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

Hello and welcome to the practice of Dr. Ruthie Norman, LICSW LLC. Your first visit to a new therapist is very important, and you may have many questions. The informational forms attached will provide additional information about services. Your appointment will be approximately 50- 60 minutes.

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)

_____ _____

Parent/Guardian Name Parent/Guardian Signature

_____

Date

Dr. Ruthie Norman LICSW LLC

Trauma Treatment & Recovery Psychological Services

Parent/Guardian name:_____DOB:_____

Parent/Guardian name:_____DOB:_____

Client
Name: _____ Date of Birth: _____

Address: _____City_____

State _____Zip:_____Email:_____

Primary Phone Number:_____Secondary:_____

Emergency Contact Name: _____

Relationship to You: _____ Phone: _____

School Information

What is your current school experience?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good ☐ I don't know

School Name: **Current Grade:**	
Address:	
Phone:	
Your counselor at School:	

Briefly describe the issue(s) for which you are seeking help:

What are your goals for therapy?

Is participation in therapy mandated? ____YES _____NO If yes, please explain:

Is there any history of physical, sexual or emotional abuse? ❑ Yes ❑ No ❑ Unknown

Is there any history of prolonged separations? ❑ Yes ❑ No ❑ Unknown

Is there any history of traumatic events? ❑ Yes ❑ No ❑ Unknown

If yes, to any above, please specify:

_____

_____

_____

How would you generally describe your child's overall mood?

❑Positive (happy, laughing, upbeat, hopeful) ❑Mixed, but more positive than negative

❑Negative (depressed, cranky, angry, hostile) ❑ Mixed, but more negative than positive

_____

Who is living in same household as child:

NAME	AGE	RELATIONSHIP TO CHILD

Other significant people NOT living in the same household:

NAME	AGE	RELATIONSHIP TO CHILD

Check any areas in which your child/teen is having problems:

❑Weight
❑Health
❑Motor Skills
❑Communication
❑Nightmares
❑Bedwetting Behavior
❑Self-Harm
❑Suicidal Thoughts
❑Sleep
❑Hygiene
❑Diet and Eating
❑Aggressive Behavior
❑Getting Along with Kids
❑Getting Along with Adults
❑Drug Use
❑Mood
❑ Nervous Habits
❑Relationships
❑Sexual Acting-Out
❑Suicidal Thoughts
❑Fire-Setting
❑Hurting Animals
❑ Delinquent Behavior
❑Separation Anxiety
❑Respect
❑Focus
❑ Other

Briefly explain the boxes you checked:

Substance Use

Have you ever used or abused the following substances? If yes please include current use, past use, amounts, frequency, any withdrawal symptoms, and last use.

❑ **Alcohol**		❑ **Sedatives**	
❑ **Marijuana**		❑ **Tobacco**	
❑ **Cocaine**		❑ **Laxatives**	
❑ **Speed**		❑ **Synthetic Drugs**	
❑ **Narcotics**		❑ **Over the counter medications**	
❑ **Psychedelics**		**Other _____**	

Any problems associated with use? YES / NO If yes, Please Explain:

Have you ever been in treatment for substance use? YES / NO If yes, Please Explain:

Medical Information

Have you ever been hospitalized for any significant medical issues? YES / NO

Do you have any current or history of medical issues? YES / NO If yes, explain:

Is there anything you would like me to know?

CURRENT SYMPTOM CHECKLIST

Please check all symptoms that you're currently experiencing.

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

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? □ Yes □ No If **yes**, please provide **CURRENT** information:

_____

_____

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

Dr. Ruthie Norman LICSW LLC

Trauma Treatment & Recovery Psychological Services

Primary Care Physician

Name:_____Phone:_____

Address:_____

Medication Disclosure

☐ I **am <u>NOT</u>** currently taking any medications either over the counter or by prescription.

☐ I **<u>AM</u>** currently taking the following medications (prescription & over the counter):

Medication Name: _____

Dosage: _____

How long have you been on this medication? _____

Prescribing Doctor's Name: _____

Address: _____

Phone: _____

Side Effects: _____

Taking as prescribed? ☐YES ☐NO

Additional Medications:

_____

_____

_____

_____

_____

_____

Taking as prescribed? □Yes □ No

_____ _____ _____

Parent/Guardian Name | Parent/Guardian Signature | Date

_____ _____

Client Name | Client Signature (If applicable)

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: Primary Care Physician (PCP)_____

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 understand that my records are protected under state and federal law and cannot be disclosed without my written consent except as otherwise specifically provided by law. Further, I understand that if my records involve alcohol or drug abuse, they are also protected under Federal Regulation 42 CFR Part 2. If I have indicated above that my alcohol or drug abuse records may be generally disclosed to entities that are not my treating provider(s) or third party payer, I understand that I may request a list of entities to whom my information has been disclosed. I also understand that disclosure of HIV/AIDS or Genetic Testing related information may be restricted by me. I understand the above and voluntarily 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.)***

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

PURPOSE(S) OF USE/DISCLOSURE

□ Continuing care/treatment □ My personal records □ Sharing with other providers/coordination of care

□ Legal matter □ Insurance (such as health, life, or disability insurance)

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

☑ Verbally **and/or** ☑ Paper Document via: ☑ Mail ☑ Fax ☑ Electronic Format (when possible)

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**

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.
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_____ _____

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

_____ _____

Print Name **Date**