Kathy Grosh, Psy.S., LLP

750 S. Monroe Street
Monroe, MI 48161
(734) 639-2262

CLIENT PERSONAL INFORMATION

Date ________________

Birthdate ______________________ S.S. # ______________________

Name ______________________ Phone # ( ) ______________________

Address ______________________ City ______________ Zip ________

Employer ______________________ Occupation ______________________

PRIMARY INSURANCE INFORMATION

Name of Insured ________________
Relationship to Client ________________
Insured's Birthdate ________________
S.S. # ________________
Address ________________
City __________ State __________
Zip ________________
Home Phone( ) ________________
Employer ________________
Occupation ________________
Insurance Company ________________
Ins. Co. Phone # ________________
Group # ________________
Plan # ________________
Contract # ________________

SECONDARY INSURANCE INFORMATION

Name of Insured ________________
Relationship to Client ________________
Insured's Birthdate ________________
S.S. # ________________
Address ________________
City __________ State __________
Zip ________________
Home Phone( ) ________________
Employer ________________
Occupation ________________
Insurance Company ________________
Ins. Co. Phone # ________________
Group # ________________
Plan # ________________
Contract # ________________

DISCLOSURE STATEMENT

I understand that, Kathy Grosh, Psy.S., LLP. is a clinical psychologist in independent practice and is solely responsible for her practice. All matters including therapeutic issues, financial issues, etc. are the responsibility of the psychologist.

AUTHORIZATION AND RELEASE

I authorize and request my Insurance Company to pay directly to the provider.
I understand that my Insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on y behalf or my dependents.
I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
I authorize release of Information to all my Insurance Companies.
I permit a copy of this authorization to be used in place of the original.
I authorize use of this form on ALL my Insurance submissions.
If unable to keep appointment, kindly *give 24 hours notice, otherwise a charge will be made for the time reserved.*

X________________________________ Date ______________________

Thank you for filing out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

Confidential Adult Pre-Counseling Assessment

Today's Date:________________________________

Name:____ Date of Birth:_________ Sex:______
Address:____
Telephone Home:______________ Cell:______________ Work/Other:______________
Email:____
Presently living with: Parents___ Spouse___ Roommate___ Alone___ Other___
Marital Status: Single___ Married___ (# of years___) Divorced___ Separated___
Widowed___ Significant Other___
Previous Marriages?_____ Dates?_______________________________________
If separated, divorced or widowed, when did that occur?____________________
Occupation:____________________________________ Total hours/week:___________
Religious affiliation:_________________________ Church?__________________________
Active/Inactive:____
Emergency contact:_____________________________ Phone:___________________________
Referred by:____

Family Information:

Last Grade Completed:___________

Relationship	Name	Birth date	Age
Spouse			
Child			
Child			
Child			

Are parents: Married___ Divorced___ Widowed___
Other noteworthy childhood relationships:_____________________________________
____
Significant childhood events (divorce, deaths, sickness, trauma, etc...):_______________
____
____

Medical/Physical History:

Describe any physical problems you have that require medication or physical care:____________

____

Are you currently receiving medical treatment? Yes___ No___

When did you last consult with your primary care physician?_______________________

Name of Doctor____

Are you currently taking any prescription medications? Yes___ No___

If yes, please list by name and dosage:__________________________________

____

Do you use alcohol or drugs: Yes___ No___

If yes, please describe frequency and type:______________________________

Has the use of alcohol/drugs ever affected your life adversely?___________________

If yes, please describe:____

Have you ever had counseling before: Yes___ No___

If yes, please describe and list name of person(s):__________________________

____

Briefly describe the problem that prompted you to seek counseling at this time:__________

____

____

Have there been times when the problem got better or disappeared? Yes___ No___

If yes, when?____

What do you think helped?____

____

____

Were there times when the problem was especially bad? Yes___ No___

When?_________________ What made it bad?______________________________

____

Is there anything else that you believe might be important for your counselor to know at this time?____

____

What do you want from counseling? What are your goals?_________________________

____

____

____

Notice of Privacy Practices
For the Practice of:

Kathy Grosh, Psy.S., LLP
Clinical Psychologist

Your medical/psychological information is personal. We are committed to protecting your personal information. We create a record of the care and services you receive. This record is needed to comply with legal requirements. This notice applies to all of the records generated in this practice by either this psychologist or by one of the office employees.

This office is required by law to:
1. Make sure that treatment information is kept private;
2. Give you this notice of our legal duties and privacy practices with respect to treatment information about you; and
3. Follow the terms of this notice.

How this Office May Use and Disclose Your Personal Information

All the ways we are permitted to use and disclose information about you fits into one of these general categories:

For Treatment. Information about you may be discussed with your physician with your signed consent or without your consent in a life-threatening emergency.

For Payment. We may use and disclose information about you so that the services you receive at this office may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to share a diagnosis or treatment plan so that your health plan will pay this psychologist or reimburse you for treatment.

For Phone Messages. We may have to contact you regarding emergency changes in appointments. In the event that we have to leave a message, the message will be to contact this office. If you do not want us to call your home/office or to leave a message, please submit this in writing to this psychologist. We will not be discussing any information about you or with you on a cell phone without your written permission. Pleased be advised that if you leave a message on our office answering machine, at (734)639-2262, it may be heard by someone other than your Psychologist.

As Required by Law. We may disclose information about you when required to do so by federal, state or local law. For example, we may be required by law to report child abuse and neglect and threats of harm to another person.

To Avert a Serious Threat to Health or Safety. We may use and disclose information about you when necessary to prevent a serious threat to you or for the safety of the public or another person. Any disclosure would be made only to a person able to help prevent that threat.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may use information about you to defend this office or to respond to a court order signed by a judge.

Limits to Confidentiality. Paper copies of billing information are kept in a locked room that is accessible to other psychologists who share the office building. Billing information stored electronically is also available to other psychologists who share the office building. For a list of these other psychologists, please contact this psychologist.

Your Rights Regarding Your Personal Treatment Information

You have the following rights regarding your personal information:

Right to Inspect and Copy. You have the right to inspect and copy your treatment information with the exception of any psychotherapy notes.

To inspect and copy your treatment information, you must submit your request in writing to this psychologist. We may charge you a fee for the cost of copying, mailing and other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied that denial may be reviewed. For information regarding a review, please contact this psychologist.

Right to Amend. If you feel information we have about you is incorrect or incomplete, you may ask to amend that information.

A request for an amendment must be made in writing and submitted to this psychologist. You must provide in this request your reason for amendment.

Your request may be denied if it is not in writing or if you ask us to amend information that:

1. was not created by us;
2. is not part of the information kept in this office;
3. is not part of the information which you would be permitted to inspect or copy;
4. is accurate and complete.

Right to an Accounting of Disclosure. You have a right to request an accounting of disclosures. This is a list of disclosures this office has made about your treatment information.
You must submit such a request in writing. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure we may make of your treatment information.

We are not required by law to agree with your request for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing to this psychologist.

Right to Request Confidential Communications. You have a right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to this psychologist. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You may obtain a paper copy of this notice from this psychologist.

Revisions to this Notice

This psychologist reserves the right to revise this notice. Any revised Notice will be effective for the information we already have about you. A revised notice will be posted in this psychologist's office.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with this psychologist or with the Secretary of the Department of Health and Human Services.

This psychologist will not penalize you for filing a complaint.

For the Practice of:

Kathy Grosh, Psy.S., LLP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have read a copy of this psychologist's Notice of Privacy Practice Form.

Signature of client ______________________________

Date ________________

Signature of Witness ______________________________

Date ________________

Documentation of Failure to Obtain Signed Acknowledgment

On _________________ 20__, _________________ presented this Acknowledgment of Receipt of Notice of Privacy Practices From to _________________ (Client). The client refused a signature when requested.