For Office Use Only

Chart#: _____

Dx: _____

Ins: Yes No

The Centre

1290 Main Street, Suite B, Daphne, AL 36526
(251) 625-0118 ♦ Fax: (251) 625-0116

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): _____

Stepparents: _____

Email Address: _____

Referred by: _____

EMPLOYMENT INFORMATION:

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

Employer: _____ Phone: _____
Address: _____

Spouse's Employer: _____ Phone: _____
Address _____

EMERGENCY CONTACT (someone not residing in your home)

Name: _____ Relationship: _____

Phone: _____ Address: _____

The Centre

New life begins at The Centre.

Robert E. Colclough, M.A., LPC,
Julie Taylor, LPC, RPT,
Jay Stone, M.A, NCC, LPC
Aubrie Custred, LMFT

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.)

_____

_____

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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:	$160.00
Family/Couple's Therapy:	$160.00
Consultation:	$220.00 per hour
Computer Evaluation:	$100.00
*Court Fees	$350.00-$500 per hour

*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.

Client Signature:_____

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Security Code: _____

(from back of card or front if Amex)

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

Email Address for receipt _____

Client Name: (if different from above) _____ Client Number _____

I hereby authorize The Centre to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Client Signature Date

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1290 MAIN STREET STE B
DAPHNE AL 36526-8624
2516250118

5. Informed Consent for Psychotherapy

General Information

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. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The 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. There are no miracle cures. 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/her self 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.

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.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

The Centre

Telehealth Treatment Consent

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.

Client Consent

Client Signature:_____

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DAPHNE AL 36526-8624
2516250118

2. Notice of Privacy Practices

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record 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 this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery

request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
a. For my use in treating you.
b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY 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 HIPPA Notice of Privacy Practices.

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

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:

_____

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
☐ Feeding problems
☐ Sensitive to light / noise / texture
☐ Excessive restlessness
☐ Sleep problems
☐ Fussy or unhappy
☐ Colic
☐ Head-banging
☐ 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
☐ Hand flapping
☐ Putting things in the mouth
☐ Sniffing excessively
☐ Repeating words or phrases inappropriately
☐ 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
☐ Child rearing problems
☐ Health problems
☐ Peer relationships
☐ "Other" problem _____

☐ Family relationships
☐ Drug or alcohol problems
☐ Employment problems
☐ Frequent change of household

☐ Legal problems
☐ Abuse behavior
☐ School problems
☐ Frequent moves

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.