Margie Smith and Associates, LLC

PLEASE PRINT CLEARLY

Today's Date: _____/_____/_____ Your Email Address: _____

Last Name: _____ First Name: _____ Middle Name: _____

Address: Street: _____ City: _____ State: _____ Zip Code: _____

Home Phone#: _____ Date of Birth: _____/_____/_____ Soc. Sec. #: _____

Gender: M___ F___ Race: _____ Marital Status: S ___ M ___ Sep. ___ Div. ___ Wid. ___ No. of Dependents: _____

Employer: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____

Gross Yearly Family Income: $_____ Sliding Scale Fee: $_____

(THIS IS INCOME BEFORE TAXES. ALSO INCLUDE INCOME FROM INVESTMENTS, PENSIONS, ETC.)

Denomination/Faith: _____ **Local Church/Parish/Synagogue:** _____

Emergency Contact: _____**Relationship:** _____ **Phone:** _____

Physician: _____ **City/State:** _____ **Phone:** _____

Who referred you?:_____ **Relationship:** _____

CLIENT IS RESPONSIBLE FOR PAYMENT

Shall we file insurance claims on our behalf? _____**YES** _____ **NO** (If you answered yes, please fill in the following and attach a copy of the front and back of your insurance card)

Name of Primary Insurance Carrier: _____ Date Coverage began: _____/_____/____

Subscriber ID#: _____ Name of Policyholder: _____ Date of Birth: _____/_____/____

Employer:_____ Group Number: _____

Patient relationship to the policyholder: Self _____ Spouse _____ Child _____ Other ____ (_____)

I have reviewed the following information on the back of this agreement:

___ HIPPA Notice of the Privacy Practices ___ Informed Consent to Treatment

___ Statement of Patient's Rights ___ Statement of Patient's Responsibilities

I accept these terms during our professional relationship.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

(PLEASE TURN OVER. YOU MAY REQUEST A COPY OF ANY FORM YOU WISH TO KEEP)

OFFICE USE ONLY: Outside Billing _____

Circle if client is eligible for Minister Care benefits: UMC BAP EPIS LUTH BTSR UNION/PSCE Other _____ DSM-IV Diagnosis Code: _____

HIPPA NOTICE OF PRIVACY PRACTICES OF MSA

A. We have a legal duty to protect health information about you.
B. We may use and disclose Protected Health Information about you in the following circumstances:
   1. We may use and disclose Protected Health Information about you to provide health care treatment to you.
   2. We may use and disclose Protected Health Information about you to obtain payment for services.
   3. We may use and disclose your Protected health Information for health care operations.
   4. We may use and disclose Protected Health Information under other circumstances without your authorization.
   5. You can object to certain uses and disclosures.
   6. We may contact you to provide appointment reminders.
   7. We may contact you with information about treatment, services, products or health care providers.
C. You have several rights regarding Protected health Information about you:
   1. You have the right to request restrictions on uses and disclosures of Protected Health Information about you.
   2. You have the right to request different ways to communicate with you.
   3. You have the right to see and copy Protected Health Information about you.
   4. You have the right to request amendment of Protected Health Information about you.
   5. You have the right to a listing of disclosures we have made.
   6. You have the right to a copy of this notice.

INFORMED CONSENT FOR TREATMENT

I understand that therapy offers no guarantees. By working with my therapist, I have the opportunity to get help with the problems and concerns I bring to therapy. I understand that I will benefit in proportion to the effort I put into making changes and acting in new and different ways. I will develop these new choices in cooperation with my therapist. This effort will not be limited to the time in a session but will include being committed to making the effort in between sessions. If I do not do these things outside the office, I understand that the effectiveness of the therapy will be limited.

I agree to collaborate with my therapist or to discuss with him or her the reasons why I cannot. I agree to ask any questions I have to clarify my therapeutic goals and to monitor progress towards them.

I understand that therapy will end when the goals of the therapy are met. I also understand that I can terminate my therapy at any time I wish. I agree to notify my therapist if I choose to end the therapy before the goals are met. I also understand that my therapist can end therapy if we do not make progress, or if our relationship working together does not produce results, or if I am no longer able to pay for therapy. If therapy is terminated early, my therapist will make every effort to refer me to another appropriate source of therapy or assistance.

STATEMENT OF PATIENT'S RIGHTS

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Patients have the right to have their treatment and other patient information kept private.
- Only in an emergency, or if required by law, can records be released without patient permission.
- Patients have the right to information from staff and providers in a language they can understand.
- Patients have the right to have an easy-to-understand explanation of their condition and treatment.
- Patients have the right to know all about their treatment choices, regardless of cost or if they are covered by insurance or not.
- Patients have the right to get information about MSA's services and role in the treatment process.
- Patients have the right to provider qualification information.
- Patients have the right to know the clinical guidelines used in providing and/or managing their case.
- Patients have the right to provide input on MS&A's policies and services.
- Patients have the right to know about complaint, grievance and appeal procedures.
- Patients have the right to know about State and Federal laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process.
- Patients have the right to share in the formation of their plan of care.

STATEMENT OF PATIENT'S RESPONSIBILITIES

- Patients have the responsibility to give providers the information they need. This si so they can deliver the best possible care.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients should not take actions that could harm the lives of employees, providers or other patients.
- Patients have the responsibility to keep their appointment. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- Patients have the responsibility to let their providers know about problems with paying fees.
- Patients have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the patient and the provider.

Margie Smith and Associates, LLC

AVAILABILITY AND EMERGENCY PROCEDURES:

Clients may contact their counselor between sessions by leaving a message on voice mail. If you need to talk to someone right away, and cannot wait for a return call, you can call the 24-hour mental health crisis services for your locality: Richmond: 809-4100; Henrico County: 261-8484; Hanover County: 356-4200; Chesterfield: 748-6356. If an emergency situation arises in which you are being harmed or are in danger of harming yourself or someone else, please call 911, or go to the nearest emergency room.

CONFIDENTIALITY:

The standards of the Virginia Board of Health Professions, and the insurance companies require our counselor to keep treatment records. All information disclosed within sessions and the written records pertaining to these sessions are confidential and may not be revealed to anyone without your written permission, except where the law requires disclosure. To take action to protect endangered individuals from harm when in the therapist's judgment danger exists, law may require disclosure in these circumstances: where there is reasonable suspicion of child or elder abuse or neglect; where a client presents a danger to him/herself or to another person.

PAYMENTS CANCELLATIONS, AND INSURANCE:

Your sliding scale fee is determined by your gross family income and number of persons in the family. The amount is established in conversation with your counselor in the first session. Payment is due at each session, including the initial interview. Payments can be made by cash or check. There will be a fee for returned checks from the bank. A regular session is 50 minutes. For sessions not covered by insurance, for missed appointments, or for late cancellations, the client will pay a sliding scale fee of $ _____.

As part of the process of assessing what treatment is appropriate, your counselor may use testing and/or consultation, charged at your sliding scale fee. All scheduled appointments must be cancelled 24 hours in advance, or you will be charged your sliding scale fee for the missed appointment or late cancellation. Insurance companies do not reimburse for missed appointments.

If you wish to use insurance which covers outpatient mental health at MS&A, we are willing to file for those benefits. It is your responsibility to know the specifics of your coverage, to pre-authorize or verity authorization for services, and to provide complete and accurate insurance information. You are responsible for whatever portion of the payment insurance does not cover. We cannot guarantee that your insurance company will cover your counseling.

The client has agreed to pay the following amount at each visit: $ _____.

I have reviewed the above information in this agreement. I have had the opportunity to ask questions and accept these terms during our professional relationship. Based on the terms of this agreement, I consent to participate in an evaluation and treatment with my counselor at Margie Smith and Associates, LLC. I understand that this agreement can be withdrawn at any time.

_____ _____

Client Signature **Date**

_____ _____

Counselor Signature **Date**

Margie Smith and Associates, LLC

PERMISSIONS RELATING TO INSURANCE

I authorize permission for MS&A to contact my insurance company, _____ (Name of Insurance Company), as necessary to pursue and/or inquire regarding professional counseling services. I authorize the release of any medical or other information necessary to process claims for insurance payment. I also authorize payment of benefits to MS&A as the supplier of services accepting assignment of benefits.

_____ _____

Client Signature **Date**

In order to coordinate services, your insurance company may ask whether MS&A has contacted your **primary care physician. Do you wish to give permission for this contact?**

_____ I hereby **give permission** to the MS&A to contact my physician (Name)_____, located at _____, telephone _____, to inform my physician that I am being seen by (Counselor's Name) _____, for treatment of (Main Concern) _____.

_____ I **do not give permission** to the MS&A to contact my physician.

_____ _____

Client Signature **Date**

To be completed by your counselor:

_____

_____

_____

Re: (Client Name) _____ Date of birth _____

Dear Dr. _____:

In an effort to coordinate care, I want to inform you that _____ is seeing me for treatment of _____.

The setting is outpatient _____ Individual Counseling _____ Group Counseling
_____ Family Counseling _____ Other: _____

If you need further information, please call me at (804)282-8332.

Sincerely,

_____ _____

Counselor Signature & Credentials **Date**

OFFICE USE ONLY: Date sent to physician: _____ By: _____ (initials)

04/2008

Margie Smith and Associates, LLC

Account # _____

CONFIDENTIAL PERSONAL HISTORY INVENTORY

(Complete or check all blanks that apply. Circle areas you wish to discuss further. Add extra pages if needed.)

NAME: _____ Age: ____ Ethnicity _____ Today's Date: _____

Education: (Circle last year) Grade School 1 2 3 4 5 6 7 8; High School 9 10 11 12; College 1 2 3 4 5 6+

Occupation: _____ Satisfied? _____ Get along with co-workers and employer? _____

Military history? ___No ___Yes (List branch of service and years)_____

What individuals and groups are your support system? _____

_____

CONCERNS AND GOALS: What concerns do you bring to counseling? _____

_____

_____

What stressful events contributed to your difficulties? When did each happen? _____

_____

_____

Check your areas of concern: _____ Job _____ School _____ Family _____ Marriage _____ Social relationships ____ Physical

_____ Psychological _____ Legal _____ Financial _____ Faith _____ Other: _____

What do you hope to accomplish by coming to counseling? _____

_____

What do you need from your counselor? _____

HEALTH INFORMATION: Rate your physical health: _____Excellent _____Good _____Average _____Poor _____Declining

Medical Conditions: _____None _____Asthma _____Chronic Pain _____Cancer _____Diabetes _____Pulmonary Disease

_____Cardiovascular problems (Heart, Blood Pressure) _____Allergic to _____

Weight change recently? ____No ____Yes (Lost _____lbs. Gained _____lbs. Over what time period? _____)

How do you exercise and how often? _____

List important present or past illnesses, and injuries causing limitations: _____

_____

What do you do to relax? _____

Date of last medical exam: _____ Allergies: _____

List current medications, including dose, prescribing physician and purpose for each. (Attach page if needed.)

_____

_____

Check symptoms you are now experiencing- Physical: Pain in _____ Discomfort in _____
Mood: ___Sadness ___Hopelessness ___Low self-esteem ___Mood swings ___Irritable ___Numb ___Withdrawn
Anxiety: ___Worry ___Panic attacks ___Jitteriness ___High stress level ___Physical symptoms ___Excessive fear
Thought: ___Confusion ___Obsessions ___Easily distracted ___Poor concentration ___Less able to think ___Flashbacks
___Difficulty remembering ___Loneliness ___Helplessness ___Loss of pleasure ___Guilt
Behavior: ___Disorganized ___Aggressive ___Impulsive ___Reckless ___Compulsive acts ___Self-injury
Sleep Problem: ___Early-morning awakening ___Sleeping too much ___Unable to sleep ___Waking up tired
Eating Problem: ___Binge eating ___Obesity ___Low weight ___Obsession about food ___Self-induced vomiting
Concern about use of: ___Alcohol ___Tobacco ___Drugs ___Spending ___Gambling ___Internet ___Overwork ___Television
___Marijuana ___Cocaine ___Pornography ___Other (_____)
Thoughts of suicide: ___Plan for suicide ___History of suicide in family ____**Threats of violence or violence toward others**

PLEASE TURN OVER

CONFIDENTIAL PERSONAL HISTORY INVENTORY

Page 2 (Please complete other side also)

(Complete or check all blanks that apply. Circle areas you wish to discuss further. Add extra pages if needed.)

What has been your history of dealing with emotional difficulty?

____ Prior counseling If yes, when? _____ Helpful? ___ What were the issues? _____

____ Self-help group _____

____ Helpful family or social support system

____ Suicide attempt(s) When? _____

____ Addictive use of _____

____ Faced problems alone

____ History of abuse or neglect By whom? _____

____ Psychiatric hospitalization(s) When? _____

RELIGIOUS BACKGROUND: Faith preference: _____ Childhood religious background: _____

Do you believe in God? ____Yes ____No ____Uncertain Do you pray? ____Yes - (___Often ___Sometimes ___Rarely) ____No

What beliefs, values or practices are important to you? _____

_____

PERSONALITY INFORMATION: List three(3) of your most important strengths _____

_____

What is strength for you? _____ Where can you get it? _____

List two(2) areas of needed growth _____

FAMILY OF ORIGIN: Parents' marital status: _____Married _____Never Married _____Divorced _____Remarried _____Widowed

If not raised by birth parent(s), who raised you? _____

Rate childhood home: ____Happy ____Average ____Unhappy ____Abusive (toward whom? _____)

____Parents used alcohol ____Parents used drugs (___Seldom ___Sometimes ___Often ___Addicted)

Father: Occupation _____ If living, age_____ If deceased, your age at his death _____

Describe him in 3 words: _____

Mother: Occupation _____ If living, age_____ If deceased, your age at her death _____

Describe her in 3 words: _____

Your birth position in your family (e.g. 1st of 3 children): _____ of _____ children

List sisters' and brothers' names, ages, sexes and marital statuses _____

_____

MARRIAGE/RELATIONSHIP INFORMATION: Status: ___Single ___Married ___Committed relationship ___Dating

___Separated ___Divorced ___Widowed

First name of spouse or significant other: _____ Age: ____ Occupation: _____

Satisfaction with relationship: ____Very satisfied ____Satisfied ____Neutral ____Dissatisfied ____Very Dissatisfied

Area of concern in the relationship: ____Communication ____Conflict ____Money ____Children ____In-laws ____Sex

____Infidelity ____Jealousy ____Personal habits ____Alcohol/drug use ____Trust Other _____

How would your partner describe this issue? _____

If married, in what year: _____ Ages when married: _____Self _____Spouse

How long did you know your spouse before marriage? _____ Have you ever consider divorce? ____Yes ____No

If yes, what were the reasons? _____

List previous marriage(s) of self or spouse: (former spouse's first name; dates married; how ended): _____

_____

CHILDREN: If you have children, list names, ages, sexes, and describe each in 3 words: _____

_____

OPTIONAL QUESTION: If your life story had a title or a theme, what would it be? _____