Stephanie Wright Consultation, PLLC

Michigan Licensed Professional Counselor
License # 6401011218

Please provide the following information and answer all applicable questions. The information you provide here is protected as confidential information. Please print clearly.

Name:_____
(Last) (First) (M.I.)

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

_____
(Last) (First) (M.I.)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□Single □ Domestic Partnership □ Married □ Separated □Divorced □ Widowed

Please list any children/age: _____

Address:_____
(City) (State) (Zip)

Home phone: _____May we leave a message? □Yes □No

Cell Phone: _____May we leave a message? □Yes □No

E-mail: _____May we email you? □Yes □No

Referred by (if any): _____

PRESENTING PROBLEM:

MENTAL HEALTH HISTORY:

Mental Health/Substance Abuse Treatment History
Previous Diagnosis, outpatient treatment, hospitalizations, treatment outcomes, etc.
□ No previous history of mental health or substance abuse

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes: Previous Therapist/Practitioner: _____

If person other than client (parent/guardian) is filling out form does your child know their diagnosis? □Yes □ No

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, etc.):

Alcohol/Substance Abuse	□Yes □No	_____
Anxiety	□Yes □No	_____
Depression	□Yes □No	_____
Bipolar/Mood Disorder	□Yes □No	_____
Domestic Violence	□Yes □No	_____
Eating Disorders	□Yes □No	_____
Schizophrenia	□Yes □No	_____
Suicide/Suicide Attempts	□Yes □No	_____

Other addictive behaviors of concern (Gambling, eating, sex, cleaning, shopping, Internet, work, financial/legal problems. etc.):

SUICIDE/HOMICIDE ASSESSMENT

Client has/had:	PAST	PRESENT
Suicidal/homicidal thoughts	□ Yes □ No	□ Yes □ No
Suicidal/homicidal plans	□ Yes □ No	□ Yes □ No
Prior suicide attempts	□ Yes □ No	□ Yes □ No
Self-harm	□ Yes □ No	□ Yes □ No

Additional Comments**:**

PHYSICAL/SEXUAL ABUSE ASSESSMENT

Physical/sexual abuse	□ Yes □ No	□ Yes □ No
Physical/sexually abusive	□ Yes □ No	□ Yes □ No

Additional Comments:

MEDICAL HISTORY:

Name of PCP: _____ Date of last physical exam_____

Current medical problems:

Previous medical problems (including surgeries/hospitalizations):

Medications: _____

PSYCHOSOCIAL INFORMATION:

Briefly describe communication patterns with parents, siblings, peers, etc. :

Family Relationships (Describe childhood, current home environment and family dynamics, how immediate family relates to each other, violence in family, if any):

Social Information (address social/leisure time and stress management activities, interaction with peers):

Resources & Supports (current family and social networks utilized as resources for client):

Education (are there any current academic issues of concern?)

Does your child have an IEP/504?

Classification:_____

Other academic supports:_____

Cultural (address any special treatment considerations related to cultural/racial background:

Anything additional you would like to discuss?:

NOTICE OF PRIVACY AND CONFIDENTIALITY. Privacy and confidentiality is a cornerstone of psychotherapy. Discussions between a therapist and client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the state licensing board or other regulatory body. If you have any questions about confidentiality, you should bring them to my attention so that we can discuss the matter further. By signing this consent form, you are giving your consent to me to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing me and holding me harmless from any departure from the right of confidentiality that may result.

For all patients, I keep records describing the patient's clinical condition and treatment, but I avoid documenting potentially embarrassing personal information if I can do so in a manner consistent with medical responsibility. Psychotherapy notes will have a higher level of protection under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy regulations that took effect in April 2003. Their contents may not be divulged without your specific authorization, which is not permitted to be required as a condition of insurance coverage. (Other exceptions to the special protection of psychotherapy notes under law are to prevent harm to the patient or others, for the therapist's defense in legal actions, regulatory actions, regulatory oversight of the therapist's professional status, confidential supervision in training situations, or investigation by a medical examiner in the event of a patient's death.)

I serve as the Privacy Official and Contact Person as required by HIPAA. I keep both paper and electronic medical records. Paper records are locked at all times when the office is closed, and any electronic files are password protected to protect your information. You have the right to view your general medical record (but not psychotherapy notes) and request amendments within a reasonable period of time. Records will be retained at least as long as required by law. If you give consent for release of medical information from your genera! medical record, in compliance with HIPAA, I will disclose only the minimum amount of information necessary to serve the purpose for which the request has been made. Also under HIPAA regulations, 1 will provide you with a notice of privacy practices. I must ask you to sign a separate consent form and acknowledgement that I have given you this notice.

Under HIPAA your consent is not required for physicians to release information for treatment, payment, or healthcare operations. However, I have the right to offer you the opportunity to withhold consent for release of any or all information, with the understanding that if you withhold consent, it may not be possible for me to communicate with your doctors or to submit insurance claims or give supporting clinical information without further action on your part to give consent. I believe that it is important for doctor-patient relationship to offer you the choice of giving or withholding consent, rather than assuming that you accede to the HIPAA regulation's automatic consent.

Client Signature: _____ Date _____

CONFIDENTIALITY AND THIRD-PARTY PAYERS

You should realize that any information given at your request to an insurance company or managed care company is thereafter beyond my control. Health insurance companies sometimes give information to other agencies which may affect your future eligibility for life, disability, or other insurance. Some employers obtain identifiable data from administrators of their health insurance. Medicare and other insurance plans have the right to inspect the medical records of subscribers who file claims. In my experience, such events are rare, and I would resist them to the greatest extent legally possible, but it is important that you know that this can happen if you choose to file claims for insurance. Other breaches of privacy could occur in extreme situations that are beyond my control, are required by law, or are essential to prevent imminent, serious harm. Please acknowledge that you read this Notice by signing below.

Client Signature: _____ Date _____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1.Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.

2.You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the above email address.

3.You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4 Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5.If this office initiated this authorization, you must receive a copy of the signed authorization.

6. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records. Please acknowledge that you read this Notice by signing below.

STEPHANIE WRIGHT CONSULTATION, PLLC
Michigan Licensed Professional Counselor Email: stephaniewright226@gmail.com

Client Signature: _____ Date _____