PSYCHSTRATEGIES, INC.

Client Information Form

Date: _____

Client Name: _____ Sex: ☐ M ☐ F ☐ Other: _____ DOB: _____

Do you prefer a male or female therapist? ☐ Male ☐ Female ☐ Don't Care

When are you available for therapy ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Anytime

Do you prefer a specific time? ☐ AM ☐ PM ☐ Doesn't Matter

May we correspond via email? ☐ Yes ☐ No Email Address: _____

Client Address: _____
Street City State Zip

Client Telephone: Home _____ Cell _____ Daytime _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed

Client Social Security #: _____

Person Completing Form, **if not the Client:** _____ Telephone: _____

Primary Care Physician: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____

Cash Pay: ☐ Yes ☐ No

Please fill out all of the following information – even if a copy of your insurance card is attached:

Primary Insurance: _____ Telephone: _____

Insurance Billing Address: _____

Name of **Policy Holder**: _____ DOB: _____

Exactly as it Appears on the Card

Policy Holder ID #: _____ **SS #:** _____ Group #: _____

Policy Holder Mailing Address (if different from Client): _____

Policy Holder Telephone: _____ Relationship to Client: _____

EAP: Name of Employer _____

EAP Company _____ Auth #: _____

# of Sessions Authorized _____ Date Range: _____

Are you involved in any legal proceedings (e.g. Workers' Compensation Claim, Child Custody Dispute, Etc.) which may involve your Clinician? ☐ Yes ☐ No If yes, please describe: _____

How did you hear about PsychStrategies and who referred you to us? _____

I authorize my insurance carrier to pay PsychStrategies (please sign):

_____
Signature

For Clinician Use Only:

Clinician Name: _____ # _____ Dx: _____ Copay/Session: _____

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PSYCHSTRATEGIES, INC.

Client History, Concerns & Goals

Client Name: _____ **Date:** _____
(If you are here for Couples Therapy, please complete one form for each partner.)

Form Completed by: _____ Relationship: _____

Please fill in the following information as completely as possible. All information is covered by our Confidentiality Policy (see attached Office Policies). **Use the back of this form if necessary.**

1) Describe what has happened recently that led you to seek counseling now. _____
_____
_____

2) Describe current concerns and symptoms. _____
_____
_____

3) Check the response that best applies (please check only one):

a. **My current concerns and symptoms are:**
- ☐ the continuation of a long-standing condition
- ☐ a recent worsening of an on-going condition
- ☐ the reoccurrence of a previous condition
- ☐ significantly different from any previous condition
- ☐ my first occurrence of any condition

b. **My current symptoms developed:**
- ☐ suddenly (less than four weeks)
- ☐ gradually (one to several months)
- ☐ very gradually (one to several years)

4) **Medical History:** Please list major injuries, illnesses or surgeries:

Condition	Dates	Treatment

5) Are you currently on any medication? ☐ Yes ☐ No

Medication	Dosage	Prescribing Physician	Date Started

Allergies/Sensitivities to any medications: _____

6) Any psychiatric medications you have taken in the past (and are NOT currently taking): ☐ Yes ☐ No

Medication	Dosage	Prescribing Physician	Date Started

7) Name of Spouse/Significant Other: _____ Age: _____
Children - Name(s) and age(s): _____
Parents - Name(s) and ages(s): _____
Please describe your current family situation and relationship history: _____
_____
_____

Client History, Concerns and Goals – Continued

Client Name: _____

8) Please indicate any significant prenatal events and developmental history: _____
_____
_____

9) Please list other substances that you use. ***Include amount and frequency.***

Alcohol _____ Heroin _____
Marijuana _____ Psychedelics _____
Caffeine _____ Methamphetamine_____
Tobacco _____ Other _____

10) Have you been in psychotherapy or been hospitalized in a psychiatric facility? ☐ Yes ☐ No
If yes, please list names of past clinicians and hospitalizations, dates and reason for treatment: _____
_____
_____

11) Has anyone in your immediate or extended family had a psychiatric illness? ☐ Yes ☐ No
If yes, please list relationship and nature of illness: _____
_____

12) Education: _____

13) Current employment and work history (summary): _____
_____
_____

14) Describe your relationship within your family of origin. Include parental substance abuse issues, as well as other relevant life events: _____
_____
_____

15) Briefly describe your current support system (family, friends, organizations, self): _____
_____
_____

16) Briefly describe your strengths and weaknesses: _____
_____
_____

17) Please describe your goals for therapy:
a. _____
b. _____
c. _____

18) Do you have thoughts about hurting yourself or others? ☐ Yes ☐ No If yes, please describe: _____
_____
_____

PSYCHSTRATEGIES, INC.

Office Policies

Legal and Ethical Policies: Without pressure or coercion, I, the client/guardian, consent to treatment for myself and/or my legal guardian. All information disclosed in sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my, the client/guardian's, written permission, except where disclosure is required by law.

The reporting of information disclosed in session is *required by law* under the following circumstances:

- If a client presents an imminent danger to self or others or is gravely disabled (severely disoriented or in danger due to a psychiatric condition) authorities must be notified.
- If a client expresses a serious threat of harm to an identifiable person, that person must be warned and the police must be notified.
- If there is *reasonable suspicion* of a child, dependent, or elder abuse or neglect, authorities must be notified.

The reporting of information disclosed in session *may be required*:

- If the client's mental status is placed at issue in litigation initiated by me, the client/guardian.
- In the event of a court order or subpoena, information, records, or testimony about the client may have to be produced.

I, the client/guardian, have the right to review and/or receive a copy of the client's protected health information. If the treating clinician deems that releasing such information might be harmful in any way, the clinician will either deny my request or provide the records to an appropriate and licensed mental health professional of the client/guardian's choice.

I, the client/guardian, may end treatment at any time by notifying the clinician in person or by telephone.

Financial Responsibilities: I, the client/guardian, assume primary financial responsibility for all professional services rendered and understand that any balance due will be billed to me on a monthly basis. I, the client/guardian, am responsible for the standard fee of $_____ per session or insurance contracted rate per session. Payment is due at the time that services are provided. Insurance co-payment per session is $ _____.

Cancellation Policy: If the client misses an appointment or cancels an appointment without giving 24 hours notice I, the client/guardian, will be charged $ _____ for the missed session. Please be advised that missed appointments and late cancellations are *NOT* covered by insurance.

Services provided outside of the client's usual scheduled session (i.e., telephone consultations, site visits, travel time, longer sessions, etc.) may be charged to me, the client/guardian, at the clinician's standard fee, unless otherwise agreed upon.

If payment of the client's account is over 120 days late or if it goes to collection, all fees including collection and attorney fees will be my, the client/guardian's, responsibility.

Insurance Policies:

I, the client/guardian, consent to have claims submitted to the client's insurance company. Yes _____ No _____

I, the client/guardian, am ultimately responsible for charges incurred even though services will be billed to the client's insurance company. PsychStrategies will bill the client's primary insurance company only. PsychStrategies will not bill a secondary insurance (except when Medicare is the primary insurance). A receipt for services can be provided upon request. I, the client/guardian, understand that not all issues/conditions/problems that may be the focus of treatment are reimbursed by insurance companies. I understand that the client's insurance benefit may only provide for crisis intervention, and that, therefore, a brief therapy model with solution-focused therapy or problem-solving techniques may be used by the clinician.

I, the client/guardian, consent to have PsychStrategies release the client's protected health information to the client's insurance company in order to receive payment for claims. I understand that the client's protected health information will include diagnostic information, dates of service, and other information as requested by the client's insurance company for payment. I, the client/guardian, understand that PsychStrategies has no control over or knowledge of what insurance companies do with the submitted information or who has access to this information after it is released.

Client Signature: _____ Print Name: _____

Office Policies – Continued

It is my, the client/guardian's, responsibility to verify the specifics of the client's insurance coverage and be aware of and inform PsychStrategies of any changes that may occur to the client's insurance coverage. It is my, the client/guardian's, responsibility to be aware of the amount of the client's insurance co-payment and any changes to the amount of the client's copayment.

General PsychStrategies Policies: I, the client/guardian, consent to release the client's protected health information to all PsychStrategies clinicians who participate in the client's treatment.

EMERGENCY PROCEDURES:

- ***Non-Emergency:*** To contact my clinician between sessions, I, the client/guardian, can leave a message on the voicemail number provided. Clinicians check messages regularly during the week.
- ***Emergency:*** If I, the client/guardian, think I or the client is having an emergency, I will call 911 or go to the nearest Emergency Room with the client.

Satisfaction Survey: I agree to allow PsychStrategies to mail a Satisfaction Survey to my mailing address. ☐ Yes ☐ No
The Satisfaction Survey will be mailed within one year of your first appointment.

Grievances & Appeals: It is the policy of PsychStrategies that the client/guardian or other individual who voice concerns, complaints, or grievances have the right, within a responsible period of time, to file a grievance to be heard by an impartial staff member (General Manager). The General Manager of PsychStrategies will provide a written response to a grievance within twenty (20) working days from the date a grievance is filed. If additional time is needed due to extenuating circumstances, the client/guardian will be given written notification. The following procedure will be observed when a grievance is to be filed with PsychStrategies.

1) When a client/guardian expresses a concern, complaint, or grievance regarding past and/or present services, he/she must submit in writing and must be signed by the client or the individual submitting the grievance on the client's behalf (must include the date, time, description and name(s) of the clinicians and/or staff member(s) involved) to:
   PsychStrategies, Inc.
   Attn: General Manager
   1160 North Dutton Avenue
   Suite 230
   Santa Rosa, CA 95401
2) If the griever is not satisfied with the General Manager's response, he/she may submit the written grievance to the President of the Board of Directors, Robert Mosby, PhD. The President of the Board of Directors will provide a written response within fifteen (15) working days.
3) If the griever still feels the grievance has not been resolved, he/she will be advised and referred to outside entities.
4) The General Manager will keep a written record of all grievances received, this record will include a copy of the grievance, documentation reflecting process used and resolution/remedy of the grievance (if applicable, also any documentation of extenuating circumstances for extending the time period for resolving the grievance beyond twenty one (21) working days). The General Manager receiving and/or addressing a complaint will provide the necessary documentation and when appropriate, refer the person to a more appropriate resource. Records will be kept in a locked filing cabinet accessible only to the General Manager and President of the Board of Directors. Periodically, the General Manager will review the grievances for informational purposes that may be used in enhancing the clinical services PsychStrategies provides.

If the client's insurance company denies additional sessions, I, the client/guardian, may appeal for additional sessions. Appeals to decisions made by PsychStrategies may be made directly to the client's insurance company. Appeals/Grievances regarding the client's insurance company can be made to the Department of Managed Healthcare at (800) 400-0815.

I, the client/guardian, request a copy of this form. ☐ Yes ☐ No
If requested, a copy of this form was provided to the client/guardian. Date: _____ *Staff Initials:* _____

I have read the above statements, understand them, and agree to comply with them:

Client/Legal Dependent Name (Signature)	Date	Print Name
Client/Legal Guardian Name (Signature)	Date	Print Name
Clinician Name (Signature)	Date	Print Name

PSYCHSTRATEGIES, INC.

Acknowledgment of Receipt of Notice of Privacy Practices

By signature of this form, you acknowledge receipt of the *Notice of Privacy Practices that* PsychStrategies has given you. The *Notice of Privacy Practices* provides information about how PsychStrategies may use and disclose your protected health information (PHI). You are encouraged to read it in full.

The *Notice of Privacy Practices* is subject to change. If PsychStrategies changes its *Notice of Privacy Practices*, you may obtain a copy of the revised form from your clinician, from our website at www.psychstrategies.com or by contacting our main office at (707) 303-3200.

Please discuss any questions about the *Notice of Privacy Practices* of PsychStrategies with your clinician.

I acknowledge receipt of the *Notice of Privacy Practices* of PsychStrategies.

_____ _____

Signature of Client/Guardian Date

Inability to Obtain Acknowledgment of Receipt of Notice of Privacy Practices

I have made good faith attempts to obtain my client's acknowledgment of his/her receipt of the *Notice of Privacy Practices* of PsychStrategies, including _____
(Describe good faith attempts)

_____.

However, because of _____
(reason(s) why acknowledgment was not obtained)

_____, I was unable to obtain my client's acknowledgment.

_____ _____

Signature of Clinician Date