For Office Use Only

Chart #: _____

Dx: _____

Ins: Yes No

The Centre

CLIENT INFORMATION SHEET

(Please print clearly)

DATE: _____

Full Legal Name of Client: _____ Nickname: _____

Cell Phone #: _____ Home Phone #: _____

Mailing Address: _____

City _____ State _____ Zip _____

Date of Birth: _____ Age: _____ Gender: _____

Marital Status: _____ Spouse's Name (if applicable): _____

If client is a child, please provide parents' or guardians' names.

Father: _____ Mother: _____ Guardian(s): _____

Step-Parents: _____

Referred by: _____

EMPLOYMENT INFORMATION:

(If client is a minor, please provide parent's employer info.)

Employer: _____ Phone: _____
Address: _____

Spouse's Employer: _____ Phone: _____
Address _____

INSURANCE INFORMATION:

We will make a copy of your insurance card to keep on file. Please let us know if you have a secondary insurance company.

EMERGENCY CONTACT (someone not residing in your home)

Name: _____ Relationship: _____
Phone: _____ Address: _____

THE CENTRE

Robert E. Colclough, M.A., L.P.C., L.M.F.T.
Linda I. Colclough, M.S., L.P.C.
Rev. Cheryl Bray, M.S., L.P.C.
Julie Taylor, L.P.C.

FAMILY MEMBERS

Name: _____ Relationship: _____
Date of Birth: _____ Age: _____ Education: _____
Employment: _____

Name: _____ Relationship: _____
Date of Birth: _____ Age: _____ Education: _____
Employment: _____

Name: _____ Relationship: _____
Date of Birth: _____ Age: _____ Education: _____
Employment: _____

Name: _____ Relationship: _____
Date of Birth: _____ Age: _____ Education: _____
Employment: _____

PRESENTING PROBLEM:

_____

_____

_____

TREATMENT HISTORY: (Please include treatment provider names and dates seen.)

_____

_____

Family, marital, and individual therapy are available to help people resolve family discord, make living relationships better, enhance parenting skills, or help individuals deal with personal issues in their lives. Sessions may include seeing people individually, with their partner, or with the entire family. Who should be attendance will be worked out in advance with the counselor.

Fee Structure:

Individual Therapy:	
Initial Session	$135.00
Follow-Up	$125.00
Family/Couple's Therapy:	
Initial Session	$135.00
Follow-Up	$135.00
Consultation:	
Inside Office	$135.00 Hour
Outside Office	$150.00 Hour
Psycho-educational Evaluation:	$800.00
*Court Fees	$350.00-$500 Service Hour
Computerized Test	$80.00

*Rates for court cases may vary depending on the complexity of the case.

*24 HOUR CANCELLATION POLICY:

If you do not show up for your scheduled appointment, and you have not notified us at least 24 hours in advance, you will be charged for the cost of the session as booked. Insurance will not pay for missed sessions. This office does not practice double booking; the time assigned for your appointment is intended to be devoted to you. We appreciate your understanding.

I understand I am responsible for my fees at the above listed rates.

_____

Signature

The Centre

1290 Main St, Suite E
Daphne, AL 36526
Office: (251) 625-0118 Fax: (251) 625-0116

NON-COVERED SERVICES POLICY
FOR **BLUE CROSS/BLUE SHIELD AND**
OTHER INSURANCE CARRIERS

As my client, I want to provide you the best care possible. There may be certain services that I feel are necessary for your care that **are not covered by your Blue Cross/Blue Shield of Alabama Preferred Care contract or other insurance carriers.** You will be expected to pay for those services in full. For example, certain psychological testing, psychotherapy or psycho-educational evaluations may not be covered by your contract. If you have any questions about your Blue Cross or other insurance plan such as whether a particular service is covered or not, our office staff will be happy to assist you. Thank you for your understanding.

I have read and understand that services not covered by my insurance plan will be my responsibility to pay in full.

Signature:_____ Date:_____

Services that may not be covered as explained to Client:

Psychological Evaluations
Psycho-educational Evaluations
Psychotherapy/Counseling

Effective 8/18/08

EFFECTIVE DATE: OCTOBER 1, 2008

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Centre is required to protect the privacy of your confidential personal health information, referred o below as protected health information ("PHI"). This Notice of Privacy Practices ("Notice") is provided to you as a requirement of the privacy regulations issued under the Heath Insurance Portability and Accountability Act of 1996 ("HIPPA"). This notice describes how The Centre may use and disclose your PHI to carry out treatment, payment and healthcare operations and for other purposes that are permitted or required by law. This notice also describes your rights to access and control your PHI. The Centre will make a good faith effort to obtain from you a written acknowledgment of receipt of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of users or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

FOR PAYMENT: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, and insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or to her personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care and for whom you have signed authorization.

FOR HEALTH CARE OPERATIONS: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review you record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice's policies and procedures and that of an health care professional authorized to enter information into your medical chart, and member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at The Centre. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care of payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care of the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with the practice of with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the office manager at 625-0118. All complaints must be submitted in writing.
You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosure of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you proved us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

PATIENT OR PATIENT'S REPRESENTATIVE **DATE**

The Centre

1290 Main St, Suite E
Daphne, AL 36526
Office: (251) 625-0118 Fax: (251) 625-0116

Practice Statement and Disclosures

When a person or a family is experiencing distress over problems or potential problems, it is often difficult to know how to get started with the change process. The whole purpose of our office is to help you find the answers you need and the right solutions that are necessary to create the positive changes you seek.

It is our intent that this office is set up to provide an environment that is conducive to positive change. Please feel free at any time to ask our staff questions that you might have about the evaluation or therapy process. We hope you find our office atmosphere to be professional, but not so "business-oriented" that you would be uncomfortable to ask our staff for assistance.

This information packet may be useful in explaining our services, fees, and general information about our approach to treatment. It is our belief that change occurs best in an atmosphere of mutual understanding and straightforward progress toward a goal. Therefore, please do not hesitate to discuss with us any questions or concerns that you might have about the work we will be doing together.

Expectations

For those coming to us for counseling, the overall purpose of our relationship will be to assist in your choices about situations you believe to be troublesome. You should expect timely replies to your request. You should expect that the procedures and techniques used in our time together will be based on sound principles from our field and that they reflect the current methods of assisting persons with counseling needs. You should also know that since counseling is about trying new and different ways of behaving, thinking, and feeling, certain risks are possible for both you and those around you who may be uncomfortable with your new ways of acting, thinking, and feeling. However, if you are determined and committed to our goals, you should expect benefits from our time together.

For those coming to us for an evaluation, the purpose of our relationship will be to assist in educational and/or career planning as well as personal/relational issues. You should expect an assessment of your or your children's strengths and weaknesses in order to seek appropriate school/career placement or personal insight.

Office Hours

Sessions are scheduled by appointment (except in cases of emergency). Standard office hours are Monday, Tuesday, Wednesday, Thursday and Friday from 9:00 AM to 6:00 PM. When available, early or late appointments may be scheduled. Marital, Family and individual sessions run from 45 to 50 minutes. The remaining 10 to 15 minutes of the therapy hour is used by the therapist to review progress made in the session and to plan the next session.

Emergencies

Our office is not presently equipped to provide after-hours emergency care. If a psychological emergency occurs after regular office hours, we suggest that you contact the nearest hospital emergency room.

Cancellation

This office does not practice double booking; the time assigned for your session is intended to be devoted to you. As a result, it is important to notify the office at least twenty-four (24) hours in advance, if you need to cancel the appointment so this time can be given to someone else. If you cancel an appointment without the required notice or if you elect not to meet your session, you will be charged a minimum fee of $50.00.

Payment for Professional Services

Fees are to be paid at the time of each session. VISA and MASTERCARD will be accepted. Patients are responsible for the full fee. If your insurance pays a portion of the fee, you will be reimbursed for any excess fee paid within 45 days. Our mental health providers do not accept assignment from insurance companies. You will be responsible for the full fee amount listed in this information packet.

Insurance/Third Parties

Many times, fees for counseling services may be paid partially by insurance companies or some similar management organization. If you elect to use resources of your insurance or another third party, you should know the information such as diagnosis, impressions, or similar types of personal information are typically required by the insurance company or management organization to secure payment.

Managed Health Care Administration
Initial Assessment Child/Adolescent Program
Parent Questionnaire
Page 1

Clinician Notes:

Date: _____

Patient Name: _____ Date of Birth: ____/____/____

Age of Patient: _____ Name of person completing this form_____

Relationship to Patient: _____

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

I. Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any previous treatment for the problem? ☐ Yes ☐ No If yes, explain:

II. Medical History:

Name of Pediatrician or Family Doctor: _____
Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? ☐ Yes ☐ No

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed:

☐ Seizures	☐ Heart Problems	☐ Weight Problems	☐ Head Injury
☐ Asthmatic condition	☐ Chronic Fatigue	☐ Chronic Headaches	☐ Depression
☐ Chronic Hearing Loss	☐ Stomach Problems	☐ Suicidal Thoughts	☐ Surgeries

☐ Other _____

Please explain any item that you checked and list any medication(s) that were *previously* prescribed.

Allergies (Please list all of your child's allergies):

Current Medications (Please list all of your child's current medications other than above):

Clinician Signature:

_____

Managed Health Care Administration
Initial Assessment Child/Adolescent Program
Parent Questionnaire
Page 2

Clinician Notes:

III. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? ☐ Yes ☐ No If yes, please explain and include dates of service, location, clinician's name.

List any psychiatric or mood medications that your child has been prescribed in the past (if more than 3 medications, use the back of this page):

Name of medication	Prescribed by	Dose level	Side effects
1.			
2.			
3.			

IV: Developmental History:

A: Relating to your child's birth:

Your child's weight at birth: ____lbs. ____oz. Was this a full term birth? ☐ Yes ☐ No If no, explain:

Did either parent use drugs or alcohol at the time of conception? ☐ Yes ☐ No If yes, explain:

Were there any complications with the labor & delivery such as jaundice, infection etc.? ☐ Yes ☐ No If yes, explain:

Were there any problems after birth? ☐ Yes ☐ No If yes, explain:

B. Pre-school/Toddler Temperament: Please check the following items that apply.

☐ Did not enjoy being held	☐ Excessive restlessness	☐ Colic
☐ Feeding problems	☐ Sleep problems	☐ Head-banging
☐ Sensitive to light / noise / texture	☐ Fussy or unhappy	☐ Difficulty bonding

C. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

_____ Sitting alone _____ Walking _____ Put words together _____ Toilet trained

D. Unusual behaviors/Speech patterns:

☐ Spinning	☐ Putting things in the mouth	☐ Repeating words or phrases inappropriately
☐ Hand flapping	☐ Sniffing excessively	☐ Saying "I" for "You"

V. School/daycare History:

Did your child attend daycare? ☐ Yes ☐ No If yes, what was their age? ____ Any problems? _____

What were your child's grades on their last report card? _____

What is the name of your child's primary teacher? _____

Clinician Signature:

_____

Clinician Notes:

Name of **Current School:**	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Name of **Past Schools:**	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Has your child ever been:
evaluated for a learning disability? ☐ Yes ☐ No If yes, what grade? _____ When? _____

placed in Special Education Classes? ☐ Yes ☐ No If yes, what type of class? _____

_____

tested by the school system? ☐ Yes ☐ No If yes, when? _____

expelled or suspended? ☐ Yes ☐ No If yes, please describe: _____

_____

Does your child have a current IEP (Individual Education Plan)? ☐ Yes ☐ No
Does your child have a current 504 plan? ☐ Yes ☐ No

VI. Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child been: arrested? ☐ Yes ☐ No
assigned a probation officer? ☐ Yes ☐ No If yes, their name: _____
jailed? ☐ Yes ☐ No

Has your child: ever appeared in juvenile court? ☐ Yes ☐ No
or other family member ever been reported to DHR? ☐ Yes ☐ No
been assigned a DHR caseworker? ☐ Yes ☐ No
If yes, their name: _____
ever been a victim of child physical or sexual abuse? ☐ Yes ☐ No

If you answered yes to any of these questions, please explain:

VII. Family Medical History:

☐ Sudden death ☐ Heart disease (especially dysrhythmias) ☐ Diabetes mellitus
☐ Obesity ☐ Narrow Angle Glaucoma ☐ Seizures

Clinician Signature: _____

Clinician Notes:

VIII. Family Psychiatric History:

Has any member of your child's family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADD/ADHD, etc.? ☐ Yes ☐ No If yes, please explain:

IX. Social / Family History:

Biological mothers' full name: _____ Biological fathers' full name: _____

Biological parents marital status: ☐ Married to each other ☐ Divorced ☐ Separated

If divorced from one another, has either remarried? Mother ☐ Yes ☐ No
Father ☐ Yes ☐ No

If the biological parents are divorced or separated, who has custody of the patient? _____

Type of custody? _____

Stepmothers' name: _____

Stepfathers' name: _____

List all relatives who presently live in the same household as your child (if more than 5 please list on back of this sheet):

Name	Relationship	Type of Employment / Student Grade Level
1.		
2.		
3.		
4.		
5.		

Please check any of the following stressors that presently affect your child:

☐ Family financial problems ☐ Family relationships ☐ Legal problems
☐ Child rearing problems ☐ Drug or alcohol problems ☐ Abuse behavior
☐ Health problems ☐ Employment problems ☐ School problems
☐ Peer relationships ☐ Frequent change of household ☐ Frequent moves
☐ "Other" problem _____

Please explain how any item you checked affects your child.

Clinician Signature:
_____

Reminder: Please bring a copy of any custody papers to the initial appointment.