Carter Counseling Center

Patient Information Form

Client Name: _____ Date _____

SS#: _____ Date of Birth: _____ Gender: ___ Marital Status: _____

Street Address: _____ City _____ Zip_____

Phone: (_____) _____-_____ E-mail Address: _____

Please sign here, authorizing Carter Counseling Center to email reminders about appointments:

_____

Signature

Client's Employer: _____

Business Phone: (_____) _____-_____ Ext: _____

Spouse/Parents Name: _____

Address (if different than client): _____

Employer: _____

Phone: (_____) _____-_____

Insurance Information

Primary Insurance Carrier: _____

Policy Number: _____ Group Name/Number:_____

Subscriber: _____ Date of Birth: _____

Address (if different than client): _____

Employer: _____

Secondary Insurance Carrier:_____

Policy Number: _____ Group Name/Number:_____

Subscriber: _____ Date of Birth: _____

Address (if different than client): _____

Employer: _____

Please present your insurance card so we may obtain a copy for your file.

Responsible Party: _____

Address (if different than client): _____

Phone: (_____) _____-_____

Emergency Contact: _____

Address (if different than client): _____

Phone: (_____) _____-_____

If you have an emergency, please call 913) 390-3172.
If the office is closed call 911, or go to your nearest emergency room.

Primary Physician: _____

Address: _____

Phone: (_____) _____-_____ Your Health Status: ____Excellent ____Good ____Fair ____ Poor

Date of last Physical Exam: _____ Do you have a physical disability? ____ Yes ____ No

List ALL current medical diagnosis for which you are currently being treated:

_____

_____

_____

List ALL current medications, including birth control, over the counter medication and supplements:

_____

_____

_____

Have you ever been hospitalized for mental health or substance abuse treatment? ____ Yes ____No

# of times: _____ When & Where: _____

_____

_____

Is there a chance you may be pregnant? ____ Yes ____No

# of abortions _____ # of miscarriages _____ # of stillbirths _____

Do you own a gun? ___ Yes ___ No

Developmental History – Please indicate the client's history in relation to the following:

Clients Prenatal and Birth	**Yes**	**No**	**Details**
Prenatal stress or injury	___	___	_____
Prenatal drug/alcohol exposure	___	___	_____
Anesthesia, pain medications	___	___	_____
Anoxia (oxygen deprivation @ birth)	___	___	_____
Premature/late delivery	___	___	_____
Medical problems after birth	___	___	_____

Clients Growth and Development	**Typical**	**More**	**Less**	**Details**
Activity level	_____	____	_____	_____
Motor/coordination development	_____	____	_____	_____
Infections/allergies	_____	____	_____	_____
Emotional development	_____	____	_____	_____
Behavior concerns	_____	____	_____	_____
Appetite/digestion	_____	____	_____	_____
Language/speech development	_____	____	_____	_____

Clients Physical Traumas	**Yes**	**No**	**Details**
Head injury (even minor falls, etc.)	___	___	_____
Coma (loss of consciousness)	___	___	_____
Accidents (list all)	___	___	_____
High fever	___	___	_____
Serious illness	___	___	_____
Surgery	___	___	_____
Drug overdose/poisoning	___	___	_____
Recreational drug use	___	___	_____
Stroke	___	___	_____

Psychological Stress/Life Changes	**Yes**	**No**	**Details**
Death in family	___	___	_____
Divorce/remarriage	___	___	_____
Move/relocation	___	___	_____
School change	___	___	_____
Job change	___	___	_____
Family member chronic illness	___	___	_____

Medical Problems	**Yes**	**No**	**Details**
Allergies	___	___	_____
Asthma	___	___	_____
Seizures/Epilepsy	___	___	_____
Chronic Pain	___	___	_____
Head Injury	___	___	_____
Frequent Illnesses	___	___	_____
Headaches	___	___	_____
Dizziness/Fainting	___	___	_____
Thyroid Disease	___	___	_____
Stomach/Bowel Problems	___	___	_____
Chronic Illness	___	___	_____

Please indicate if the **client** and/or **family member(s)**
currently experience or have a
history of any of the following symptoms.

	Client Current	Client History	Family		Client Current	Client History	Family
Unable to Concentrate				Phobias/Fears			
Feeling mind is playing tricks				Anxiety/Nervousness			
Racing thoughts				Anger/Temper Tantrums/Rages			
Restless/unable to sit still				Verbal fighting with others			
Forgetfulness/Memory problems				Worried about weight or appearance			
Hyperactive/Too much energy/Always on the go				Compulsions/Repetitive Behavior			
Sad or depressed				Obsessions/Repetitive thoughts			
Crying spells				Trouble with sleep			
Gambling Problems				Difficulty making decisions			
Thoughts of harming self or others				Behavioral Problems: Oppositional/Stubbornness			
Change in appetite				Loss of interest			
Change in weight				Suicidal thoughts			
Binge/Purge food				Physical fighting with others			
Stealing/Lying				Self-harm Behaviors			
Tension				Defiant of authority			
Over Ambitious				Hearing voices others don't hear			
Social Withdrawal				Relationship Problems			
Destruction of Property				Overly sensitive			
Communication Problems				Inferiority Feelings			
Overly dependent				Nightmares			
Cruelty to people/animals				Shyness			
Seeing things others don't see				Thinking other people are spying on you			
Impulsivity				Mood Swings			
School/Work Problems				Attention Problems			
Low energy/Fatigue				Alcoholism			
Panic Attacks				Drug addiction			

Please circle the **five current problems** listed above
which are the **most distressing** to you or your child.

Carter Counseling Center

Please carefully read and sign below each section.

Financial Payment Policy:

1. It is your responsibility to verify coverage with your insurance carrier.
2. The services rendered to you are solely your responsibility. As a courtesy to our patients, we will bill your insurance company for counseling sessions. If the insurance company has failed to pay within a 45 day period, we will expect you to pay the balance of your bill in full. You will then have to collect from your insurance company.
3. QEEG Assessments and Neurofeedback Training are separate charges from psychotherapy. You are personally and fully responsible for all charges for these services.
4. You are fully responsible for any balance not covered by your insurance carrier.
5. It is your responsibility to inform Carter Counseling of any changes in your insurance information, immediately upon knowledge of said changes.
6. If you fail to give 48 hour notice of cancellation of your scheduled appointment, or you fail to show up for your scheduled appointment, you will be charged a $75.00 fee. Genuine emergencies can be discussed with your clinician.

I herby understand the financial policy described above:

Signature of Client or Guardian: _____

Notice of Privacy Signature:

Carter Counseling Center has given me access to the Notice of Privacy Practices. I am aware that I am able to have a copy of this policy at any time.

Signature of Client or Guardian: _____

Insurance Signature on File:

I request that payment of authorized medical benefits be made on my behalf to the provider of any services furnished me by Carter Counseling Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services.

I understand that my signature requests that payment be made and authorized release of medical information necessary. This includes both primary and secondary insurance carriers.

Signature of Client or Guardian: _____

Consent for Treatment

I consent to be treated at Carter Counseling Center for counseling in individual, couples, family or group therapy.

Signature of Client or Guardian: _____

Limits of Confidentiality:

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens to harm another person(s), including murder, assault or other physical harm.
3. The client is a minor (under 18 years of age) and reports suspected child abuse, including but not limited to physical and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a therapist.

State law mandates that mental health professionals may need to report these situations to the appropriate person and/or agencies. Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of the state.

Having read and understood the above, I agree to these limits of confidentiality.

Signature of Client or Guardian: _____

Attendance Notice

We understand that emergencies occur (including illness), requiring a need for appointments to be canceled. Without a valid reason, we require a minimum 48 hours notice of cancelation. Also, repeated absences for illness will not be accepted as valid.

I understand that it is up to Carter Counseling Center's discretion to charge a $60 late cancellation/no show fee if I do not give 48 hours notice of cancelation of my appointments.

I understand that if I repeatedly cancel or fail to attend my scheduled appointments, my treatment with Carter Counseling Center may be terminated.

Signature of Client or Guardian: _____

Court Fees

I understand that if Carter Counseling Center's professional counselors are required to testify in court, we charge an hourly rate of $150 per hour, which includes preparation time (including time spent talking with your lawyer), deposition time, travel time (to and from), wait time and time spent in court. A minimum ten business days notice is required as well as a retainer of $300 at time of request.

Signature of Client or Guardian: _____

Reports or Letters

We will be happy to provide a written report or letter upon your request. We charge an hourly rate of $60 for time spent reviewing the file and composing written reports and letters. This fee must be paid before the report or letter is released.

Signature of Client or Guardian: _____

Carter Counseling Center

Rights & Responsibility Statement

Rights:

1. You have the right to fair treatment; regardless of your race, religion, gender, ethnicity, age, disability or source of income
2. You have chosen to receive treatment services and understand you may terminate therapy at any time, unless ordered by the court.
3. You understand there is no assurance that you will feel better. Because psychotherapy is a cooperative effort between you and your therapist, you will work with your therapist in a cooperative manner to resolve your difficulties.
4. You must understand during the course of your treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve your problems.
5. You understand that records and information collected bout you will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.
6. You understand that state and local laws require that your therapist report all cases in which there exists a danger to self or other.
7. You understand that there may be other circumstances in which the law requires your therapist to disclose confidential information.
8. You understand you may be contacted by your health plan to ensure continuity and quality of your treatment and/or after the completion of treatment, to assess the outcome of treatment.
9. You have read/or been explained your BASIC RIGHTS including:
    a. The right to be informed of various steps and activities involved in receiving services.
    b. The right to share in the formation of the plan of care/treatment plan.
    c. The right to confidentiality under federal and state laws relating to the receipt of services.
    d. The right to make an informed decision whether to accept or refuse treatment.
    e. The right to contact and consult with counsel at your expense.
    f. The right to select practitioners of your choice at your expenses.

Responsibilities:

1. It is your responsibility to treat those giving you cares with dignity and respect.
2. It is your responsibility to give your healthcare providers the information needed to provide the best possible care.
3. It is your responsibility to ask questions about your care.
4. It is your responsibility to follow your medication or treatment plan that is agreed upon by you and your healthcare professionals.
5. It is your responsibility to tell your therapist and your other health care professionals about medication changes, including medications given to you by others.
6. It is your responsibility to keep your appointments. You should call as soon as you know that you need to cancel and appointment.
7. It is your responsibility to tell your health care professionals when your treatment plan is not working for you.
8. It is your responsibility to report concerns about the quality of care you receive.
9. It is your responsibility to let your health care professionals know of problems with paying your fees.

I understand that my therapist, health plan representatives, and my primary care physician may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically on year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above:

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date