Patient Information:

Patient's Birth Name: _____

Patient's Preferred Name:_____

Preferred Pronouns:_____

Patient's Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Patient's Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ On leave

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) -_____-_____ Cell Phone: (_____) -_____-_____

Work Phone: (_____) -_____-_____ Other Phone: (_____) -_____-_____

E-Mail Address: _____

How would you like to be notified?: ☐ Phone ☐ Text ☐ Email ☐ None

☐ *By checking this box, I give permission to QCC to send non-sensitive information through the means above*

Emergency Contact Information:_____

Name | Relationship to Client | Telephone Number

☐ *By checking this box, I give QCC permission to contact the abovenamed person in the case of an emergency*

How did you hear about us: _____

(Name) (Company)

Insurance Information:

Insurance Company: _____

Insured Person: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Insured's Street Address: _____

Insured's City: _____ State: _____ Zip:_____

Insured's Phone: (_____) - _____ - _____ Insured's Birth-Assigned Gender: ___

Insured's Date of Birth: _____/_____/_____

Insured's Employer: _____

Insured's ID # (from card): _____

Insured's Group # (from card): _____

Insurance Phone Number (back of card): (_____) - _____ - _____

Patient Health Information:

Symptoms:

___Anxiety	___Depression	___Sleep problems	___Thoughts of suicide
___Panic	___Unusual thoughts	___Anger outbursts	___Changes in weight
___Crying spells	___Memory problems	___Sexual problems	___Relationship issues
___Treated unfairly	___Frequent pain	___Low energy	___Concentration issues
___Restlessness	___Nausea	___Eating disorder	___Legal problems
___Drug use	___Drinking problem	___Boredom	___Hopelessness
___Stress	___Shyness	___Work problems	___Confusion
___Guilt feelings	___Suspicion	___Loneliness	___Thoughts of hurting others
___Compulsions	___Worried	___Money problems	___Difficulty with decisions
___Specific fears	___Mourning	___Physical illness	___Poor motivation
___Feeling abandoned	___Meaninglessness	___Perfectionism	___Unusually sensitive
___Irritability	___Social withdrawal	___Feeling misunderstood	___Troublesome thoughts
___Religious concerns	___Disappointment	___Impulsive	___Hearing strange voices
___Feeling inferior	___Irrational thoughts	___Mood swings	___No problems or concerns

Enter any additional concerns or symptoms in the blanks below:

What stresses or life changes have you experienced recently?

Have you seen a therapist in the past?

YEAR	PROBLEM	THERAPIST OR CLINIC	HOW LONG

Your family growing up:

RELATIONSHIP	FIRST NAME	PERSONALITY/MENTAL HEALTH ISSUES

About your childhood: (Check the descriptions that apply to you)

___Happy childhood	___Neglected	___Moved frequently
___Physically abused	___Few friends	___Sexually abused
___Weight problems	___Popular	___Parents divorced
___Family fights	___Poor grades	___Conflict with teachers
___Drug or alcohol use	___Good grades	___Sexual problems
___Depressed	___'Spoiled'	___Anxious
___Not allowed to grow up	___Attention problems	___Anger problems

Who lives with you now?:

RELATIONSHIP	FIRST NAME	PERSONALITY/MENTAL HEALTH ISSUES

Relationship history:

How many times have you been married? ☐ Partners' Name(s): _____

How old were you at the time of your marriages? ☐

Briefly describe any problems in your current or past marriages or cohabitation relationships:

_____

_____

_____

Education & Occupation:

Are you currently (check as many as apply)…….. ☐ Working ☐ In School ☐ Retired ☐ On leave

Highest level of education so far? ☐

What was your major or favorite subject? ☐

How many hours per week are you working? ☐

In what field do you usually work? ☐

What is your current or most recent job title? ☐

Home Life:

How do you spend personal time? (List hobbies, sports, clubs, groups, family activities, etc) _____ _____ _____

How many contacts do you have each month with friends outside of work or school? ☐

Who can you talk with about personal feelings or private matters? ☐

Are you satisfied with your romantic life? ☐

Briefly describe what you like and dislike about your current romantic and friendship lives. _____ _____ _____

Health:

Check each accident or illness you have experienced:

___Recent surgery ___Head injury

___Seizures ___Thyroid problems

___Drug/alcohol abuse treatment ___Neurological disorder

___Chronic pain ___Headaches

___Diabetes ___Hormone problems

___Infertility ___Miscarriages

List any other chronic health problems you may have:

_____

_____

_____

How many hours do you sleep in an average night? ☐

How many drinks containing alcohol do you consume in an average week? ☐

Which recreational drugs have you used in the last year? ☐

List prescriptions or over the counter medications you may take, along with the purpose of the medication. _____ _____ _____

Do you exercise? How? How often? ☐

Do you use tobacco? How much? ☐

Who is your primary care physician? ☐

When was your last physical? _____/_____/_____

Are you concerned about your physical health? ☐

List any addition things that it might be important for your therapist to know: _____ _____ _____

Patient Name: _____

PRIVACY PRACTICES POLICY:

What Information Is Protected 1. Information your doctors, and other health care providers put in your medical record 2. Conversations your therapist has about your care or treatment with others 3. Information about you in your health insurer's computer system 4. Billing information about you at your clinic 5. Most other health information about you held by those who must follow these laws.

Health Insurers and Providers who are covered entities must comply with your right to: 1.Ask to see and get a copy of your health records 2.Have corrections added to your health information 3.Receive a notice that tells you how your health information may be used and shared 4.Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing 5.Get a report on when and why your health information was shared for certain purposes 6.If you believe your rights are being denied or your health information isn't being protected, you can file a complaint with your provider, health insurer or the U.S. Government.

To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared: 1. For your treatment and care coordination 2. To pay doctors and hospitals for your health care and to help run their businesses 3.With your family, relatives, friends, or others you identify

The following disclosures of your Personal Health Information require written authorization: 1) if the PHI is used or disclosed for marketing purposes; 2) if the disclosure constitutes a sale of PHI; 3) most uses and disclosure of psychotherapy notes. (Covered entities that don't record or maintain psychotherapy notes are not required to include a statement in their NPPs about the authorization requirement.) Uses and Disclosures of PHI not covered by this Notice of Privacy Practices will only be made with the written permission of the individual and must state that this authorization may be revoked by the individual as "provided in the regulations".

You may restrict certain disclosures of PHI to a health plan if you have paid for the service out of pocket, in full.

You will be notified in writing if your unsecured PHI is compromised.

Acknowledgement of Privacy Practices Policy: I acknowledge that I am aware of QC Counselor's Notice of Privacy Practices. I understand that QC Counselor has the right to revise these information practices and to amend the Notice of Privacy Practices. I understand that in the event that the Notice is revised, the revised Notice will be posted at QC Counselor and I understand that I may obtain a current Notice of Privacy Practices at any time from the office manager at QC Counselor.

_____ _____

Signature of Patient/Parent/Guardian/Representative Date

_____ _____

Printed Name Relationship to Patient

Patient's Agreement to be Treated and to be Financially Responsible:

I acknowledge that the patient, or responsible party for the patient, is responsible for payment of fees unless otherwise agreed upon. _____ INITIAL

I further understand that I may be charged $40 for any missed appointments or for appointments that are cancelled without 24 hour notice. _____ INITIAL

I also understand that failure to meet the financial obligations related to my appointments and charges may result in disruption of service and/or being the subject of legal action, which may include being turned over to a collection agency or sued in small claims court. If I am turned over to collections, I understand that a fee will be assess to my account to cover collections cost up to 33.3% of my total bill _____ INITIAL

I give my consent to be treated at QC Counselor.

I authorize QC Counselor to release information necessary for billing only to my insurance company and/or financially responsible party. I authorize QC Counselor to release treatment plans necessary for authorization to my insurance company. I also authorize QC Counselor to release information to the referring individual or organization and to my family physician. I further acknowledge and authorize that anonymous details of my case may be reviewed by other members of QC Counselor staff for the purpose of treatment review and crisis management. I direct the insurer to pay, without equivocation, directly to QC Counselor all benefits due as a result of my scheduled visits or charges.

_____ _____

Signature of Patient/Parent/Guardian/Representative Date

Form: qcc0222