**New Client Information - ADULT**

***CONFIDENTIAL FORM***

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*First Middle Last*

Current Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Calls will be discreet, but please indicate any restrictions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language Spoken/Used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contract:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I will only contact this person if I believe it is a ‘life or death emergency.’ Please provide your signature to

indicate that I may do so: (Your Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ❑ Single ❑ Partnered ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Sexual & Gender Identity: \_\_ Heterosexual \_\_Lesbian \_\_Gay \_\_Bisexual

\_\_Transgender \_\_ Asexual \_\_ In Question \_\_Other

Racial/Ethnic Identity:

\_\_African/African-American/Black \_\_ Latino/Latino-American \_\_Bi-Racial/Multi-Racial

\_\_American Indian/Alaska Native \_\_White/European-American \_\_Not listed

\_\_ Middle Eastern/Middle Eastern-American \_\_Asian/Asian-American/Asian Pacific Islander

Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* May I have your permission to thank this person for the referral? \_\_\_\_\_**Yes \_\_\_\_\_No**
* If referred by another clinician, would you like for us to communicate with one another?

**\_\_\_\_\_Yes \_\_\_\_\_No**

Service Requested: ❑ Therapy ❑ Evaluation ❑ Consultation ❑ Other

What are your specific concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice these problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# INSURANCE INFORMATION

Person Responsible for Paying Bill:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: Dr. Barnes does not accept secondary insurance and does not file claims for secondary insurance. However, if you have a secondary insurance provider it will be important to discuss this with Dr. Barnes as soon as possible. In most situations where there is more than one insurance provider, insurance companies may refuse to reimburse for services rendered. If this occurs, you will be held financially responsible for services rendered and payment will be expected to be made at the time services are rendered or immediately upon non-payment by your insurance provider.**

Secondary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Barnes files insurance claims for reimbursement as a courtesy to her clients. However, you must supply the appropriate information to enable her to obtain reimbursement otherwise all fees for service will become your financial responsibility. Dr. Barnes requires at least a 48 hour notice of any change in insurance in order to obtain the proper authorization for treatment and to file your claim. **If you fail to give Dr. Barnes at least a 48 hour notice of a change in insurance, all charges could become your financial responsibility. Additionally, if you have insurance coverage and fail to report this to Dr. Barnes and then later attempt to recoup your ‘self-pay’ payments you will be reported to the appropriate authorities as this is considered a fraudulent act**. Please be advised Dr. Barnes utilizes an Electronic Claims Submission Program/Company to process claims. All client information is handled with utmost confidentiality and meets HIPPA compliance.

**Assignment of Insurance Benefits**

I request that payment of authorized third party benefits be made on my behalf to Dr. Carolyn Barnes, Psy.D. for any services provided to me or my dependents. I understand my signature also authorizes release of any information contained in my or my child’s records to any relevant insurer, or to its assignees, necessary to pay a claim. By my signature I acknowledge that I am ultimately responsible for payment of all fees for all services rendered regardless of insurance coverage.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of responsible party Date

# SLIDING FEE SCHEDULE

This is based upon household income and evidence of need. I understand that the full fee for each therapy session is due and payable at the time of service. Please be aware you may be asked to provide proof of income.

**Sliding Fee schedule For Therapy** 0 - $30,000 Determined by Dr. Barnes

$30,001 - $50,000 $95 per session

$50,001 –$75,000 $120 per session

Above $75,001 $150 per session

Our agreed upon fee for therapy is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# STATEMENT OF PROVIDER INDEPENDENCE

Each provider in this office works with a group of independently practicing mental health professionals. While the mental health professionals share office space, each provider is completely independent in providing you or your child with clinical services and as such is fully responsible for those services. Each provider’s professional records are separately maintained and no member of the group can have access to client records without your specific, written consent.

# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act (HIPAA)

I have had the opportunity to review and/or request a copy of the Notice of Privacy Practices of Dr. Carolyn Barnes. I understand that if any changes are made to this Notice of Privacy Practices, a revised copy will be posted in the office. I also understand that if I wish to receive additional copies of this notice, or if I have any questions with regard to this notice of privacy practices, I may contact:

Carolyn Barnes, Psy.D., LLC

404 Peterson Avenue North

Douglas, GA 31533

Phone: 706-622-6553

Fax: 706-622-6551

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Signature of responsible party Date

# Client-Therapist Agreement AND Informed Consent to Receive Psychological Services

**Psychotherapy Has Both Potential Risks as well as Potential Benefits**

These risks may include for example, uncomfortable levels of unpleasant emotions and that individuals receiving therapy may feel worse, emotionally, before they begin to feel better. Furthermore, clients often seek psychological services because they wish to change some aspect of their lives, behavior, or environment. Changes in the client frequently produce changes in relationships and other areas of the client’s life. While it is my intention to help my clients manage changes in all areas of their life as they arise, it is important for the client to recognize the potential impact of any changes that may occur before they begin treatment. Informed consent refers to your right to an explanation of your or your child’s condition and proposed treatment plan. You and/or your child have the right to participate in the planning of treatment, to refuse treatment, or to discontinue treatment at any time. Respect and non-discrimination are offered to all regardless.

**Professional Relationship**

Because of the nature of therapy, the ‘designated’ client and your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only a professional relationship. If my clients and I were to interact in any other ways, we would then have a "dual relationship" which may impact my objectivity. In order to offer all of my clients the best care, my judgment needs to be purely focused on your needs, this is why your relationship with me must remain professional in nature.

You should also know that therapists are required to keep the identity of their clients confidential. As much as I would like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my duty to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

**Statement Regarding Ethics, Client Welfare & Safety**

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you.

Additionally, at times people find they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as they begin discussing certain sensitive areas of their life. However, a topic usually isn’t sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once we are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

**The Initial Diagnostic Interview**

The Initial Diagnostic Interview takes place during the first few sessions. During this time, I will be reviewing my client’s symptoms and prior history of treatment. After the initial session, I along with the client and/or client’s parents/guardian will decide together if psychotherapy or psychological testing would be helpful, and who would be the best treating provider for you or your child. Moreover, I or the client and/or client’s parents/guardian may decide that you or your child would be better treated with a different service provider, in which case I can assist you with a referral to another provider. If we both decide that I am the appropriate treatment provider, I will plan to schedule one 45-55 minute session per week at a mutually convenient time.

**Out of State Treatment**

I am a licensed Psychologist in the state of Georgia and can only provide mental health services within the state of Georgia. Due to the varying laws and requirements governing each individual state, if any client finds themselves in a crisis situation and seeks mental health services while either they or their therapist is located outside the state of Georgia (i.e. vacation, training, etc.) it may be necessary for me to refer the client to a local Emergency Room or to a local mental health provider. While you are encouraged to contact me during any time of crisis, please be aware there may be laws and regulations which impact how and when I can provide mental health services to you or your child as my client.

**Technology Statement**

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to me that I maintain your confidentiality, respect your boundaries, and ascertain that your relationship with me remains therapeutic and professional. Therefore, I have developed the following policies:

**Phone Calls and Phone Consults:** You are welcomed and encouraged to call the office to change or schedule appointment times or if there is a major change or crisis with the client between sessions. I also understand that you may have questions or concerns after appointment times. Please be aware I will do my best to return calls within 24 hours, however I see clients by hourly appointments and am unable to do phone consults. If you have therapy questions that are not an emergency (‘life or death’ nature) please wait until your next appointment, or call to schedule an appointment to discuss your concern. If you feel frequent phone calls or consults are necessary, we may need to increase the frequency of your therapy sessions.

In case of a life threatening situation, contact 911 immediately! Please be aware that clinicians are not always available to immediately respond to emergencies. It is usually best in these situations to go directly to the nearest hospital Emergency Room or contact 911 for help. The occasional brief phone consultation is not charged. However, please be advised that **phone consultations over 10 minutes will be billed at the same rate as office visits, and is generally not covered by your insurance provider.**

**Cell phones**: It is important for you to know that cell phones are not completely secure and confidential. However, I realize most people have and utilize a cell phone. I may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with me. Please be aware I use Kaspersky to encrypt data on my cell phone as a means of enhancing and protecting the confidentiality of my clients and to ensure HIPPA compliance. Again, even with the encryption service I cannot guarantee that the use of a cell phone will be completely secure and confidential.

**Text Messaging and Email:** Both text messaging and email are not a secure form of communication to discuss confidential matters, nor is it a way to receive emergency mental health treatment. When utilizing these technological means, your confidentiality may be compromised. However, I realize many people prefer to text and/or email because it is a quick way to convey information. **It is my office policy to NOT accept text messages from clients**. However, if you accept these risks and limitations for emails, you are allowed to contact me by EMAIL only, as long as you take into consideration and accept responsibility for the confidential matter of the communication. If you prefer, you are welcome to call the office and, if necessary, leave a message. Depending on the nature of your email(s), I may email back a brief message or contact you by phone. Please understand I cannot provide treatment recommendations or Emergency mental health assessment by email. **Additionally, please know that it is my policy to utilize emails strictly for brief topics such as appointment discussions or confirmations.** More specifically, as a courtesy, I generally send my clients an appointment reminder by email which includes the date and time of your appointment and possibly information regarding payment or insurance issues. While I utilize an encryption program, health care information sent by regular email can be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. **If you understand these risks and prefer NOT to accept these risks and would prefer NOT to receive an appointment reminder by email, please let me know immediately!** If you agree to receive appointment reminder emails from me, you agree to accept

responsibility for these risks, and will not hold me responsible for any event that occurs after I have sent the email reminder. You also need to know that I am required to keep a copy of emails as part of my client's clinical record.Please note I generally keep copies of any email discussing topics other than appointment reminders.

**Facebook, LinkedIn, Instagram, Pinterest, Etc**: It is my policy not to accept requests from any current or former client on social networking sites such as Facebook, LinkedIn, Instagram, Pinterest, etc. because it may compromise your confidentiality. I do not have a business Facebook page, a Twitter account nor am I on LinkedIn. You are discouraged from following me on any of these pages because the general public will be aware of the fact your name is attached to me as a Psychologist. If you choose to ignore my request not to follow me on any of these media, you might want to consider using an alias to keep your connection with me confidential, but that is entirely your decision.

**Google, etc.:** It is my policy not to search for my clients on Google or any other search engine. I respect your privacy and make it a policy to allow you to share information about yourself with me as you feel appropriate. If there is content on the Internet that you would like to share with me for therapeutic reasons, please print this material and bring it to your session.

**Twitter & Blogs**: I generally do not post psychology news on Twitter or write an entry on a blog. However, if you find such an entry and have an interest in following either of these, please let me know so that we may discuss any potential implications to our therapeutic relationship. Once again, maintaining your confidentiality is my priority, therefore, in this type of situation I recommend you use ever security means available which will help address the confidentiality issue of your having a public link to my content.

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Please feel free to ask questions, and know that I am open to any feelings or thoughts you have about these and other modalities of communication.

**Communication with Primary Care Physician**

Treatment with me may be coordinated medically with your or your child’s Primary Care Physician, School, Employer, Physical Therapist, Speech Therapist, or Occupational Therapist, and other service providers involved in your or your child’s cross-disciplinary services. By signing this consent to assessment and treatment, you also consent and give authorization for records to be exchanged between myself and your Primary Care Physician or other cross-disciplinary service providers.

**Confidentiality Statement:**

The client’s right to privacy is protected by Federal and State Laws. For minor children, the parent/guardian is the holder of privilege within the therapist/client setting. This means that information discussed during treatment is confidential and that no information can be released to anyone without written authorization from the parent/guardian or client (if 18 or older), subject to the exceptions outlined below.

1. If I have reason to believe that a child, disabled person, or elder person has been abused, neglected or exploited then I am legally required to file a report with the appropriate authorities.
2. If a client expresses serious intent to harm him/herself or another person I may be required to take protective actions. These may include but are not limited to crisis mental health evaluation at a hospital Emergency Room, calling police, and/or voluntary or involuntary hospitalization.
3. There may be other situations that limit my legal ability to maintain client confidentiality, for example, if psychological assessment or treatment is ordered by a court OR if a Judge requires the client’s mental health records be released to the requesting Judge, I am legally obligated to release the client’s records.
4. If the client or client’s parent/guardian chooses to use a third party or insurance provider to pay for services, clinical information will be released to obtain payment of fees. Additionally, all clients using third parties or insurance providers to provide partial or complete payment of fees should be aware that any and all of the information provided to the paying organization could be made available by that organization to: employers providing the insurance benefits, other insurance companies/agencies requesting the information, and other health-care providers that have contact with the insurance company.
5. If your account is turned over to a Collection Agency, necessary information will be released in order to secure payment or settle the debt.
6. According to the Patriot Act, I may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. According to the Patriot Act, I cannot reveal when I have disclosed such information to the government.

**Confidentiality & Records**

The client’s communications with me will become part of a clinical record of treatment for the client, and it is referred to as the client's Protected Health Information (PHI), protected by both federal and state law. The PHI of the client will be electronically stored on a password protected computer which is encrypted and located in my locked office. Additionally, the PHI of the client is confidential, with the following exceptions: (1) the client directs me to tell someone else and signs a “Release of Information” form; (2) I determine the client is a danger to themselves or to others; (3) the client or client’s parents report information about the abuse, neglect, or exploitation of a child, an elderly person, or a disabled individual who may require protection; (4) the sessions are being billed to a third part payer or an insurance company, and the client's paying institution requires me to submit information about treatment for claims processing or utilization review; (5) the client’s account is turned over to a Collection Agency and it is necessary to release information in order to secure payment or settle the debt; (6) I am ordered by a judge or court to disclose information or to testify; or (7) in situations where I am required to legally adhere to the Patriot Act. Regarding an order by a judge, my license does provide me with the ability to uphold what is legally termed “privileged communication.” Privileged communication is the client's right to have a confidential relationship with a therapist. If for some unusual reason a judge were to order the disclosure of the client's private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what the client says confidential. However, you should be aware that if a judge orders the disclosure of your information, I do not have the legal authority to maintain your confidentiality.

**Parents and Collateral Participants**

Participation of parents, siblings, spouses, friends, and sometimes extended family members means these individuals are ‘collaterals’ who participate on behalf of the designated client. More specifically, collaterals are not considered to be a client and are not the focus of treatment. Collaterals have less privacy protection and should not expect full confidentiality rights. No record or file will be maintained on collaterals although notes about them may be entered into the designated client’s file as it reflects important information about family or relationship dynamics that promote or interfere with the client’s treatment. If you have privacy concerns, please discuss them with me.

Clinicians specializing in the treatment of children have long recognized the need to treat children in the context of their family. Parents/guardians of minor children in particular have more rights and responsibilities in their role as collateral than in other treatment situations where the identified client is not a minor. Nevertheless, due to the sensitive nature of counseling and the fragile stage of development that your child is currently experiencing, forming a therapeutic bond with me as his/her therapist is very critical at this point. It is important that he/she feels safe and comfortable discussing personal and private topics with me. In an effort to respect the privacy and sensitive needs of your child, I generally do not discuss the content of therapy sessions in detail with parents/guardians. Rather, it is my anticipation that through the therapeutic process new skills and insights will be gained by your child so she/he can discuss these sensitive topics with you in her/his own time. If your child is too young to do this, the parent/guardian and I will definitely have family meetings to assist in this process.

Additionally, as a collateral participating in therapy with the designated client, you should expect me to request that you examine your own attitudes and behaviors to determine if you can make positive changes that will be of benefit to the designated client. Moreover, if at any time I make the assessment that the designated client is in danger or might be a danger to others, if abuse/neglect is suspected or reported, or if there are any other concerns related to the health and welfare of the designated client, the client or parents/guardians of minor clients and in some situations, the collateral will be notified immediatelyso that the necessary actions and precautions can be taken.

**Confidentiality of Minors**

Adolescents age 14 and over have the right to request treatment and confidentiality, and confidentiality may also be an important issue for youth under the age of 14 years. As a parent/guardian, you are being asked to agree to certain limitations to your access to your child’s records and to specific details of what is discussed in therapy in order to facilitate your child’s ability to benefit from treatment. I reserve the right to make clinical decisions regarding confidentiality issues between adolescents and parents/guardians. Parents/guardians will be informed of any serious health or safety issue concerning the client, with the understanding that this determination will be based upon my clinical judgment. Please feel free to discuss any questions or concerns about this with me.

**In Case of an Emergency**

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I immediately available at all times. If at any time this does not feel like sufficient support for you or your minor child, please feel free to inform me so the two of us can discuss additional resources for you or your minor child or transfer the case to a therapist or clinic with 24-hour availability. However, if you or your minor child is feeling that I am not giving you or your minor child enough support, this is an issue that will need to be discussed in session. Generally, I will return phone calls within 24 hours during a normal business week. Occasionally, I will plan to be out of the office for an extended period of time (i.e. training, vacation) before which I generally notify my clients via verbal or written communication. If you or your minor child has a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

* Call 911
* Go to your nearest emergency room.
* Call Behavioral Health Link /GCAL: 800-715-4225 or other crisis hotline

**Our Agreement to Enter into a Therapeutic Relationship**

I sincerely hope this document has been helpful in explaining your role in the therapeutic process, your rights, risks, and my procedures. I am available to discuss the content of this form with you and to answer any questions you have regarding this information. If you have any questions about any part of this document, please discuss them with me as soon as possible.

Please print, date, and sign your name below indicating that you have read and understand the contents of this “Client-Therapist Agreement and Informed Consent to Receive Psychological Services” form as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practicesmade available to you on my website or in written form per your request. Your signature also indicates you agree to abide by the terms of the Client-Therapist Agreement and Informed Consent to Receive Psychological Services form and you are authorizing me to begin treatment with you or your minor child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Name (Please Print) Client Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

**If Applicable:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s or Legal Guardian’s Name (Please Print) Parent’s or Legal Guardian’s Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

# Financial Policy and Payment Agreement

Your clear understanding of my Financial Policy is important to our professional relationship. Please ask if you have any questions about my fees or about your financial responsibility.

I will ask to see your or your child’s insurance card and driver’s license on your first visit and will scan your card into my system as needed to keep your information current. **It is your responsibility to notify me *immediately* of any changes in insurance coverage.**

**Structure of Sessions and Professional Fees:** The fee for the initial diagnostic interview is $180 per 45-55 minute session. Individual therapy is $150 per 45-55 minute session. If there are occasions when you or I feel the typical 45-55 minute session is not enough time, it will be necessary to discuss the need for additional time prior to the appointment. Fees for other services, such as letter writing or attendance at meetings are described elsewhere in this document. Fee payment is due at the time of service**. It is your responsibility to immediately inform me of any changes in address, phone number, or insurance coverage which may impact the collection or reimbursement of fees.**

**Missed appointments:** **Once an appointment is scheduled, you will be expected to pay $100 for the reserved time unless you provide 24 hours advance notice of cancellation.**  As a courtesy, I MAY send you an email to remind you of your appointment. However, remembering to keep, cancel, or reschedule your appointment is your responsibility. **If you miss or cancel your first appointment, unless there are extraordinary circumstances, you will generally not be rescheduled.** Two or more no show or late cancelled appointments will likely result in a termination of our therapeutic relationship.

**Cancellation Policy:** In the event that a client is unable to keep an appointment, the client or their parent/guardian must notify me at least 24 hours in advance. **If such advance notice is not received, the client or their parent/guardian will be financially responsible for the missed session and will incur a $100 fee for each session missed.** Please note that insurance companies do not reimburse for missed sessions.

*Additionally, if the client frequently misses or cancels appointments it will become necessary to reassess their commitment to and continued participation in psychotherapy.*

**Forensic Fees.** Because of the difficulty of legal involvement, I charge a Forensic Rate of $250 per hour for preparation or attendance at any legal proceeding. If you or your child becomes involved in legal proceedings that require my participation, you will be expected to pay the forensic rate for all of my professional time, including but not limited to, phone calls, preparation for the case, record copying and mailing, time traveling to and from legal proceedings, travel and parking expenses, time testifying, and time spent waiting to be called to testify. A minimum of 3 hours forensic time or $750 is payable in advance. All fees collected for forensic services are non-refundable, even if a court appearance is cancelled or rescheduled. A subpoena will not negate fees generated. You should understand that insurance does not pay for these services. Further, you will be responsible to pay my forensic rates even if I am called to testify by another party.

**Insurance.** As a courtesy, I will bill your insurance carrier for your or your child’s services if am a participating provider with that company. However, you are expected to pay any deductibles, copays, or coinsurance amounts not paid for by your insurance company. Please be aware that although my office does file claims with your insurance company, **all charges are the responsibility of the client or client’s parent/guardian from the first date services are rendered**. If payment is not received, or if the payment that is received from the insurance company is incorrect, a reasonable effort will be made to resolve the issue with your insurance company. However, you may then be billed directly for the amount not received. It will then be your

responsibility to contact your insurance carrier to resolve the issue. If such problems do arise, you are encouraged to contact your insurance company promptly, as any balance unpaid within 60 days of the date of service may be turned over to a Collection Agency. If I am not a participating provider with your insurance company you are responsible for paying the full fee for services provided. If requested I will, as a courtesy, provide you with information should you decide to request reimbursement from your insurance company.

**Deductibles, Copayments and Coinsurance.** The client’s insurance requires me to collect their designated deductible, copay or coinsurance at the time of service. Please be prepared to pay the deductible, copay or coinsurance prior to your or your child’s session. **MINOR CLIENTS:** The adult accompanying the minor client shall be responsible for making a co-payment at the time services are rendered. For minors not accompanied by an adult, non-emergency treatment may not be provided unless payment is presented or arrangements for co-payment have been made in advance.

**Self-Pay**: You may choose to self-pay for psychological services for various reasons. Examples include clients whose insurance provides insufficient or no mental health coverage, those without insurance coverage or those who do not want to use their insurance. You will also self-pay for services provided in addition to treatment which may include attendance at school meetings, letter writing on behalf of the client, or treatment provided outside the office.

**For those clients or client’s parent/guardian who fail to immediately report insurance coverage either obtained at the beginning of psychological services or later acquired on behalf of the client and then presents insurance coverage as a means of receiving reimbursement for self-pay fees will be reported to the appropriate authorities as this is considered a fraudulent act. I reserve the right to withhold reimbursement of fees until the charge of fraud is legally and ethically resolved.**

**Attending meetings:** I charge a fee of $150 per hour for my attendance at meetings, such as IEP meetings, on behalf of the .client. My travel time will also be assessed in most cases.

**Returned check fees**: If your check is returned from the bank for nonpayment, I will charge you a returned check fee of $30. You will also be charged for any additional bank charges that may result. I am happy to provide an insufficient fund receipt to the client upon their request. If the client or client’s parent/guardian incurs frequent returned checks, I may choose to refer them to a new Therapist.

**Overdue accounts**: If your account is not paid in full for 60 days, and arrangements have not been made for payment, your account will be in collections status. This means that I may choose to use legal means to secure payment. This may include turning your account over to a collection agency or going to small claims court which will require the disclosure of otherwise confidential information.

**Letters:** I charge $30 for each half hour required to write a letter on behalf of a client.

**Records requests:** Invoice for records production (calculated per formula contained in O.C.G.A. § 31-33-3, adjusted annually by the Department of Community Health includes Administrative Fees ($25.88), Certification Fees ($9.70), $15/Hour Professional Time (allowable per § 9-11-26 [civil]or§ 17-16-9 [criminal]), $0.97/page for first 20 pages, $0.83/page for pages 21 through 100; $0.66/page for pages 101 and above.

**I have read the financial policy and agree to abide by its terms.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Responsible Party Date**

# Authorization to Share Health Information with Primary Care Physician

Client name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Carolyn Barnes, Psy.D., LLC to release health information on behalf of the client named above to the Primary Care Physician named below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Primary Care Physician)

I understand that this release of information is to permit our treating physician to monitor the aforementioned Client’s health status and to coordinate care with Dr. Barnes. This release will automatically expire 12 months from the date signed or at the conclusion of treatment. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization either I or my child can still receive treatment from Dr. Barnes. I understand I may inspect or copy the information to be disclosed. I understand that information that is disclosed as a result of this authorization may be re-disclosed by the recipient and no longer protected by law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or parent/guardian Date

# Authorization to Release Protected Health Information

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist to contact them regarding your treatment, please read carefully and complete this document. Any information shared will be for the sole purpose of facilitating maximum care to you as the client. *Please note that treatment is not conditioned upon your signing this authorization, and you have the right to refuse to sign this form.*

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize Dr. Carolyn Barnes to exchange health information, academic information, IEP information, psychological evaluation information, behavior, and/or disciplinary information with the following individual(s) or organization(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additionally, the above named parties, therapist & person(s) or entity (entities) designated, agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

**Please indicate your preference regarding the information to be shared:**

❍ The parties stated above may discuss my medical and/or mental health information without

limitations.

❍ I would prefer to limit the information shared between the parties stated above. The limitations I

would like to specify are as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the purpose of:** ❍ assessment, treatment planning, and treatment continuity

❍ other – Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information before it is disclosed. I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations. If I have questions about the disclosure of my or my child’s health information, I can contact Dr. Carolyn Barnes at 706-622-6553.

I understand I have a right to revoke this authorization at any time and that I must do so in writing with date and signature to Dr. Carolyn Barnes and must be received by Dr. Carolyn Barnes at her current office address to be effective. I understand revocation will not apply to information already released under this authorization. Revocation will not apply to our insurance company when the law provides our insurer with the right to contest a claim under our policy. Unless otherwise revoked, this authorization will expire when treatment is terminated, when the child reaches the age of adulthood, or under the following situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand my or my child’s health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), treatment for drug and alcohol abuse, or human immunodeficiency virus (HIV). It will include information about behavioral and mental health services.

All parties give permission for a faxed or photocopied signature to serve as an original signature regarding this authorization unless otherwise indicated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Client or Legal Representative Signature Date

# FAMILY DATA

Are there any family problems that may be contributing to your present difficulties?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your relationship with your mother?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your relationship with your father?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your parents still married?\_\_\_\_\_\_\_\_\_\_\_\_\_ If they divorced, how old were you when they separated or divorced, and how did this impact you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Were there any other primary caregivers who you had a significant relationship with? \_\_\_Yes \_\_\_No If so, please describe how this person may have impacted your life: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How many sisters do you have? \_\_\_\_\_\_ Names & Ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many brothers do you have? \_\_\_\_\_\_ Names & Ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How would you describe your relationships with your siblings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Does anyone in the family have any of these concerns** (i.e., Mom, Dad, Siblings, Grandparents, Aunts, Uncles, and Cousins)?

|  |  |  |
| --- | --- | --- |
| Anxiety: | ADD/ADHD: | Depression: |
| Bipolar Disorder/Manic Depression: | Schizophrenia: | Obsessions & Compulsions (OCD): |
| Suicide: | Learning Problems: | Mental Retardation: |
| Autism/Asperger’s Disorder: | Anger Problems: | Eating Disorder: |
| Substance Abuse/Alcohol Abuse: | Legal Trouble: | Domestic Violence: |

Physical Abuse: Sexual Abuse: Psychiatric Hospitalization:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nervous Breakdown:

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# RELATIONSHIPS/ SOCIAL SUPPORT and SELF-CARE

POOR EXCELLENT

Currently in Relationship? \_\_\_\_ How Long? \_\_\_\_ Relationship Satisfaction: 1 2 3 4 5 6 7 8 9 10

Married/Life Partnered? \_\_\_\_\_ How Long? \_\_\_\_ Previously Married/Life Partnered? \_\_\_Yes \_\_\_No

If so, length of previous marriages/committed partnerships:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? \_\_\_Yes \_\_\_No If YES, how many and what are their names and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any problems any of your children are having:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List the names and ages of those living in your household:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please briefly describe any history of neglect, domestic violence or trauma:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever experienced emotional, verbal, physical and/or sexual abuse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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POOR EXCELLENT

Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7 8 9 10

Please briefly describe your coping mechanisms and self-care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is spirituality important in your life and if so please explain:­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# EDUCATION and CAREER

High School/GED\_\_\_\_ College Degree\_\_\_\_ Graduate Degree(or Higher)\_\_\_\_ Vocational Degree\_\_\_\_

Did you have any learning problems in school?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did you receive special education services or get special help in high school?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you enrolled in a school program now? ❑ No ❑ Yes, What School?\_ GPA? \_\_\_\_\_ If no, do you wish to attend any higher education in the future?

What is your current employment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POOR EXCELLENT

Employment Satisfaction: 1 2 3 4 5 6 7 8 9 10

Any past career positions that you feel are relevant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you think are your strengths?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What do you think are your weaknesses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# PHYSICAL CONDITION

*Do you have any of the following concerns?*

Disabilities: \_\_\_\_\_\_

Serious medical problems:

Serious Injury:

Diseases:

Seizures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:

Date of last physical examination:

Previous medical hospitalizations (Approximate dates and reasons):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list Medications Prescribed, Dosages, Date of Initial Prescription or Refill: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last hearing and vision screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# HEALTH AND LIFESTYLE

Exercise habits: ❑ Sedentary (no exercise) ❑ Occasional vigorous exercise ❑ Regular Vigorous exercise

Alcohol habits: ❑ No use ❑ Occasional use ❑ Frequent use

Are you concerned about the amount you drink?

Tobacco habits: ❑ No use ❑ Occasional use ❑ Frequent use

Are you concerned about your smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illegal Substance/Drug Use History:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Drug | Dates of Use | Amount Taken | Frequency | Other |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Have you incurred any legal charges or legal difficulties as a result of your drug use? ❑ Yes ❑ No

If yes, please explain: ).

List your major interests (sports, hobbies, activities).

What do you enjoy most about your life?

### MENTAL HEALTH HISTORY

|  |  |  |
| --- | --- | --- |
| Have you ever seen a mental health provider for any reason (psychiatrist, psychologist, counselor, etc.)? | | |
| Year | Reason | Name of Provider |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Have you ever been hospitalized for a mental health reason? | | |
| Year | Reason | Name of Facility |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**BEHAVIORAL CHECKLIST**

*(Please check the behaviors that are of concern to you)*

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Have you ever been sad or depressed for more than two weeks? |  |  |
| Have you ever had so much energy that you didn’t need to sleep, and made big plans or bad decisions? |  |  |
| Have you ever been so anxious that you couldn’t do anything, or even leave the house? |  |  |
| Do you often feel the need to count, check or clean things in a special way? |  |  |
| Do you ever have several minutes of extreme anxiety or fear that comes out of the blue? |  |  |
| Do you ever feel that you can’t control your thoughts or that people can read or control your mind? |  |  |
| Do you have trouble sleeping? |  |  |
| Have you ever attempted to harm yourself or kill yourself? |  |  |

**Please add any additional information that you would like for Dr. Barnes to know:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature of Person Providing Information Date**