** Please read the following documents that are included in the attached file: *Notice of Privacy Practices, Informed Consent to Treatment & Disclosure Statement & Contract Agreement for Services* as they provide important information. You will be asked to sign an *Acknowledgment Form* that is included in the intake packet confirming you have received, understand and agree to the terms of these documents. Please feel free to let me know if you have any additional questions or need more information.
→ *The following briefly explains the documents mentioned above to read:*

- **Notice of Privacy Practices-** I am required by law to provide you with a copy of the HIPAA Notice of Privacy Practices so you can understand your rights and protections related to the use and disclosure of your identifiable health care information.
- **Informed Consent to Treatment-**Your consent to treat and agreement for psychotherapy services
- **Disclosure Statement & Contract Agreement for Services-**This document explains my office policies and procedures and your contract for agreement for psychotherapy services.

→ If you would like for me to coordinate care with any of your providers **The Release of Information form** should be completed that authorizes release of psychotherapy information. Please complete a form for **each** individual/agency who you authorize for me to coordinate with. Examples: primary care physician (PCP), school providers, psychiatrist, community providers, extended family members, your emergency contact, etc.). *Please note, some insurances require specific authorizations- we can discuss should this apply to you.*

The above documents are also available at www.DrRuthieNorman.com in the Forms section.

I look forward to meeting with you!

Dr. Ruthie Norman, LICSW

Dr. Ruthie Norman LICSW LLC

Trauma Treatment & Recovery Psychological Services

Insurance Assignment, Release & Authorization

For your first appointment please bring with you your insurance card

_____ ____/_____/_____

(Client Name) **Date of Birth**

Primary Insurance: _____

Policy Number:_____

Subscribers Name_____Date of Birth ____/____/____

Address: _____

Phone Number:(_____)_____

Client's relationship to subscriber: _____

Authorization/Referral Required: □ YES □ NO □ UNKNOWN

Copay:_____ Co-Insurance: _____Deductible:_____

INSURANCE ASSIGNMENT, RELEASE & AUTHORIZATION

I hereby authorize the release of Protected Health Information; including any/all medical records relating to my mental health treatment, to the insurance company indicated above. I further agree and acknowledge that my signature on this document authorizes Dr. Ruthie Norman, LICSW, LLC to submit claims for payment of services rendered without obtaining my signature for every claim. I understand and agree I will be bound by this signature as though I had personally signed each claim. I hereby authorize the insurance indicated above the authorization to speak with and provide payment directly to Dr. Ruthie Norman, LICSW, LLC. I further acknowledge that any insurance benefits paid to Dr. Ruthie Norman, LICSW, LLC will be credited to my account in accordance with the above assignment. I understand providing insurance information is not a guarantee of my coverage. I am responsible for payment, in full, of all session fees or other service fees incurred by myself or my minor child.

_____ _____

Client Name Client Signature (If applicable)

_____

Date

Intake Assessment Form

Please provide the following information and answer the questions below. Please note; **Information you provide here is protected as confidential information.** Please Fill out this form and bring it to your first session.

Today's Date: _____

GENERAL INFORMATION

Name:

_____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth date: _____/_____/_____ Age: _____ Gender [ ] Male [ ] Female

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: ( ) May I leave a message Yes ☐ No ☐

Cell/Other Phone: ( ) May i leave a message Yes ☐ No ☐

E-mail: _____

Referred by (if any): _____

Race/ Cultural Considerations:_____

Religion/Faith:_____

Education

High School: _____

(Where) (Last grade completed) (Graduated? Y or N)

Post High School Education/College:

_____

_____

Is or was school performance a concern for you?
If yes, explain:

_____

_____

Marital Status

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Never

Years Married: _____ Years Divorced: _____

Are you currently in a romantic relationship? _____

If yes, for how long? _____

On a scale of 1-10 how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Do you have children? YES___NO___ Siblings? YES__ NO___ Living Parents? YES____ NO____

Name	Age	Sex	Occupation or Grade	Living with you?	Biological, Adopted, or Step
Children:					
Siblings:					
Parents:					

Describe your relationship with:

Parents:_____

Siblings:_____

Extended Family Members: _____

Husband/Wife/Significant Other:_____

Your Children: _____

Health History

Primary Physician: _____

Primary Physicians Address: _____

Primary Physicians Phone: _____Date of Last Exam_____

Please List Allergies if Any_____

Have you previously received any type of mental health services (Psychotherapy, Psychiatric services, ECT.)?
Yes_____
No_____
If yes, when and where?
_____
_____

Have you attended any support groups in the past or presently:
_____

Are you currently taking any prescription medications?
Yes_____
No_____
Please list:
_____
_____

Have you ever been prescribed psychiatric medication?
Yes_____
No_____
Please list:
_____
_____

Any history of side effects?
_____

CURRENT SYMPTOM CHECKLIST
Please check all symptoms that you're currently experiencing.

☐ Depressed Mood ☐ Racing Thoughts ☐ Excessive Worry ☐ Anxiety
☐ Panic Attacks ☐ Sleep Disturbance ☐ Avoidance ☐ Loss of Interest
☐ Suspiciousness ☐ Hallucinations ☐ Excessive Energy ☐ Frequent Crying
☐ Change in Appetite ☐ Binging/Purging ☐ Forgetfulness ☐ Excessive Guilt
☐ Fatigue ☐ Increased irritability ☐ Decreased Need for Sleep

☐ Other: _____

CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING IN THE PAST 30 DAYS:

- ☐ Intense feelings of sadness, hopelessness that lasts for most of the day.
- ☐ Diminished interest in activities that you normally enjoy.
- ☐ Feeling tired all the time even with 6-8 hrs of sleep a night.
- ☐ Increased indecisiveness nearly every day.
- ☐ Increased distractibility nearly every day.
- ☐ Elevated mood outside or a normal range for you.
- ☐ Increased energy or sleeplessness.
- ☐ A feeling of constant euphoria.
- ☐ Decreased need for sleep.
- ☐ Increased activities in projects or other goal directed activities.
- ☐ Seeing or hearing things that others don't see or hear.
- ☐ Feeling as if you are moving through sand.
- ☐ Intense fear of social situations or commitments.
- ☐ Increased fear of death.
- ☐ Feeling dizzy, lightheaded, faint or nauseas.
- ☐ Increased irritability.
- ☐ Increased restlessness or feeling on edge.
- ☐ Feelings that something bad might happen to you.
- ☐ Experiencing an event that caused significant emotional distress.
- ☐ Feelings of being watched.
- ☐ Recurrent or persistent thoughts that are bothersome.
- ☐ Recurrent nightmares.
- ☐ Avoidance of reminders of a significant emotional event.
- ☐ Persistent negative beliefs about yourself
- ☐ Being easily startled.
- ☐ Feeling as though you are disconnected from the world around you.
- ☐ Finding it difficult to pay attention.
- ☐ Inability to follow through on tasks when asked.
- ☐ Difficulty organizing or keeping track of things that are needed daily.
- ☐ Avoidance of tasks that require sustained mental effort.
- ☐ Inability to remain in one place for an extended period.
- ☐ Decreased school or work productivity.
- ☐ Difficulty with specific school subjects.
- ☐ Avoiding regular meals or vomiting after consuming a meal.
- ☐ Difficulty forming or engaging in relationships.
- ☐ Feelings of abandonment.
- ☐ Difficulty maintaining relationships.
- ☐ Cutting or other self-harm thoughts or behavior.
- ☐ Any other issues that cause significant distress

Please answer the following questions related to your history, to the best of your ability. These questions are intended to help with your therapy process. All information is completely confidential.

History of diagnosis or current Diagnosis: □ Yes □ No
If yes, please explain:_____

History of psychiatric symptoms: □ Yes □ No **History of hospitalization:** □ Yes □ No
If yes, please explain:_____

History of suicide attempts: □ Yes □ No **History of suicidal ideation:** □ Yes □ No **History of homicidal ideation:** □ Yes □ No
If yes, please explain:_____

History of self-injurious behaviors: □ Yes □ No
If yes, please explain:_____

Have you utilized crisis services in the past: □ Yes □ No
If yes, please explain:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMAITON

*How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you are currently experiencing:_____

_____

*How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in?

_____

_____

Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

Yes_____ No_____

If yes, approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

If yes, when did you begin to experience this?

_____

Are you currently experiencing any chronic pain?

If yes, please describe:

_____

_____

Are any physical characteristics or body image a concern? Explain:

_____

_____

Is sexual functioning an area of concern for you? Explain:

_____

_____

Substance Use

Do you drink alcohol more than once a week? Yes_____ No_____

If yes, how often? _____

Is alcohol an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

How often do you engage in recreational drug use?

Daily____ Weekly____ Monthly _____ Never____

Is recreational drug use an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle ECT.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Abuse History Have you experienced physical, sexual or emotional abuse? Yes___ No___
If yes, briefly explain:

_____

Legal History Do you have a history of any legal charges? Yes_____ No_____ If yes, briefly explain:

_____

Are you currently on probation or parole? Yes_____ No_____

If yes,
explain_____

_____

Is treatment court ordered? Yes_____ No_____

Employment

Are you currently employed? Yes____ No_____

If yes, what is your current employment situation?

_____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Additional Information

What do you consider to be some of your strengths?

_____

What do you consider to be some of your weaknesses?

_____

What would you like to accomplish out of your time in therapy?

_____

Is there anything else you feel I should know or that you are concerned about?

AUTHORIZATION FOR THE USE OR DISCLOSURE OF INFORMATION

Dr. Ruthie Norman, LICSW, LLC

CLIENT NAME: _____ DATE OF BIRTH:_____ DATE ___ / ____/ _____

By signing this Authorization for the Use or Disclosure of Information, I authorize Dr. Ruthie Norman, LICSW, LLC to receive and release information from or to the person or organization named below, electronically, verbally or in writing:

Organization/Individual_____ Attention:_____

Address: _____(Fax#)_____(Phone)_____

INFORMATION TO BE USED/DISCLOSED

□ The entire clinical/medical record (all information)

□ Only services **from:** **to:**

☑ All information in my clinical/medical record related to services provided to me by: Dr. Ruthie Norman, LICSW, LLC

□ Other (describe as specifically as possible):

_____

_____

□ _____

_____

INFORMATION REQUIRING SPECIFIC AUTHORIZATION

I consent to disclosure of my confidential health care information regarding alcohol and drug abuse records, HIV/AIDS and/or Genetic Testing to those persons/ agencies named above, by initialing the boxes below. I understand that if I do not initial a category below, the information related to that category will not be released.

_____**Alcohol or Drug Abuse** _____ **HIV/AID** _____ **Genetic Information**

I understand that if I do not initial a category above, the information related to that category will not be released.

PURPOSE(S) OF USE/DISCLOSURE

___ Continuing care/treatment ___ My personal records ___ Sharing with other providers/coordination of care ___ Legal matter

Information may be released in the following format(s):

✓ Verbally ✓ Paper Documents ✓ Mail ✓ Fax ✓ Electronic Format ✓ Email ✓ Phone

AUTHORIZATION

I have read and understand the terms of this Authorization and agree that:

1. With my signature, the protected health information ("PHI") specified above will be released to the recipient designated above.
2. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
3. I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from DR RUTHIE NORMAN LICSW LLC except when: (i) my refusal may limit ability to provide safe and effective care; (ii) I am receiving research-related treatment, or (iii) I am receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these excepts apply, my refusal to sign an authorization may result in my not obtaining treatment from DR RUTHIE NORMAN LICSW LLC

AUTHORIZATION FOR THE USE OR DISCLOSURE OF INFORMATION

DR RUTHIE NORMAN LICSW LLC

4. I understand that I may revoke this authorization at any time, except that the revocation will not have any effect on any action taken by DR RUTHIE NORMAN LICSW LLC prior to receipt of my written notice of revocation. I may revoke this authorization in writing to DR RUTHIE NORMAN LICSW LLC.

This authorization will automatically expire one (1) year from the date it is signed, unless otherwise indicated here:_____

_____ _____

Signature of Client or Legal Representative **Relationship if signed by Legal Representative**

_____ _____

Print Name **Date**

Informed Consent for Psychotherapy Form

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1.*If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.*

2. *If a client threatens grave bodily harm or death to another person.*

3. *If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.*

4. *Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.*

5.*Suspected neglect of the parties named in items #3 and # 4.*

6. *If a court of law issues a legitimate subpoena for information stated on the subpoena.*

7. *If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.*

8.*Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.*

Treatment Consent

I acknowledge and agree to the following:

- I understand that in therapy I may do all or some of the following: gain additional skills, address specific problems, gain a better understanding of myself, resolve painful experiences, and improve cognitive functioning & emotional well-being.
- I understand that I may learn a variety of coping mechanisms, problem solving strategies and other behavioral approaches. I understand that I may also gain insight into thinking patterns and behavior by the use of cognitive-behavioral therapy.
- If I have any questions or concerns about my treatment I will communicate them to my therapist and my therapist will answer them to the best of her ability.
- I understand that various therapeutic techniques are useful tools in many cases but there is no guarantee of a specific outcome.
- I agree to actively engage in my treatment by attending scheduled appointments.
- I understand that I may terminate therapeutic services at anytime.

My signature below indicates that I have read and understand the above consent to treatment with Dr. Ruthie Norman, LICSW, under the conditions specified above. I hereby give my consent to treatment.

_____	_____	_____
Client Name	Signature	Date

Dr. Ruthie Norman LICSW LLC
Trauma Treatment & Recovery Psychological Services

ACKNOWLEDGEMENT OF NOTIFICATIONS

I acknowledge receipt of the following documents provided to me by Dr. Ruthie Norman LICSW LLC: **NOTICE OF PRIVACY PRACTICES, INFORMED CONSENT FOR PSYCHOTHERAPY & DISCLOSURE STATEMENT AND AGREEMENT FOR SERVICES CONTRACT FORM.** I understand that these documents are also available on Dr. Ruthie Norman''s website but that I may also at anytime request a hard copy if I am unable to access it.

CLIENT NAME:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of **HIPAA Notice of Privacy Practices.** My signature below also confirms that this document has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.

_____ _____

Client Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF INFORMED CONSENT FOR PSYCHOTHERAPY

I consent to treatment provided by Dr.Ruthie Norman, LICSW who is a Licensed Independent Clinical Social Worker (LICSW) in the state of Massachusetts, license #117743. If I have a concern or complaint regarding my treatment, I will talk with her about it. If I believe that she has been unwilling to listen and respond, or that she has behaved unethically, I can contact The Board of Registration of Social Workers which oversees licensing. By signing below, I am consenting to treatment provided by Dr.Ruthie Norman, LICSW and I am acknowledging that I have received a copy of the document: ***Informed Consent for Psychotherapy***. My signature below also confirms that this document has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.

_____ _____

Client Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF DISCLOSURE STATEMENT AND AGREEMENT FOR SERVICES CONTRACT

My signature below authorizes Dr.Ruthie Norman, LICSW, LLC to provide psycho-therapeutic services determined to be clinically appropriate for myself, the client. I have read and understand the terms stated in this disclosure and contract. I fully understand the scope of the services and confirm that this contract has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.I agree to abide by the terms outlined and stated in this contract and throughout the course of our therapeutic relationship.

_____ _____

Client Signature Date