



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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Head trauma |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease |

Please check the symptoms or conditions that frequently apply:

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

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.)*

- | | | | |
|--------------------------------------|---------------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Hopeless | <input type="checkbox"/> Happy | <input type="checkbox"/> Fearful | <input type="checkbox"/> Confused |
| <input type="checkbox"/> Tense | <input type="checkbox"/> Contented | <input type="checkbox"/> Anxious | <input type="checkbox"/> Angry |
| <input type="checkbox"/> Distrustful | <input type="checkbox"/> Lonely | <input type="checkbox"/> Jealous | <input type="checkbox"/> Guilty |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Helpless | <input type="checkbox"/> Bored | <input type="checkbox"/> Frustrated |
| <input type="checkbox"/> Excited | <input type="checkbox"/> Energetic | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Suspicious | <input type="checkbox"/> Other: _____ | | |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Under eating | <input type="checkbox"/> Temper outburst | <input type="checkbox"/> Impulsiveness |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Hurting others |
| <input type="checkbox"/> Over eating | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Spending sprees |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Decreased interest | <input type="checkbox"/> Odd behavior |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Increased drinking | <input type="checkbox"/> Hurting self |
| <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Isolation | <input type="checkbox"/> Social withdrawal |
| <input type="checkbox"/> Increased energy | <input type="checkbox"/> Increased smoking | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Loss of control | <input type="checkbox"/> Fears | <input type="checkbox"/> Unable to keep job |
| <input type="checkbox"/> Decreased energy | <input type="checkbox"/> Taking too many risks | <input type="checkbox"/> Concentration problems |
| <input type="checkbox"/> Avoiding activities, places, people | <input type="checkbox"/> Mood altering with drugs | |
| <input type="checkbox"/> 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: _____

Substance Abuse/Alcohol Screening

1. At what age did you first drink alcohol? _____
2. Who introduced you to alcohol? _____
3. How much do you drink? _____
4. What do you drink? _____
5. Date of last drink: _____
6. Are any members of your family heavy drinkers or alcoholics? _____
7. What is your drinking pattern?
___ alone ___ daily ___ weekly ___ binges ___ other _____
8. Has your drinking been problematic with any of the following?
___ spouse ___ children ___ extended family ___ friends ___ work ___ other _____
9. Have you ever been arrested related to drinking?
___ DWI/DUI ___ drunken fights ___ disorderly behavior ___ underage drinking ___ other _____
10. Have you ever been hospitalized for alcohol use? _____
11. What are your symptoms?
___ blackouts ___ tremors ___ D.T.s ___ seizures ___ hallucinations
___ other _____
12. Have you ever taken Dilantin or any other drugs for seizures? _____
13. Are you aware of changes in the amount of alcohol required to get the effect you want? _____
14. Do you have, or were you treated for:
___ pancreatitis ___ cirrhosis ___ hepatitis ___ esophagitis
15. Have you had previous treatment?
___ detoxification ___ rehabilitation ___ halfway house ___ outpatient ___ other _____
16. Have you experienced tingling, pain, or numbness in your hands or feet (neuropathy)? _____
17. Have you ever attended AA meetings? _____
18. Have you ever had a sponsor? _____

Drug History

1. At what age did you first use drugs? _____
2. Who introduced you to drugs? _____
3. Have you ever been arrested for using and/or selling drugs? _____
4. Do you expect to benefit from this program? _____
If so, how? _____
If not, why not? _____
5. Have you received any other type of mental health treatment or counseling? _____
If so, why, when, and where? _____
6. Have you ever attempted suicide? _____ If so, when and how? _____

Drug History, continued

Have you used any of the following drugs?

___ marijuana	age at 1 st use _____	frequency _____	last used _____
___ inhalants	age at 1 st use _____	frequency _____	last used _____
___ cocaine	age at 1 st use _____	frequency _____	last used _____
___ crack	age at 1 st use _____	frequency _____	last used _____
___ heroin	age at 1 st use _____	frequency _____	last used _____
___ methadone	age at 1 st use _____	frequency _____	last used _____
___ tranquilizers	age at 1 st use _____	frequency _____	last used _____
___ Valium	age at 1 st use _____	frequency _____	last used _____
___ Librium	age at 1 st use _____	frequency _____	last used _____
___ Quaaludes	age at 1 st use _____	frequency _____	last used _____
___ pills	age at 1 st use _____	frequency _____	last used _____
___ dust	age at 1 st use _____	frequency _____	last used _____
___ LSD/PCP	age at 1 st use _____	frequency _____	last used _____
___ black tar	age at 1 st use _____	frequency _____	last used _____
___ prescription	age at 1 st use _____	frequency _____	last used _____
___ over the counter	age at 1 st use _____	frequency _____	last used _____
___ other	age at 1 st use _____	frequency _____	last used _____

Analysis of Current Problems

1. Circle any of the current behaviors that apply to you:

weight gain/loss	suicide attempts	lazy	frequent crying	drinking too much
self harm	loss of control	withdrawal	smoking	working too hard
can't keep a job	sleep problems	using drugs	extreme fears	outbursts of temper
hyperactive behavior	working too much	other _____		

2. Circle any of the feelings that often apply to you:

anger	bored	content	jealous	optimistic
unhappy	guilty	hopeless	relaxed	helpless
energetic	confused	sad	lonely	restless
hopeful	tense	rested	happy	depressed
panic	joyful	ashamed	other _____	

3. Circle any of the physical symptoms that apply to you:

headaches	tiredness	blackouts	sexual problems	fainting spells
stomachaches	chest pain	tensions	tremors	forgetfulness
dry mouth	twitches	back pain	numbness	hearing things
dizziness	rapid heart beat	tingling	spasms	excessive sweating
other _____				

4. Identify any serious health problems that you have (include dates). _____

Domestic Violence Report

Physical Abuse: Have you done the following to your partner?

	Yes	No	How Often	Comments
Slapped	_____	_____	_____	_____
Punched	_____	_____	_____	_____
Choked	_____	_____	_____	_____
Pulled hair	_____	_____	_____	_____
Pushed	_____	_____	_____	_____
Restrained	_____	_____	_____	_____
Kicked	_____	_____	_____	_____
Used weapon	_____	_____	_____	_____
Thrown things	_____	_____	_____	_____
Other	_____	_____	_____	_____

Yes No

Coercion and Threats: Have you?

Threatened to take the children away from your partner?	_____	_____
Threatened suicide?	_____	_____
Threatened to injure your partner or children?	_____	_____
Threatened to hurt your partner's friends or family?	_____	_____
Threatened to destroy property?	_____	_____
Threatened to leave your partner?	_____	_____
Insist your partner take part in illegal activities?	_____	_____
Threatened your partner if she didn't drop charges against you?	_____	_____

Using Intimidation: Have you?

Made your partner afraid by looks, actions, or gestures?	_____	_____
Yelled, pounded your fist, or punched walls?	_____	_____
Smashed things in front of your partner?	_____	_____
Driven recklessly with her in the vehicle?	_____	_____
Hit or mistreated pets?	_____	_____

Domestic Violence Report, continued

	Yes	No
Emotional Abuse: Have you?		
Put down your partner or called her names?	_____	_____
Told your partner not to feel a certain feeling (sad, hurt, angry)?	_____	_____
Humiliated your partner?	_____	_____
Using Isolation: Have you?		
Kept your partner from going to work, school, out with friends?	_____	_____
Listened to your partner's phone calls?	_____	_____
Followed your partner around?	_____	_____
Told your partner that she is not spending enough time at home?	_____	_____
Asked your partner what was said and done while she was out?	_____	_____
Minimizing, Denying, and Blaming: Have you?		
Made light of the abuse and did not take seriously your partners' concerns?	_____	_____
Told others that the abuse didn't happen?	_____	_____
Told your partner that she was the cause of the abuse?	_____	_____
Blamed alcohol or drug use for the cause of the abuse?	_____	_____
Using Children: Have you?		
Tried to make your partner feel guilty about the children?	_____	_____
Used the children to relay messages?	_____	_____
Used visitation to harass your partner?	_____	_____
Threatened to take the children away?	_____	_____

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