Carter Counseling Center

Patient Information Form

Client Name: ____ Date: _____________________

SS#: _____________________________ Date of Birth: _______________ Gender: ____ Marital Status: ____

Street Address: ____

Home Phone: (_______) _______-____________ Cell Phone: (_______) ______-___________

E-mail Address: ____

Client's Employer: ____

Business Phone: (______) ______-____________ Ext: __________

Spouse/Parents Name: ____

Address (if different than client): ____

Employer: ____

Home Phone: (_______) _______-____________ Cell 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): ____

Home Phone: (_________) _________-_____________ Cell Phone: (_________) ________-______________

Emergency Contact: ____

Address (if different than client): ____

Home Phone: (_________) _________-______________ Cell Phone: (_________) ________-_____________

If you have an emergency, please call (402) 502-1716.
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:

Prenatal and Birth	Yes	No	Details
Prenatal stress or injury	___	___	
Prenatal drug/alcohol exposure	___	___	
Birth trauma (forceps, breech, etc.)	___	___	
Anesthesia, pain medications	___	___	
Anoxia (oxygen deprivation @ birth)	___	___	
Premature/late delivery	___	___	
Medical problems after birth	___	___	

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

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

Carter Counseling Center

Release of Information to Primary Care Physician

I, _______________________________________, for myself or child _________________________________

Herby authorize Carter Counseling Center to:

_____ Release any applicable information to my Primary Care Physician.

Primary Care Physician: ____

Address: ____

Office Phone: _____________________________ Fax: ______________________________

_____ Not release any applicable information to my Primary Care Physician.

These records may be released in verbal, photocopied written or facsimile format(s).

I understand that my records are protected under the applicable state law concerning health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CRF-Part2), and cannot be disclosed without my written consent unless otherwise provided by the state or federal regulations. I also understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it. This release will automatically expire 6 months from the date of termination unless other stated.

Signature of Client or Guardian: ____ Date: __________________

Signature of Witness: ____ Date: __________________

Please indicate if the **client** and/or **family member(s)** (parents, grandparents, brothers, sisters, aunts, uncles, and/or children) **currently experience** or have a **history** of any of the following symptoms.

	X Client	X Family	X Current		X Client	X Family	X Current
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				Sexual Problems			
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-mutilating			
Tension				Defiant of authority			
Over ambitious				Extreme sibling rivalry			
Social Withdrawal				Fire setting			
Destruction of Property				Overly sensitive			
Truancy				Sexual acting out			
Overly dependent				Run away			
Cruelty to people/animals				Shy			
Seeing things others don't see				Thinking other people are spying on you			
Impulsive				Mood Swings			
Bed-wetting/soiling				Attention Problems			
Low energy/Fatigue				Alcoholism			
Shortness of breath				Drug addiction			
Headaches				Poor Appetite/Picky Eater			
Racing heartbeat				Inferiority Feelings			
School/Work Problems				Relationship Problems			
Nightmares				Hearing voices others don't hear			
Difficulty Relaxing				Difficulty making decisions			
Communication Problems				Financial Problems			

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

Carter Counseling Center

Financial Payment Policy
Privacy Practices Signature
Insurance Signature on File
Limits of Confidentiality
Consent to Treatment
Attendance Notice

Please carefully read and sign below each section.

Date: ______________________________ Name: ___________________________________

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 psychotherapy/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 24 hour notice of cancellation of your scheduled appointment, or you fail to show up for your scheduled appointment, you will be charged a $50.00 fee. Genuine emergencies can be discussed with your clinician. (This statement does not apply to anyone covered under Iowa or Nebraska Medicaid Plans).

I herby understand the financial policy described above:

Signature of Client or Guardian: ____ Date: ________________

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: ____ Date: ________________

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: ____ Date: __________________

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: ____ Date: __________________

Consent for Treatment

I consent to be treated by Dr. David J. and/or Patricia L. Carter for counseling in individual couples, family or group therapy.

Signature of Client or Guardian: ____ Date: __________________

Attendance Notice

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: ____ Date: __________________

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