New Patient Information Adult (18+)

Client's name: _____Date: _____

Gender: ___ F ____ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger management ____ Anxiety ____ Coping ____ Depression

___ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

___ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs

___ Other mental health concerns (specify): _____

Family Information

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Marital Status (more than one answer may apply)

___ Single

___ Legally married
Length of time: _____

___ Widowed
Length of time: _____

____ Divorce in process
Length of time: _____

____ Separated
Length of time: _____

____ Annulment
Length of time: _____

____ Unmarried, living together
Length of time: _____

____ Divorced
Length of time: _____

Total number of marriages: _____

Assessment of current relationship (if applicable): _____ Good ____ Fair ___ Poor

Parental Information

___ Parents legally married

___ Parents ever divorced

____ Parents have ever been separated

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? _____ Yes ____ No

If Yes, please describe: _____

Has there been history of child abuse? ____ Yes __ No

If Yes, which type(s)? ____ Sexual ____ Physical ____Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): _____

Comments re: childhood development: _____

_____

Social Relationships

Check how you generally get along with other people: (check all that apply)

___ Affectionate ____ Aggressive _____ Avoidant ____ Fight/argue often ____ Follower

___ Friendly ____ Leader _____ Outgoing ____ Shy/withdrawn ____ Submissive

___ Other (specify): _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? _____ Yes _____ No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ____ Not __ Little ____ Moderate _____ Much

Are you affiliated with a spiritual or religious group? _____ Yes _____ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ____ Yes __ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? _____ Yes _____ No

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes __ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? _____ Yes _____ No

If Yes, please describe: _____

Past History

Traffic violations: _____ Yes __ No DWI, DUI, etc.: ____ Yes __ No

Criminal involvement: _____ Yes __ No Civil involvement: ____ Yes __ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: _____ Currently enrolled in school? _____ Yes _____ No

___ High school grad/GED

___ Vocational: Number of years: ___ Graduated: _____ Yes _____ No Major: _____

___ College: Number of years: ___ Graduated: _____ Yes _____ No Major: _____

___ Graduate: Number of years: ___ Graduated: _____ Yes _____ No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Currently:

_____FT _____PT _____Temp ____Laid-off ____Disabled ____Retired

____Social Security____Student ___Other (describe): _____

Military

Military experience? ____ Yes _____ No Combat experience? ___ Yes _____ No

Where: _____

Branch: _____ Type of discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

____ Drug abuse	____Alcoholism	___Vomiting
____Abdominal pain	____ Epilepsy	_____ Allergies
___ Abortion	____ Sleeping disorders	_____ Fainting
___Eating problems	___Menstrual pain	_____ Chronic pain
___ Anemia	____ Constipation	_____ Sexual problems
___ Vision problems	___Fatigue Arthritis	____Frequent urination
___ Asthma	____ Headaches	_____ Kidney problems
___Hearing problems	____ Stroke	_____Chest pain
___ Bed wetting	____ Hepatitis	_____ Cancer

___ High blood pressure ____ Dizziness ____Miscarriages

___ Diarrhea ____Diabetes ____Neurological disorders

___ Neurological disorders ____ Nausea ____ Other (describe): _____

List any current health concerns: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ____ Yes __ No

If Yes, describe: _____

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Most recent surgery			
Other surgery			
Upcoming surgery			

Please check if there have been any recent changes in the following:

___ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

___ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
Inhalants								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Reason(s) for use:

___ Addicted ____ Build confidence ____ Escape ____ Self-medication

___ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? ___

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes ___ No If Yes, describe: _____

Have drugs or alcohol created a problem for your job? _____ Yes _____ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon,)	____	____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying
____ Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist us in understanding your concerns or problems: _____

_____

_____

What are your goals for therapy? _____

_____

_____

Do you feel suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

New Patient Information

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Date_____ Client's Social Security #_____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Ext)_____

Birthdate____/____/____ Age_____ Gender __F __M Race_____

_____Name of Spouse/Guardian_____ Phone_____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment_____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship_____ Phone_____Work_____

Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Physicians_____ Phone_____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place_____ Phone_____ Hrs____

Spouse: Place_____ Phone_____ Hrs____

Insurance Information

Primary Insurance_____ Secondary Insurance_____

Phone_____ Phone_____

Contract/ID#_____ Contract/ID#_____

Group/Acct#_____ Group/Acct#_____

Subscriber_____ Subscriber_____

Subscriber Date of Birth _____ Subscriber Date of Birth_____

Client's relationship to Subscriber Client's relationship to Subscriber

__Self __Spouse __Child __Other_____ __Self __Spouse __Child __Other_____

Referral Source

How did you hear of this office clinic (or from whom)?_____

Pat Fogle (NPI 1790752319) _____ **Carol Gindratt (NPI 1518018761)** _____
Carl McQueen (NPI 1457447823) _____ **Cynthia Young (NPI 1326142449)** _____
Sarah St. Cyr (NPI 1871852947) _____

CLIENT INTAKE FORM

(Please print clearly)

Client NAME_____ **Appt Date/Time** _____

Client DOB _____ **SSN**_____ **Email**_____

Client Phone: Home_____ **Work**_____ **Cell**_____

Client Address_____**City**_____**ZIP**_____

Parent or Legal Guardian Name_____**Phone**_____

PRIMARY INSURANCE COMPANY_____ **Phone**_____

Group or Plan #_____ **Insurance ID#**_____

Insured Name_____**DOB**_____ **SSN**_____

Relationship to Client_____ **Employer**_____

Insured Address_____

SECONDARY INSURANCE? YES NO If YES, 2nd Ins_____**ID#**_____
(CIRCLE ONE)

ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO PROVIDER OF SERVICE. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO GIVE MY PERMISSION FOR RELEASE OF MEDICAL RECORDS INFORMATION FOR FILING OF MY INSURANCE.

_____

CLIENT SIGNATURE (Parent or Legal Guardian if Minor) **DATE**

INSURANCE VERIFICATION FOR OFFICE USE ONLY

Date Verified: _____ _ By: _____ Spoke with: _____

Coverage: _____ Co-Pay: _____

Deductible: _____ Amount Met: _____

Pre-Certification # : _____ Visits: **90791**: **90834**: **90837:** No Limitation

Dates Covered: _____ TO: _____ **Network** **Non-Network**
Starting Ending Circle One

Family Therapy (**90847**) Covered: Yes No (Circle One)
Pre-existing Wait: Yes No (If yes, end date: _____)
Claims Mailing Address (Ask if mental health is handled by another organization):

FREEDOM COUNSELING

Carol Gindratt MEd, LPC
1219 E. South 11th, Suite A
Abilene, Texas 79602
(325) 676-2039

PROFESSIONAL DISCLOSURE STATEMENT

Nature of Counseling: My approach to counseling is eclectic and based on the needs of each individual. We will work together to develop your personal goals and I will offer you more effective ways to deal with your interpersonal problems I believe that all of your behaviors are meaningful and I will help you develop insight into the reasons behind your actions so that you may understand them and move forward to change them. By doing so, we can work to develop any destructive thoughts and behaviors into more productive ones. You may be discouraged in areas of your life such as work, school, or relationships. I will encourage you to take steps to make changes in your life in order to reach your goals successfully in these areas. I believe that you are a creative, goal-oriented individual who can take responsibility for the direction of your own life. Primarily, we will focus on what is happening currently in your life, however, we may explore your past in order for us to gain insight into your current approaches to life.

INFORMED CONSENT

Counseling Relationship: Typically sessions are conducted with clients one time weekly for approximately 45-60 minutes. During our session time I will strive to establish a trusting and honest relationship to help foster your growth and health. I will endeavor to provide a safe, comfortable atmosphere in sessions, focusing my energy on you and your concerns. I ask that you come prepared to work during sessions, allowing yourself the best opportunity for help. Furthermore, I ask that discussions of your issues be limited to office sessions, where I can best focus my energy on you. Public contact, social gatherings, etc. are not good times for me to counsel with you. We will both be better served if we save these conversations for our sessions.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, continuing, or discontinuing counseling. I will strive to ensure that all efforts are directed towards helping you realize your desired outcome. There are no guarantees of outcome or effectiveness of counseling.

Costs and Reimbursements: The usual fee for the first session is $150.00, after which the basic fee for other sessions is $135.00 for 60 minutes. Longer or shorter sessions are prorated from this basic fee. Unless previous arrangements are made, payment is expected at time of service. Many times insurance will cover part or all of the fees. Additionally, I am on the panel of many insurance providers. Please ask me about your insurance or payment options and plans upon arrival.

Emergency Contacts: On rare occasions emergency contact is necessary due to the nature of the ongoing condition. I do maintain an emergency number, which is provided on an as-needed basis.

Court Appearance: I will make arrangements to offer testimony in court proceedings. The fee for this service is $200.00/hour, with a 5-hour minimum. If travel is required, mileage charges will be added at the rate of $.50/mile plus a $50.00 per day per diem. Minimum payment for this service is expected at least 1 week PRIOR to the scheduled date. I cannot guarantee refunds or credits in cases of date changes due to the major scheduling conflicts involved.

Cancellations: In order to properly serve all clients, I maintain a tight schedule. Cancellation is expected at least 24 hours in advance. Failure to cancel or missing an appointment will result in a billed No Show, which is half the standard hourly fee. Insurance will not reimburse this charge.

Confidentiality and Records: All of our communication becomes part of the clinical record. Records will remain my property. Adult client records are disposed of seven years after the file is closed. Minor clients' records are disposed of seven years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) I determine that you are a danger to yourself or someone else; b) you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person; c) I am ordered by a court to disclose information; d) you authorize me to release your records with your signature; e) I am otherwise required by law to disclose information. Based on recent HIPPA legislation, you are entitled to review the information being released to your insurance provider and approve/deny its transfer. Please note that in cases where the insurance provider refuses compensation, you will be responsible for payment. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. In the case of marriage or family counseling, I will keep confidentiality (within limits cite above) anything you disclose to me without your family knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress. Copy cost for records is $2.00 per page, payable upon receipt.

By your signature below, you are indicating that you read and understand this statement and all the information presented in it, and that any questions you had about this statement were answered to your satisfaction. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to each of it specifications.

_____	_____	_____
Client Signature/Minor's Legal Representative	Printed Name	Date

Privacy of Information Policies

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to

credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within this office or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the office or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the office (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $_2.00____ per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

Your have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

Complaints

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Texas State Board of Examiners for Licensed Professional Counselors at (512)834-6658____. If you file a complaint we will not retaliate in any way.

Direct all correspondence to:
Carol Gindratt
1219 E. South 11th, Suite A
Abilene, Texas 79602 (325)676-2039

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signature: _____ Date: _____/_____/_____

Signed by: __client __guardian __personal representative