CLIENT INFORMATION SHEET

Name: _____ Referred by: _____

Date of birth: ___/___/____ Age: _____ Social Security #: _____

Address: _____ Insurance Carrier: _____

_____ Insurance ID #: _____

City Zip

Home Phone: ( ) _____ Family Doctor: _____

Cell Phone: ( ) _____ _____

E-mail: _____ Address: _____

Employer: _____ _____

Office Phone: ( ) _____ _____

Marital status: _____ Medications taken: _____

Name of spouse/partner: _____ _____

Names and ages of children: _____

Names of others living in the home & relationship: _____

_____

Medical conditions: _____ Medication allergies: _____

_____ Previous therapy: _____

Reason for seeking therapy at this time: _____

_____

Please read and sign: Each session is 45-55 minutes. Co-payments are due each visit. You are ultimately responsible for all fees for service if your carrier does not pay a claim. If you must cancel an appointment, please provide at least 48 hour notice – because this time is reserved for you. A session that you did not attend, cannot be charged to the insurance company for reimbursement. There is a fee of $40 for appointments that were not cancelled 48+ hours in advance. Please be aware that this does not apply for group sessions. You are responsible for all group sessions whether you are able to attend or not. The fee for a missed group session is $40.

Release of information: I hereby give permission for Grunblatt Psychology and Counseling Offices, P.C. and my insurance carrier and my primary care physician to share information regarding my treatment. I permit a copy of this to be used in place of the original.

_____ _____/_____/20_____

Signature Date

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We, Grunblatt Psychology and Counseling Offices, P.C. assume that we may contact you by telephone at your home, cell and at your workplace, and in writing at your home, unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

I wish to be contacted as follows (check all that apply):

☐ At my home telephone number: _____
____ You can leave messages with detailed information
____ Leave message with call-back number only
____ Call only at specified times of day: _____

☐ At my work telephone number: _____
____ You can leave messages with detailed information
____ Leave message with call-back number only
____ Call only at specified times of day: _____

☐ At my cell phone number: _____
____ You can leave messages with detailed information
____ Leave message with call-back number only
____ Call only at specified times of day: _____

☐ SEND APPOINTMENT REMINDER E-MAILS/TEXTS: _____

☐ In writing at:

____ My home address
____ My work address
☐ Other (Specify): _____

_____ _____
Signature of patient Date

_____
Print Name

GRUNBLATT PSYCHOLOGY AND COUNSELING OFFICES, P.C.

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INFORMED CONSENT AND AGREEMENT FOR PSYCHOLOGICAL SERVICES

As we begin psychotherapy we would like to inform you about the type of work we expect we will be doing together. There are many different forms of psychotherapy. We utilize a practice we call "eclectic", which draws from a variety of procedures that have been effective in helping people deal with their emotional and social life.

While benefits can be expected from this treatment, no particular outcome can be guaranteed. We will work together to establish goals for therapy. The psychotherapeutic process can sometimes bring up upsetting feelings and, on occasion, a client may feel worse before feeling better. You will need to participate in a periodic review of your progress and goals.

As your therapists, we place a high value on the confidentiality of the information you share with us. State law and professional ethics also require psychologists, social workers, and mental health counselors to maintain confidentiality and not to release information about you without your written consent. Most of the provisions explaining when the law requires disclosure were described to you in the accompanying Notice of Privacy Practices. There are a few possible exceptions to confidentiality.

_____ **- Initial**

1. As your therapist we are required by law to report any suspected child abuse or neglect. This law is designed to protect children from harm.
2. If we learn information that could result in danger, injury or harm to you, to your personal property, or to others or to their property, then we have a duty to notify some other organizations, officials, or person who in our judgment can reduce that risk of danger.
3. If you are or become involved in litigation, the court may request a report, an evaluation, or your entire mental health record. If you are requested to sign a release for your psychotherapy records, you should consult your attorney.
4. If an insurance carrier or a managed care company is paying for your treatment, then your treatment records are available to them upon request and they are likely to put your treatment information into a central database that could be accessed by others.
5. We may consult with the therapists in the practice or professional colleagues about our work together. However, your name and other identifying information will not be revealed without your express consent.
6. If we are away or unavailable, and another therapist of the practice is covering, it may be necessary to share some information about our work together in order for the covering therapist to help you in an emergency.
7. Please be aware that if you use email or texting that those methods are not confidential, therefore please try to limit communication via email and texting to mainly scheduling issues.

We will try to discuss each situation with you before any confidential information is disclosed and we will reveal the least amount of information necessary. _____ **- Initial**

The psychotherapy session will be 45 minutes in length. If you have a **Deductible** that has not been met and/or no insurance coverage we will require a deposit of our regular charge of **$225** per intake session and **$175** for a regular individual session. Longer sessions will be pro-rated. There will be a **charge for telephone** contacts beyond 5 minutes in length. Generally, Insurance companies do not pay for phone contacts or phone sessions, thus you are responsible for those charges. Likewise, meetings outside the office related to your treatment including travel time will be billed accordingly. Should you need financial hardship consideration please let the office know ahead of time.

All copays are due at the time of service. _____-Initial

If you have a minor attending therapy you as the guardian are required to make proper payment arrangements.

_____ - Initial

You are required to give at least **48 hour notice** if an appointment must be changed or cancelled. If you give us less than 48 hour notice or no notice, you will be billed for the missed appointment. The flat fee for **a missed appointment** is **$40**. We will reschedule your appointment whenever possible. Insurance companies do not pay for broken or missed sessions.

_____ - Initial

Grunblatt Psychology and Counseling Offices, P.C. may participate in **training** clinicians who provide individual, family or couple therapy or who help run groups, or provide testing under supervision of our seasoned clinicians. This is to teach clinicians to become more experienced. Confidentiality agreements apply to everyone observing services being provided or providing services at Grunblatt Psychology and Counseling Offices, P.C.

_____ - Initial

For **Testing,** Insurance companies generally only pay for face to face contact. The time to score the tests and to write up a report will not be paid by Insurance, so you will be responsible for those charges. Usually, we request that you pay an initial retainer for testing services in the amount of $750. This retainer is based on our fee of $200 per 45 minutes for scoring or report writing. Should it take us less time or should the Insurance Company pay for such services we will gladly reimburse you for any remaining amount.

_____ - Initial

For **Therapeutic Visitation or court ordered services,** Insurance companies generally do not pay, because they are not based on medical necessity. Our fee for therapeutic visitations is $250 per 45 minute session. This fee will be applied in increments of 5 minutes to any contact in person, on the telephone, or in writing that we make with you, your attorneys, the court, or other involved parties.

_____ - Initial

For **Mental Health Evaluations**, we charge a flat fee of $3000. This fee will be applied to time spent for testing, report write ups, contact with lawyers, courts, or other entities involved.

_____ - Initial

If we are required to **testify in court**, we charge $1250 for a half day or $2500 for a full day. A retainer of $1000 is required before services begin. An additional retainer of $1500 is required if testifying in court is required, at least three weeks prior to court performance. Please also be aware that should you request us to testify in court you wave confidentiality of the content of our sessions together. We do not guarantee any outcome of our court involvement.

_____ - Initial

We are engaged to provide **psychotherapeutic treatment**, not "expert testimony" for court. As our client you agree not to require us to provide "expert testimony" in any litigation. Should we be subpoenaed or be required by a court to participate in a deposition, give testimony, records, or other information to attorneys or Court, you agree to pay us $250 per 45 minutes. (Please review section on **therapeutic visitation or court ordered services** for a more detailed explanation).

_____ - Initial

You are making **the choice to begin psychotherapy**. You have the right to end your treatment at any time. If you decide to leave treatment, you are encouraged to speak with us before leaving so we can end our work appropriately and we can assist you with making plans for future treatment if necessary. Missing three consecutive scheduled appointments without explanation or notification will constitute voluntary termination by you.

_____ - Initial

By signing below you indicate that you have read and understood this agreement and give consent to treatment.

Client's Name(s):
(Printed)_____

Signature(s):_____ Date_____/_____/20_____

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Authorization Form (HIPAA)

Authorization for Disclosure of Protected Health Information

Name of Patient: _____

1. I authorize the Healthcare practitioner Grunblatt Psychology and Counseling Offices, P.C., 124 Green Street, Kingston, New York 12401 (the 'Practitioner') and/or the administrative and clinical staff of the Practitioner to disclose my (or my child's or my ward's) protected health information, as specified below to: _____
_____(name and address of person/entity to receive information)

2. I am hereby authorizing the disclosure of the following protected health information:
_____
_____
(Specifically describe the protected health information to be disclosed such as date of service, type of service, and level of detail to be released.)

3. This protected health information is being used or disclosed for the following purposes: At the request of the individual or _____ (enter specific reason)

4. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.

7. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Patient, or Parent of Minor Patient, or Personal Representative of Patient — Date

_____ _____
Print Name of Patient, Parent of Minor Patient or Personal Representative of Patient — (If a Personal Representative state relationship to patient.)

I received a copy of this Authorization form _____ (please initial)

Psychotherapy Client Questionnaire

CONFIDENTIALITY STATEMENT:

Case records are strictly confidential. No outsider, not even your closest relative or family doctor is permitted to see your case record without your written permission or a court order.

1. GENERAL

(A) Name: _____ Date: _____

Home Phone: _____ DOB: _____ Place of Birth: _____

(B) What is your present living situation? _____

_____

(C) Names and ages of children

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

(D) Give a short history of your closest interpersonal relationships:

_____

_____

_____

_____

_____

_____

(E) Education: _____

Occupation: _____

Currently Working: _____

What is your present job situation? _____

_____

2. PROBLEM AREA

(A) State in your own words the nature and history of you chief complaint:

_____

_____

_____

_____

(B) Present interests, hobbies, activities:

_____

_____

_____

(C) How is most of your free time occupied?

_____

_____

_____

_____

(D) What are your life goals?

_____

_____

_____

(E) What are your five greatest fears?

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

3. FAMILY HISTORY

(A) Father's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

_____

Your age at time of father's death: _____

Give a description of your father's personality:

_____

_____

_____

_____

_____

_____

(B) Mother's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

_____

Your age at time of mother's death: _____

Give a description of your mother's personality:

_____

_____

_____

_____

_____

_____

(C) Brothers/Sisters (names, sex, age and something about each)

Are there significant others from your growing up years?

(D) Who are the most important people in your life? Describe

(E) Previous Medical, Psychiatric and Psychotherapy Contacts

5. MEDICAL HISTORY

(A) Have you had any of these childhood illness?

	NO	YES	DON'T KNOW
Measles			
Mumps			
Whooping Cough			
Chicken Pox			
Rheumatic Fever			
Rubella (German measles)			

(B) Have you ever suffered from any of the following illnesses?

	NO	YES	DON'T KNOW
Cancer			
TB			
Diabetes			
Thyroid Trouble			
Kidney Trouble			
High Blood Pressure			
Eye Trouble			
Heart Trouble			
Neurological Disease			
Ulcers			
Head Injury			
D.T.'S			
Allergies			

List of all allergies: _____

_____

Please List all medical hospitalizations and operations. Give diagnoses and dates:

_____

_____

_____

Any other serious illnesses? _____

_____

(C) Family History

Have any of your blood relatives suffered from any of the illnesses listed above? If yes, please specify ailment and relative:

_____

_____

_____

_____

_____

(D) Drug/Medication History

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are currently taking and/or have taken in the past. This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation can be made.

Please list all legally prescribed and illegal drugs ever used (past or present) how often you use them and what effects you seek:

_____

_____

_____

_____

_____

Have any of these drugs been prescribed by a physician?

Yes: _____ No: _____

If yes, which drugs and for what reason? _____

_____

(E) Nutrition

Is your diet unusual in any way? Yes: _____ No: _____

If yes, how? _____

_____

(F) Symptoms

Check any of the following symptoms that apply to you at this time or in the past.

Hair falling out		Big appetite		Ringing in ears	
Weight gain		Fast heart beat		Chest pain	
Fatigue		Diarrhea		Shortness of breath	
Constipation		Fainting spells		Tingling of hand/feet	
Dry Skin		Difficulty sleeping		Ankle swelling	
Weakness		Drinking too much fluid		Indigestion	
Weight Loss		Blurred vison		Urinary difficulties	
Tremor		Deafness		Problems with sexual organs	
Poor appetite		Dizziness			
Headaches		Nausea/vomiting			

(G) Menstrual history, Issues or Problems: _____

_____

_____

(H) Smoking and Drinking

Do you smoke (anything)? _____ What? _____

How much? _____ Frequency? _____

Do you drink alcohol? _____ If yes, how much? _____

What happens to you when you smoke or drink, what does it do for you?

_____

_____

Describe any physical symptoms at all that you have when you smoke or drink.

_____

_____

(I) What kind and how much physical exercise do you get?

_____

_____

_____

(J) Describe the spiritual/religious aspects of your life:

_____

_____

_____

_____

Place check mark in correct column	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel more nervous and anxious than usual.				
2. I feel afraid for no reason at all.				
3. I get upset easily or feel panicky.				
4. I feel like I'm falling apart and going to pieces.				
5. I feel that everything is all right and nothing bad will happen.				
6. My arms and legs shake and tremble				
7. I am bothered by headaches neck and back pain.				
8. I feel weak and get tired easily.				
9. I feel calm and can sit still easily.				
10. I can feel my heart beating fast.				
11. I am bothered by dizzy spells.				
12. I have fainting spells or feel like it.				
13. I can breathe in and out easily.				
14. I get feelings of numbness and tingling in my fingers and toes.				
15. I am bothered by stomach aches or indigestion.				
16. I have to empty my bladder often.				
17. My hands are usually dry and warm.				
18. My face gets hot and blushes.				
19. I fall asleep easily and get a good night's rest.				
20. I have nightmares.				

	Not At All	Mildly but it didn't bother me much	Moderately- wasn't pleasant at times	Severely- it bothered me a lot
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of worst happening				
Dizzy or lightheaded				
Heart pounding/racing				
Unsteady				
Terrified or afraid				

	Not At All (0)	Mildly but it didn't bother me much (1)	Moderately- wasn't pleasant at times (2)	Severely- it bothered me a lot (3)
Nervous				
Feeling of choking				
Hands trembling				
Shaky/unsteady				
Fear of losing control				
Difficulty in breathing				
Fear of dying				
Scared				
Indigestion				
Faint/lightheaded				
Face flushed				
Hot/cold sweats				
Column Sum				

(L) Have you ever been on worker's comp or disability? For what, how long, results?

_____

_____

_____

(M) In case of emergency, please notify one of the following three people: May I have your permission to inform one or all of these people if you are ever in danger?

Yes: _____ No: _____

1. Name: _____ Phone: _____

Address: _____

2. Name: _____ Phone: _____

Address: _____

3. Name: _____ Phone: _____

Address: _____

Signature: _____ Therapist's Signature: _____