PATTISON PROFESSIONAL COUNSELING CENTER
Helping You Live Your Life at Its Best

259 Oakdale Avenue East, Crestview, FL 32536
7 Vine Avenue N, Fort Walton Beach, FL 32548

Name _____ Date: _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Email Address _____ Cell Phone _____

Social Security Number _____ Birth Date _____

Marital Status:

____ Single
____ Married
____ Divorced
____ Separated
____ Widowed
____ Other

Employment Status:

____ Employed
____ Part Time Student
____ Full Time Student

Condition Related To:

Employment ____Yes ____ No
Auto Accident ____Yes ____ No
Other Accident ____Yes ____ No
Which State: _____

Responsible Party (if client is a minor, please indicate parent information):

Name _____ Date: _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Birth Date _____

Relationship to Client: _____

Provider you will be seeing: _____

Thank you for choosing Pattison Professional Counseling Center. We are interested in knowing how we were selected to serve you. How were you referred to us?

____ Yellow Pages ____ Talking Phone Book ____ Friend/Relative
____ Internet ____ Television/Radio ____ DUI School/Probation/Parole
____ Doctor (_____) ____ Other
____ Another Therapist (_____)

Primary Insurance Information

Please provide your insurance card so we may have a copy on file.

Insurance Company _____ ID Number _____

Policy Holder's Name _____ Policy Number _____

Policy Holder's Date of Birth _____

Policy Holder's Social Security Number _____

Employer or Company Name _____ Group Number _____

If Tricare: ___Standard ___Prime ___Active Duty ___Retired ___Deceased ___Other

Sponsor's Name _____

Sponsor's Date of Birth _____ Sponsor's Social Security No. _____

Secondary or Supplemental Insurance Information

Please provide your insurance card so we may have a copy on file.

Insurance Company _____ ID Number _____

Policy Holder's Name _____ Policy Number _____

Policy Holder's Date of Birth _____

Policy Holder's Social Security Number _____

Employee Assistance Program (EAP) Information

Name of EAP _____ ID Number _____

Name of Employee _____ Relationship to Client _____

Name of Employer or Company _____

If you do not have insurance, please indicate your annual income so that an appropriate sliding scale fee may be determined: _____

Medical History

This medical information is used to detect possible medical problems that may require a doctor's attention. Responses may result in the recommendation that you see your doctor for a physical examination.

Your Physician's Name _____ Allergies _____

Current Medications _____

Please check the symptoms or conditions that have applied to you at any time:

__ Alcoholism
__ Cancer/Tumors
__ Epilepsy
__ Hearing problems
__ Seizures
__ Allergies
__ Diabetes
__ High blood pressure
__ Kidney disease
__ Stroke
__ Anemia
__ Drug abuse
__ Eating problems
__ Head trauma
__ Heart disease

Please check the symptoms or conditions that frequently apply:

__ Abdominal pain
__ Chest pain
__ Decreased appetite
__ Frequent urination
__ Nausea
__ Stomachaches
__ Sweating
__ Shortness of breath
__ Skin problems
__ Choking sensations
__ Muscle tension
__ Muscle or joint pain
__ Other: _____
__ Bed wetting
__ Colds
__ Diarrhea
__ Headaches
__ Numbness
__ Vision changes
__ Heart pounding
__ Dizziness
__ Stuttering
__ Trembling/shaking
__ Muscle spasms
__ Sexual problems
__ Breathing difficulty
__ Constipation
__ Fainting
__ Menstrual pain
__ Sleep disturbance
__ Chills/Hot flashes
__ Rapid heart beat
__ Fatigue
__ Blackouts
__ Tic/Twitches
__ Jaw pain

Chief Concern

Please describe the primary problem/concern for which you have come to the office:

_____

_____

_____

_____

_____

_____

What do you consider to be the top three stressors in your life?

1) _____

2) _____

3) _____

Do you have problems with your work performance or boss? ___ Yes ___ No

If yes, explain: _____

_____

Do you have any legal problems? ___ Yes ___ No

If so, please state: _____

_____

Who/what is your support system? _____

Psychological Symptoms

Emotions: *(Select any of the following emotions that you find troublesome and/or apply to you in the last month.)*

__ Hopeless	__ Happy	__ Fearful	__ Confused
__ Tense	__ Contented	__ Anxious	__ Angry
__ Distrustful	__ Lonely	__ Jealous	__ Guilty
__ Sad	__ Helpless	__ Bored	__ Frustrated
__ Excited	__ Energetic	Relaxed	Restless
__ Suspicious	__ Other: _____		

Behaviors: *(Select any of the following behaviors that you find troublesome and/or apply to you in the last month.)*

__ Under eating	__ Temper outburst	__ Impulsiveness
__ Vomiting	__ Aggressive	__ Hurting others
__ Over eating	__ Nightmares	__ Spending sprees
__ Crying	__ Decreased interest	__ Odd behavior
__ Sleeping problems	__ Increased drinking	__ Hurting self
__ Impulsiveness	__ Isolation	__ Social withdrawal
__ Increased energy	__ Increased smoking	__ Flashbacks
__ Loss of control	__ Fears	__ Unable to keep job
__ Decreased energy	__ Taking too many risks	Concentration problems
__ Avoiding activities, places, people	__ Mood altering with drugs	

__ Other: _____

Mental Health History

Have you previously been seen for a mental health reason, in an office, clinic, or hospital? ___ Yes ___ No

If yes, please indicate below the date(s), location(s), Inpatient/Outpatient, and the diagnosis:

Date	Facility	Inpatient/Outpatient	Diagnosis

Do you currently have trouble with alcohol and/or drugs? ___Yes ___No
If yes, explain: _____
Have you had trouble with alcohol and/or drugs in the past? ___Yes ___No
If yes, explain: _____
Have you been treated in the past for substance abuse? ___Yes ___No
If yes, explain: _____
If yes, are you actively working a recovery program? ___Yes ___No

Family History

Please state which family members may have had any of the following:

Mental illness _____ Alcoholism _____
Mental retardation _____ Other substances _____
Cancer/Tumors_____ Heart disease _____

Any history of physical, sexual, emotional, or mental abuse? ___Yes ___No

Educational History

What is the highest grade / level of education you have completed? _____

Did you have any conduct or behavioral problems in school? ___ Yes ___ No

If yes, explain: _____

_____

Did you have a learning disability or need for special educational services?
___ Yes ___ No

If yes, explain: _____

_____

Goals for Treatment

What are your goals for treatment and what would you like to see change or be different? _____

_____

_____

Informed Consent / Treatment Agreement

I agree to make a commitment to the treatment process. I understand this means I agree to active involvement in all aspects of treatment, including:

- Attending sessions (or letting my provider know when I cannot make it)
- Voicing my opinions, thoughts, and feelings honestly and openly, whether negative or positive
- Being actively involved during sessions
- Completing homework assignments
- Experimenting with new behaviors and new ways of doing things
- Taking medication as prescribed
- Implementing my crisis response plan

I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. If it is not working, I will discuss it with my provider.

Patient's Signature _____ Date: _____

Notice of Privacy Policies and Communications

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Pattison Professional Counseling Center (PPCC) discloses patient information relating to treatment, payment, and health care operations. This information is shared with other health care providers, insurance companies, managed care companies, and other professionals.

Your health care information may be used to obtain an explanation of your health benefits and to obtain authorizations to continue treatment. Insurance/managed care companies receive treatment reports and clinical information upon request. Patient information may be disclosed for utilization reviews and for quality assurances.

Patient information is exchanged among health care providers. For example, patient information regarding diagnosis, symptoms, treatment recommendations, medication, family history, medical conditions, drug or alcohol use, and other clinical information provided by the patient is discussed among the clinician, medical doctor, psychologist, and/or other health care professionals who are involved in the patient's treatment.

PPCC may call your home or work to discuss treatment or scheduling of appointments. We may leave a message on your answering machine to remind you of your appointment or request that you return our call. The clinician's name, phone number, the office of affiliation, and the time of your appointment may be left on the answering machine. If any individual other than you answers the home telephone, the information will be given to that individual. If we call your work and you are not the individual taking the call, we will state the name of our company and our phone number to the individual answering the phone and request that you return our call.

Federal and state laws obligate PPCC to protect and safeguard all patient information. Protected health information consists of, but is not limited to, a client's name, address, phone number, and medical treatment information. The law states that our clients have the right to confidentiality, and therefore, we are obligated to insure that their protected health information remains private and confidential. If you become aware of the inappropriate disclosure of your or another client's protected health information, please report the disclosure to: Pattison Professional Counseling Center, Attn: Susan Page, 7 Vine Avenue, NE, Fort Walton Beach, FL 32548.

Upon request you may receive an accounting of all disclosures regarding your health care information. You have the right to place restrictions on the patient information that is released by PPCC. Furthermore, PPCC is required to maintain a designated record set, which includes patient medical information and billing information. You have the right to inspect, copy, and amend the patient health care information maintained in your designated record set. In order to inspect, copy, amend, or request restrictions on our health care information, please call your clinician at our office at (850) 226-4098 (Fort Walton Beach) or (850) 398-5255 (Crestview), or mail your request to Pattison Professional Counseling Center, 7 Vine Avenue, NE, Fort Walton Beach, FL 32548.

There are exceptions regarding your right to amend, copy, inspect, and restrict the release of protected health information. Information that is accurate and complete cannot be amended. Documents that are not created by PPCC may not be amended, copied, or inspected. Documents that are included in litigation may not be inspected, copied, amended, or restricted from release. Psychotherapy notes are not a part of the designated record set and, therefore, are excluded. Furthermore, other state, federal, or governmental laws may overrule your right to inspect, amend, and restrict the release of your protected health information.

_____ _____

Signature of Client/Guardian Date

Pattison Professional Counseling and Mediation Center (PPCC Inc.) is dedicated in protecting your protected health information (PHI). You agree to the following services to release specified information while being treated at PPCC Inc.

PPCC Inc. places reminder calls one business day prior to your appointment. Your first name, the appointment time at our facility, and the clinician that you will be seeing will be released via a phone message, text, email, or appointment verification for smart phones.

Text/phone message to be left at: _____ - _____ - _____

PPCC Inc. secures your medical records electronically utilizing a HIPAA HYTECH compliant service.

If you and your therapist and/or our support staff communicates via email or texting through a cell phone, you agree to and understand that your PHI may be released via your correspondence and communications. PPCC Inc. secures your PHI however, once communication is released via the internet or phone devices your information is no longer secure.

Please initial _____ to agree to receive text correspondence or emails from PPCC Inc. staff or clinicians.

Print name _____

Signature _____

Date: _____

Financial Policy

Thank you for choosing Pattison Professional Counseling Center. We are committed to your successful treatment. The following is our financial policy, which we request you read, understand, and sign prior to treatment.

Insurance: Your insurance policy is between you and your insurance company. We are not a party to that contract. If services are not covered by your insurance policy, you are responsible for all session fees. We do accept assignment of benefits from insurance companies with which we are participating providers. All Tricare/Champus clients must obtain a doctor's referral in order to file the insurance claims. If the client does not obtain a referral and insurance cannot be filed, the client is responsible for the entire session charge. We will file your insurance claims for you, either by paper claim or electronically, unless otherwise specified by you.

Assignment of Benefits: I assign my insurance benefits to Pattison Professional Counseling Center for the duration of my treatment.

Payments: All payments, co-payments or deductibles are due after each session. If your co-payment is not known on the first date of service, a co-payment of $20.00 will be collected at the time of each session until your correct co-payment can be determined. We accept cash, checks, money orders, Visa, MasterCard, and American Express for payments. We can also keep your credit card number on file and charge your card with your cost share after each visit.

Missed or Cancelled Appointments: 24-hour notification is required if you need to cancel or reschedule your appointment. A minimum of $30.00 will be charged to your account if you do not show for your scheduled appointment or give us 24-hour notification. For psychiatric patients, a minimum of $50.00 will be charged. If calling to cancel or reschedule your appointment after business hours, please leave your name, appointment date and time, and a brief message on our voice mail. We appreciate your assistance in helping us serve you better by keeping scheduled appointments.

Billing: Payment for all client statements is due in full upon receipt. A divorce decree cannot assign responsibility for an adult or child's account. Failure to pay your bill could result in your account being turned over to a collection agency. Only your name and account status will be discussed with the collection agency.

Returned Checks: A $30.00 service fee will be added to your account for each returned check from your bank. Only cash payments will be accepted if two NSF checks are received.

My signature acknowledges that I have read, understand, and agree to all parts of the financial policy of Pattison Professional Counseling Center. I also understand that my account will be turned over to a collection agency if it becomes delinquent.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date

Client Rights

I have the right to efficient and effective care individualized to my needs. My treatment provider will work with me to develop a treatment plan best suited to me. We will use this plan to help us deal with my problems as quickly and effectively as possible.

I have the right to be treated with dignity and respect. I will be treated with respect at all times. I will report any misconduct by my treatment provider, including social invitations, suggestive remarks, or unwanted touching, to PPCC management. I may call PPCC any time with questions, comments, or complaints.

My treatment provider will make every effort to meet me at our scheduled appointment time. If my treatment provider is late, he or she will extend our session, if I am willing, or we will make other arrangements by mutual agreement.

I have a right to privacy and confidentiality. All records and communications will be treated with confidentiality in compliance with applicable state and federal laws. These laws may obligate PPCC to report suspected abuse or neglect, domestic violence, and those who pose a danger to themselves or others, or when ordered to by a court of law.

Client Responsibilities

Scheduled appointments are commitments. I will make every effort to be on time for my appointment(s). I understand that time will be lost from my session if I am late for my appointment.

I am responsible to pay for services received. I am aware my insurance plan typically requires me to pay a co-payment (a dollar amount) or co-insurance (a percentage of my treatment provider's fee) at the time services are provided. My insurance plan may also have a deductible (an initial dollar amount) that is my responsibility. Additionally, certain services may be limited and/or not covered at all by my insurance plan. I understand I am financially responsible for co-payments, co-insurance, deductibles, and all services not covered by my insurance plan. My treatment provider and my insurance plan's representative will help me determine what services my insurance plan covers.

I have read this list of rights and responsibilities or had them read to me. I understand and agree to them.

_____ _____
Print Name Date

_____
Signature