CLIENT INFORMATION SHEET

Contact Information:

Client Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

IF YOU WOULD LIKE TO PAY FOR SESSIONS WITH A CREDIT CARD: Please indicate the form of payment you wish to use. We accept **Visa, MasterCard,** and **Discover.** This information will be stored in your clinical file and may be updated upon request at any time.

Credit/Debit Card Information:

Card Type (circle one): Visa MasterCard Discover

Card Number: _____

Expiration Date: _____ CVC _____

Account Holder Information
Please indicate the name and address associated with the credit card you wish to use if different than above.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

_____ _____

Signature of Client or Legal Guardian **Date**

TRI-STATE FAMILY MEDICINE & BEHAVIORAL HEALTH, LLC
17833 Fair Lady Way, Darnestown MD 20874
Tel: (301) 777-9039 Fax: (240) 556-0566
Email: tristatefamilymed@gmail.com

FOR OFFICE USE ONLY

Client #: _____
Diagnosis: _____
Insurance: _____
EAP: _____

Need Monthly Statement?
Y N

CLIENT INTAKE FORM

Date: _____

The information requested in this form will be kept confidential.

GENERAL INFORMATION:

Last Name:_____ First Name: _____ Middle Initial: _____

Birth Date: ____/____/_____ Age: ___ Gender: □ Male □ Female □ Other Social Security #_____-____-_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Employer: _____ Profession/Vocation: _____

Religious Denomination/Spiritual preference: _____

Home Phone: _____ May I leave a message? □ Yes □ No

Cell/Other Phone: _____ May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication. To authorize email communication, please complete the "Consent to Correspond Electronically" Form.

Emergency Contact:_____ Telephone: _____

Relationship to you: _____

Marital Status: □ Single □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

_____

Referred by: _____

May we thank this person? □ Yes □ No

If so, please give contact information: _____

INSURANCE INFORMATION (if applicable):

Are you using insurance benefits? □ Y □ N

Are you: □ Primary Policyholder □ Dependent Relationship to Policyholder: _____

Insurance Company Name: _____

Street Address: _____ City: _____ State: ___ Zip:_____

Insurance ID #_____ Group #_____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____/_____/_____

Policyholder's SSN #: _____-____-_____ Policyholder's Employer: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

How would you rate your current physical health? (Please Circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

How would you rate your current sleeping habits? (Please Circle)

Poor Unsatisfactory Satisfactory Good Very good

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns:

_____

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

□ No

□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ No □ Yes

Please list: _____

_____

Have you ever been prescribed psychiatric medication? □ No □ Yes

Please list and provide dates: _____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Do you drink alcohol more than once a week? □ No □ Yes If yes, how often? _____

Do you currently use tobacco products? □ No □ Yes

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? Bad 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 --- 10 Good

PLEASE CHECK ALL THAT APPLY & CIRCLE THE MAIN PROBLEM:

Difficulty with:	now	past	Difficulty with:	now	past	Difficulty with:	now	past
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following.
If yes, please indicate yourself and/or the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

History of:		Yourself / Family Member Relationship:
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Sexual Abuse	yes / no	
Suicide Attempts	yes / no	

COUNSELING CONCERNS:

What significant life changes or stressful events have you experienced recently?

Please describe the concerns that bring you to counseling at this time:

Please share what you hope to accomplish or gain through counseling:

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HIPAA CONSENT FORM

Please tell us with whom we are allowed to discuss and/or disclose your personal health information.

Please circle all that apply:

Myself Only **Spouse** **Parents** **Sibling(s)**

Adult Children **Personal Representative** **Employer**

Please print name(s) of above:

_____

_____

My signature below authorizes the release of medical information to any specialists I may be referred to and to process insurance claims/applications, prescriptions, and lab work.

I understand that under the HIPAA act, I have certain rights to privacy regarding my protected health information. I understand this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

_____
Patient / Responsible Party Name

_____ _____
Patient / Responsible Party Signature Date

_____ _____
INS/ISS Employee Signature Date

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_____
Patient / Responsible Party Name

_____ _____
Patient / Responsible Party Signature Date

_____ _____
INS/ISS Employee Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

INFORMED CONSENT

CONFIDENTIALITY STATEMENT:
All information shared in treatment is confidential except in circumstances when 1) the client is in danger to (a) him/herself or (b) others, or 2) a minor or a vulnerable adult has been physically or sexually abused or 3) a court orders information to be released. If you would like your therapist to confer with another healthcare professional or anyone else, you may sign an Authorization to Release Information form. This permission can be revoked by you at any time in writing.

LENGTH OF SESSION:
Each session is 45-50 minutes long. If you would like to schedule a double session, please feel free to ask about this. Please keep in mind that insurance companies will not reimburse for more than one session per day.

FINANCIAL AGREEMENT:
The fee per 45-50 minute visit is payable at the time of treatment. We accept cash, check, Visa, Mastercard, Discover and AMEX. Fees are subject to change.

FINANCIAL POLICY:
If you have insurance which provides mental health coverage, we are happy to confer with you in the submission of your claim forms. You are responsible for mailing them to your insurance company and tracking your reimbursement. We do not accept assignment of benefits, nor do we participate in managed care insurance plans. **If your insurance company requires authorization you must inform your therapist or you might not receive benefits.** Your therapist will discuss other fees for additional services with you when/if needed.

NO-SHOW AND CANCELLATION POLICY:
Your visit has been reserved for you. 24 hours notice is required for cancellation or you will be charged a late cancellation fee of **$75**. Please note that insurance does not cover cancellation fees.

EMERGENCIES:
If you have an emergency, please go to your nearest emergency room or call 9-1-1. You can also leave a message and ask to schedule an appointment and someone will call you as soon as we are able.

STATEMENT OF UNDERSTANDING:
I have read and understand this information sheet and informed consent.

_____ _____
Client Date

_____ _____
Parent or Guardian (if minor) Date