

Update Client Information/Adult

Revised 12/11

Client Name: _____ Gender: M F

Date of Birth: _____ Age: _____ SS#: _____

Mailing Address: _____

Physical Address: same as above _____

Home Phone: _____
Okay to leave message? With household member Yes No Initials: _____
Okay to leave message? Voice Mail/ Answering Machine Yes No Initials: _____
When leaving messages we will identify our names rather than identifying ourselves as Counseling Associates.

Cell Phone: _____
Optional. Please note: While cell phone security continues to improve, the confidentiality of cell phone communication cannot be insured to the same degree as the use of land lines. Do you wish to have your cell phone used? Yes No Initials: _____

Work Phone: _____

Employer: _____
Okay to contact at work? Yes No Initials: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____
Does Counseling Associates have your permission to use this contact information in the case of emergency? Yes No Initials: _____

Client referred by: _____

Primary Care Provider: _____ Telephone: _____

Address: _____
It is often beneficial for your therapist to communicate with your PCP in order to ensure the best possible, coordinated care. Do you wish to authorize Counseling Associates to coordinate care with your PCP?
 Yes No Initials: _____ *If yes, please sign the authorization form toward the end of this packet.*

I understand that I am responsible for charges incurred that are not covered by my insurance. I understand that I am responsible for understanding my coverage and for knowing when the limits of my coverage are being exceeded. I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits to Counseling Associates of New London, PLLC, Counseling Associates of Newport, & Counseling Associates of Claremont. A copy of this signature is as valid as the original.

Signature	Date
Witness	Date

RESPONSIBLE PARTY TO WHOM STATEMENTS WILL BE SENT:

Name:	Relationship:
Mailing Address: <input type="checkbox"/> <i>contact information provided prior</i>	
Phone:	

Primary Insurance Company: *Please provide your insurance card for copying.*

Insurance Company:		
Subscriber ID:	Group #:	
Subscriber Name:	Employer:	
Social Security #:	DOB:	Relationship to Client:

Secondary Insurance Information: *Please provide your insurance card for copying.*

Subscriber Name:	Employer:	
Social Security#:	DOB:	Relationship to Client:

Updated Health Information

Today's Date: _____ Age: ____ Height: _____ Weight: _____ M or F
 Form completed by: _____ Self Parent Guardian

Primary Physician:	Date of Last Physical:
Psychiatrist:	Current Health: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Other Specialists:	Physical Exercise:
Current Medications Rx: Rx History:	Over the Counter/Herbal:

Changes to Client Health History:

<input type="checkbox"/> Asthma or allergies:		
<input type="checkbox"/> Significant illness:		
<input type="checkbox"/> Surgeries:		
<input type="checkbox"/> Serious injury or accident:		
<input type="checkbox"/> Physical limitations:		
<input type="checkbox"/> Hospitalizations (<i>including psychiatric</i>):		
<input type="checkbox"/> Psychiatric:	<input type="checkbox"/> Anxiety <input type="checkbox"/> Other:	
	<input type="checkbox"/> Depression	
<input type="checkbox"/> Alcohol use:	<i>Quantity & Frequency:</i>	<i>Recent changes in use?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
<input type="checkbox"/> Other substance use:		

Notes:

Symptom Checklist

Please check all boxes that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> I feel restless, can't sit still | <input type="checkbox"/> I seem to be pre-occupied by certain thoughts | <input type="checkbox"/> I often worry about how much I am eating |
| <input type="checkbox"/> I feel nervous in new situations | <input type="checkbox"/> I often am in trouble at work | <input type="checkbox"/> I often worry about how I look |
| <input type="checkbox"/> I often act impulsively | <input type="checkbox"/> I feel like I need to double and triple check things that I have done | <input type="checkbox"/> I have difficulty finishing tasks |
| <input type="checkbox"/> I often feel angry | <input type="checkbox"/> I get in frequent arguments | <input type="checkbox"/> I have thought about harming myself |
| <input type="checkbox"/> People tell me I am often angry | <input type="checkbox"/> I often have headaches | <input type="checkbox"/> It is hard for me to trust people |
| <input type="checkbox"/> I don't like to be touched | <input type="checkbox"/> I feel as if I have to repeat certain things (touching, counting, washing) | <input type="checkbox"/> I am too bossy |
| <input type="checkbox"/> I have nightmares | <input type="checkbox"/> I have difficulty with clutter in my house | <input type="checkbox"/> I have a hard time controlling my feelings |
| <input type="checkbox"/> I cry for no reason | <input type="checkbox"/> I often lose my temper | <input type="checkbox"/> People tell me I talk too much |
| <input type="checkbox"/> I am sad much of the time | <input type="checkbox"/> I have difficulties getting along with co-workers | <input type="checkbox"/> I forget things easily |
| <input type="checkbox"/> I often feel guilty | <input type="checkbox"/> I am not satisfied with my job | <input type="checkbox"/> I spend too much of my time on-line |
| <input type="checkbox"/> I have trouble sleeping | <input type="checkbox"/> I feel hopeless | <input type="checkbox"/> I am always worried about what others think of me |
| <input type="checkbox"/> I am bothered by thoughts that won't go away | <input type="checkbox"/> I am easily irritated and annoyed | <input type="checkbox"/> I feel like harming myself |
| <input type="checkbox"/> Nothing seems to make me happy | <input type="checkbox"/> I am having difficulty with my children | <input type="checkbox"/> I have harmed myself in the past |
| <input type="checkbox"/> I wake up feeling tired | <input type="checkbox"/> I don't have as many friends as I would like | <input type="checkbox"/> I have trouble standing up for myself |
| <input type="checkbox"/> I wake up early in the morning | <input type="checkbox"/> I have trouble leaving my house | <input type="checkbox"/> I have a hard time making decisions |
| <input type="checkbox"/> I have gained or lost a lot of weight recently | <input type="checkbox"/> I am having difficulty concentrating | <input type="checkbox"/> Life has been very unfair to me |
| <input type="checkbox"/> I sometimes see or hear things that others do not | <input type="checkbox"/> I sometimes feel like hitting things | <input type="checkbox"/> I am afraid of some of the ideas I have in my head |
| <input type="checkbox"/> I can't feel close to others | <input type="checkbox"/> I often procrastinate | <input type="checkbox"/> I am unhappy |
| <input type="checkbox"/> I often feel I have to do things perfectly | <input type="checkbox"/> I am having some difficulties in my relationship | <input type="checkbox"/> I am worried about the future |
| <input type="checkbox"/> I find myself having frequent mood swings | <input type="checkbox"/> I am having financial concerns | <input type="checkbox"/> I have been abused |
| <input type="checkbox"/> I have panic attacks | <input type="checkbox"/> I have troubling memories that keep popping into my mind | <input type="checkbox"/> Someone I love has a substance abuse problem |
| <input type="checkbox"/> I go on frequent spending sprees | <input type="checkbox"/> I am afraid I have a drinking problem | <input type="checkbox"/> Spiritual issues are a concern to me |
| <input type="checkbox"/> Sometimes I feel as if I am having trouble breathing | <input type="checkbox"/> I am afraid I have a drug problem | <input type="checkbox"/> I have concerns related to my sexuality |
| <input type="checkbox"/> I think I am depressed | <input type="checkbox"/> I always had difficulty in school | <input type="checkbox"/> I have problems with my memory |
| <input type="checkbox"/> I worry all of the time | <input type="checkbox"/> I am often tired | <input type="checkbox"/> I have problems managing my physical pain |
| <input type="checkbox"/> I think I might have a gambling problem | <input type="checkbox"/> I seem to keep having problems on the job | <input type="checkbox"/> I can't seem to quit smoking |
| <input type="checkbox"/> I am not very trusting | | |
| <input type="checkbox"/> I have thoughts of death and dying | | |
| <input type="checkbox"/> I am afraid of certain things | | |
| <input type="checkbox"/> I am afraid of being alone | | |
| <input type="checkbox"/> I am not interested in sex | | |
| <input type="checkbox"/> I often feel worthless | | |
| <input type="checkbox"/> My partner and I can't seem to communicate | | |

Counseling Associates of New London, PLLC

Counseling Associates of New London: 35 Newport Road, PO Box 1624 New London, NH 03257 (603) 526-4230

Counseling Associates of Newport: 44 North Main Street, PO Box 43 Newport, NH, 03773 (603) 863-1672

Counseling Associates of Claremont: 5 Dunning Street, PO Box 1618 Claremont, NH 03743 (603) 542-4332

Authorization for Release of Confidential Information

I hereby authorize **Counseling Associates of New London, PLLC, Counseling Associates of Newport, & Counseling Associates of Claremont** to:

EXCHANGE individually identifiable information from the records of the person named below (which may include information concerning treatment of mental health, treatment for drug and/or alcohol abuse, and/or HIV status).

The purpose of this disclosure is to **COORDINATE SERVICES.**

Name: _____ DOB: _____

Name & Address of **Primary Care Provider & Practice** with whom information may be exchanged:

Primary Care Provider Name:	
Practice:	
Address:	
Telephone #:	

<input checked="" type="checkbox"/> Please check one: <input type="checkbox"/> The information to be released is limited to only that which is necessary to carry out the purpose of disclosure. <input type="checkbox"/> I specify that only the following information is to be disclosed:	
<input checked="" type="checkbox"/> Please check one: Specify time period from which information is to be released: <input type="checkbox"/> _____ to _____ Or <input type="checkbox"/> All dates of service.	<input checked="" type="checkbox"/> Please check all those that apply: Specify how information may be disclosed: <input type="checkbox"/> copies <input type="checkbox"/> verbal <input type="checkbox"/> fax
<input checked="" type="checkbox"/> Please check one: <input type="checkbox"/> This authorization expires in one year unless otherwise noted. <input type="checkbox"/> Specified expiration date: _____	

- I understand that I need not consent to the release of information specified above in order to obtain treatment services or have services reimbursed.
- I understand that I may revoke this consent at any time by notifying Counseling Associates of New London, PLLC in writing at P.O. Box 1624, New London, NH 03257, except to the extent it has already been relied upon.
- I understand that there is the potential for this protected health information to be redisclosed by the recipient. If the recipient is not a covered entity (e.g. insurance company, health care provider), the disclosed information may no longer be protected by federal & state privacy regulations.

X _____
Signature of Client/ Parent/ Legal Guardian

X _____
Date

Printed name of Personal Representative

Legal Authority of Personal Representative

Witness

Date



Consent to Treatment

- I acknowledge that I have received, have read (or have had read to me), and understand the **Information for Clients** brochure and the information about the therapy I am considering for myself or my child. I have had all my questions answered fully and to my satisfaction.
- I acknowledge that I have received, have read (or have had read to me), and understand the **Policy Regarding Missed Sessions**. I have had all my questions answered fully and to my satisfaction.
- I acknowledge that I have received, have read (or have had read to me), and understand the **Notification of Privacy Policies Regarding Protected Health Information**. All questions I have regarding this information have been answered to my satisfaction.
- I acknowledge that I have received, have read (or have had read to me), and understand the State of New Hampshire **Mental Health Bill of Rights**. All questions I have regarding this information have been answered to my satisfaction.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist and that, as with any treatment, there are some risks as well as many benefits with therapy. I am aware that I may stop my treatment with this therapist at any time. I understand that I will still be responsible for paying for the services I have already received. I understand that there may be consequences to such a decision outside of my therapist's control (e.g. if my treatment has been court-ordered, I will have to respond to the court).

My signature below indicates that I agree to abide by the terms outlined throughout my professional relationship with Counseling Associates. I consent to receive services from Counseling Associates of New London, PLLC, Counseling Associates of Newport, & Counseling Associates of Claremont, & I agree to take an active role in my own treatment.

<input checked="" type="checkbox"/>		
	Signature of client (or person acting for client)	Date
	Printed name	Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist

Date

We believe that it is important for clients to attend all sessions scheduled for them. Missed or canceled sessions are counterproductive and increase the time it takes to bring about the changes that you entered counseling to make. We will work hard to honor the times we set aside to meet and ask you to do the same.

To prevent misunderstandings and confusion, we have found it is important to address this issue at the outset of treatment.

Counseling Associates has a standard 24-hour cancellation policy. Please notify your therapist as soon as you know you will be unable to keep an appointment and **at least** 24 hours, preferably 48 hours, in advance of the scheduled time. This will allow other clients to access this time as well as providing us ample time to find an alternative appointment for you.

The policy of this office is to charge for those missed sessions not canceled with 24-hours notice. **Please note: Insurance and managed care companies will not pay for sessions that you miss and it would be fraudulent for us to submit a claim for these.** You will be responsible for these charges and we will bill you directly.

It is always our intent to be fair in arrangements with clients. We hope you understand that we need to be vigilant about this policy to ensure that we can afford to continue serving the needs of the community. We are sorry, but this charge is **not** waived in the case of illness. This charge is only waived in the following cases:

- In the case of poor travel conditions due to weather that result in local school closings, this charge will be waived if you call to inform your therapist prior to your appointment time that you are unable to attend.
- If you are hospitalized unexpectedly, this charge will be waived.
- If there is a death in the family, this charge will also be waived.

I have read and understood the Policy Regarding Missed Sessions and have had all of my questions answered to my satisfaction. I understand that I will be billed for all missed sessions and late cancellations for which I have not given at least 24-hour notice according to the above guidelines. I understand that I am responsible for these charges and that insurance cannot be billed. I agree to pay for these sessions at the rate of:

- For Self-Pay clients: The usual rate paid per session.
- For Insurance clients: The usual & customary rate established by your insurance company. This includes the rate covered by insurance plus any co-pay.
- Other: _____

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Client or Parent Signature

Date