

Grinstead & Associates

Missed appointment policy –

If you miss 3 appointments without calling/cancelling you will be terminated from our office. Your signature below acknowledges that you are aware of this office policy

Patient or guardian signature

Date

Grinstead & Associates

Due to a policy required by insurance companies our office must keep a **release or denial** for your current medical doctor in your file. Please sign the attached release if you like us to be able to speak to or send a summary to your medical doctor. If you choose not to sign it please "X" across the sheet, write decline and sign the bottom left side and date.

APPOINTMENTS

The therapy session will be 45-55-minute session (one appointment hour). **Once an appointment hour is scheduled, you will be expected to pay for a late cancellation unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control].* It is important to note that insurance companies do not provide reimbursement for cancelled sessions***

You will be responsible for \$50 for the first missed appointment and \$105 for any subsequent missed appointments. If this is a continuing pattern, your care may be discontinued in our clinic and we would provide you with referrals to other mental health clinics.

If patient is a Medicaid patient by state law we cannot charge for missed appointments. If a Medicaid patient no shows for an appointment they will be eligible to be discharged from therapy services and a referral will be provided to other mental health professionals.

We make every effort to make reminder calls, texts, or email if you give us permission and provide the valid information. However, reminder calls are a **courtesy**. We are not responsible in the event that you do not receive your reminder call, text, or email for any reason. Not receiving a reminder call regarding an appointment **does not** absolve your responsibility in terms of our missed appointment / no show policy.

The patient is responsible for contacting the office with any changes in phone numbers, addresses, insurance information, and legal issues pertaining to minor children.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED THIS AGREEMENT AND READ THIS AGREEMENT AND ARE CONSENTING TO TREATMENT WITH GRINSTEAD & ASSOCIATES. IT ALSO INDICATES THAT YOU AGREE TO THE TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

We require any one 14 and older to sign this agreement. For all minors, 18 and younger, a parent/guardian must also sign.

Signature of Patient

Date

Parent signature if a minor

Date

Grinstead & Associates

INFORMED CONSENT/WAIVER FOR NON-COVERED, NON-THERAPY, OR UNUSUAL SERVICES

We would like you to know that not all services we provide are covered by insurance, and we would like you to be aware of our policies regarding these services. We will do our best to remind you if we receive a request to provide any services of this nature. We will not release any information without proper signed releases of information from all parties involved in therapy. We may also request that you sign a separate consent for certain specific services.

Some specific examples of non-covered services include but *are not* limited to:

- Preparation for any services requested in regard to litigation
- Testimony in court and time spent waiting to testify or present requested information.
- Deposition for any litigation
- Reports in regard to any litigation
- Any services in response or regard to litigation
- Any fees associated with protecting your medical record including but not limited to:
 - Filing a motion to quash a subpoena
 - Letters (to attorney, school, law enforcement, DHS and others)
 - Reports (conciliation, school, etc.)
 - Meeting with attorneys and others
 - Associated travel for any non-covered services
 - School staffings, meetings with teachers and other school personnel, etc.
 - Conciliation
 - Specific phone consultations that do not include therapy
 - Requested medical records, summaries, reports, etc.
- Time blocked out for anything on this list (even if it is cancelled within 24 hours)**

SERVICES IN REGARD TO LITIGATION: WE REQUIRE PREPAYMENT IN FULL FOR ANY SERVICES IN REGARD TO LITIGATION. FEES FOR THESE SERVICES ARE \$200.00 PER HOUR. When possible, we will provide you with an estimate regarding costs for these services.

I understand that I will be billed for the therapist's time and I acknowledge responsibility for paying for these services in full.

Signature of client or guardian

Date signed

Print client name: _____

ADDENDUM TO CONSENT FOR COUPLES OR FAMILY OR GROUP THERAPY

When there is more than one person in the room with the healthcare professional there is a "limit of confidentiality." Anyone in the room could choose to speak about the session to outsiders. Although all parties should treat information shared as confidential, it is equally important that all parties involved know that confidentiality is limited.

Parents, by signing below, you are consenting to being quoted or discussed in your children's psychotherapy notes, intake or history.

Further, if any one of the parties requests copies of the chart it will require the signature of all parties that signed the original "informed consent" before any information will be released.

To maintain and protect the therapeutic process, I ask that you sign below. By signing you are also agreeing to not ask for records of these group/couple/family sessions to be released for any legal/litigation purposes.

Print name

Signature

Date

_____ declined to sign this addendum on this date: _____

_____ Therapist initials

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please **print** name of Patient

Please **sign** for Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation
 Home Phone Confirmation
 Work Phone Confirmation
 Email Confirmation
 Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation
 Home Phone Confirmation
 Work Phone Confirmation
 Email Confirmation
 Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- I was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

Signature of Privacy Officer

Grinstead & Associates

Intake Form

Please provide the following information and answer the questions below. Please note: *information you provide here is protected as confidential information.* Please fill out this form and bring it to your first session.

Patient Information

Patient Name:

(Last)

(First)

(Middle Initial)

**If under 18 years old - Name of parent/ guardian of patient:*

(Last)

(First)

(Middle Initial)

Patient Social Security # _____ - _____ - _____ Birth Date: ____ / ____ / ____ Age: _____

Address: _____

Street

City

State

Zip

Mailing address if different from above: _____

Home Phone: ()

May we contact you or leave a message? Yes No

Cell/Other Phone: ()

May we contact you or leave a message? Yes No

E-Mail: _____ May we email you? Yes No

**** Please note: Email correspondence is not considered to be a confidential medium of communication.**

If no contact is requested, please explain: _____

I was referred by: _____

How did you hear about us? _____

Emergency Contact for patient:

_____ ()

First and last name

Relationship

Phone Number

Insurance Information:

Policy Holder Name: _____ Birth date: _____

Address (if different from client) _____

Medical Insurance Company _____ Employer _____

EAP/Mental Health Company (if different from above) _____

Insurance ID number or Social Security Number (if EAP or Private Pay): _____

Relationship to Client _____

Please complete this section if the client is a minor:

Father's Name _____ Social Security Number _____

Father's Address _____ Phone Number _____

Employer _____ Date of Birth _____ Work Phone _____

Mother's Name _____ Social Security Number _____

Mother's Address _____ Phone Number _____

Employer _____ Date of Birth _____ Work Phone _____

List name and phone number of Primary Care Physician (PCP): _____

By signing below, **I AUTHORIZE THE RELEASE OF INFORMATION** necessary to process my insurance/ EAP/ managed care/ DDS claim and **I ACKNOWLEDGE FINANCIAL RESPONSIBILITY** for this account.

CLIENT SIGNATURE _____ DATE _____

AUTHORIZED SIGNATURE FOR A MINOR _____ DATE _____

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
 Moderate = Significant impact on quality of life and/or day-to-day functioning
 Severe = Profound impact on quality of life and/or day-to-day functioning

***Symptoms unchecked will be considered not applicable.**

Patient's <i>current</i> symptoms. Please check <input checked="" type="checkbox"/> all that apply:				Symptoms continued. Please check <input checked="" type="checkbox"/> all that apply:			
	Mild	Moderate	Severe		Mild	Moderate	Severe
Aggressive behaviors				Laxative/diuretic abuse			
Agitation/Irritability				Lightheaded			
Anger				Loss of touch with reality			
Anorexia				Low esteem			
Anxiety (generalized)				Mood swings			
Appetite disturbance				Muscle tension			
Bingeing/purging				Nausea			
Circumstantial symptoms				Nightmares			
Conduct problems				Obsessions/Compulsions			
Delusions				Oppositional behavior			
Depressed mood				Overly talkative			
Perception/sensations of world seems unreal				Panic attacks			
Difficulty making decisions				Paranoid thinking			
Dizziness				Phobias (fears)			
Elevated mood (Mania)				Poor hygiene			
Elimination (toileting) disturbance				Psychomotor retardation			
Emotionality				Related medical conditions			
Fatigue/low energy				Restlessness			
Feeling of choking				Seeking excessive pleasure			
Flashbacks				Self-mutilation			
Racing/Rapid thoughts				Sexual dysfunction			
Forgetfulness				Significant weight gain/loss			
Grief				Sleep disturbance			
Guilt				Social isolation			
Hallucinations				Somatic complaints			
Hopelessness				Tremble or shake			
Hyperactivity				Trouble concentrating/Distractibility			
Impulsiveness				Trouble with daily living activities			
Intrusive thoughts				Worthlessness			
Invincibility							

***Symptoms unchecked will be considered not applicable.**

MEDICAL CONDITIONS & HISTORY:

How would you rate your current physical health? GOOD FAIR POOR

Medical History: In the section below, identify if there is a history of any of the following:

Medical health history. Please check <input checked="" type="checkbox"/> all that apply:	Self (Patient)	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Maternal Aunts/Uncles	Paternal Aunts/Uncles
Allergic reaction								
Alzheimer's								
Birth defects								
Cancer								
Diabetes								
Heart disease								
High blood pressure								
Obesity								
Stroke								
Thyroid problems								
Tobacco use								
Tuberculosis								
Chronic pain								
Other* chronic or serious health issue								

If other*, please provide any important information or history:

Please describe any significant illnesses, hospitalizations or accidents you have had:

Please list any specific health problems you are currently experiencing:

CURRENT MEDICATION:

Please provide a current list/copy of all medications or complete the following:

Have you ever been *prescribed psychiatric* medication? No Yes - if yes, please list information:

Medication	Dosage	Frequency	Reason	Prescribing Doctor

Are you currently taking any prescription medication? No Yes - if yes, please list information:

Medication	Dosage	Frequency	Reason	Prescribing Doctor

SUBSTANCE USE/ABUSE:

How often do you engage in recreational (illicit/non-prescribed) drug use?

- Never
- Infrequently
- Monthly
- Weekly
- Daily

SOCIAL HISTORY:

My social support system is: a supportive network few or no friends substance abuse friends distant from family of origin

My living/housing situation is: Adequate Overcrowded Homeless Dependent on others

Dangerous/deteriorating Living companion(s) are dysfunctional

My financial situation includes: No problems Large indebtedness Poverty or below-poverty income

Impulsive spending Relationship conflicts over finances

Sexual orientation? Bisexual Gay Lesbian Straight/Heterosexual Other Prefer not to answer

Are you currently sexually active? Yes No I use protection/birth control

Sexually Satisfied Dissatisfied

EDUCATIONAL/OCCUPATIONAL HISTORY:

Current Employment: Full-time Part-time Unemployed Volunteer work Homemaker Student

Current or highest education level completed: K 1 2 3 4 5 6 7 8 9 10 11 12 GED

Some college College degree completed: _____ Other: _____

Current School or College (if applicable): _____

Grades achieved were: GOOD FAIR POOR

Name of Employer (if applicable) _____

On a scale of 1 – 10, circle current job satisfaction: (*low satisfaction*) 0 1 2 3 4 5 6 7 8 9 10 (*high satisfaction*)

Describe the work you do: _____

Length of employment: _____

Relationship with co-workers(s): GOOD FAIR POOR

Relationship with Supervisor(s): GOOD FAIR POOR

Do you enjoy your work? Is there anything stressful about your current work? _____

Served in military no-incident with incident Branch _____

LEGAL HISTORY:

Have you ever been arrested? No Yes – if yes, please provide details:

Arrest(s) NOT substance related, how many times? _____ Non-violent offense Violent offense

Arrest(s) substance related, how many times? _____

I am currently on probation/parole

I am currently in drug court

My charge was related to a domestic violence offense

I have served time in jail/prison. Total time served? _____

STRENGTHS:

What do you consider your strengths?

LIMITATIONS:

What do you consider your Limitations?

What would you like to accomplish or set as a goal(s) to achieve in therapy?

As the therapist, I have reviewed and discussed the information provided by the client above and I have clarified information and requested additional details when necessary to provide therapy.

Therapist signature

Therapist printed name