



Client(s) Information Form

GENERAL INFORMATION

TODAY'S DATE _____

CLIENT'S
NAME _____

Last

First

Middle Initial

MARITAL STATUS Single Married Divorced Separated Widowed Committed Relationship

SPOUSE/PARTNER

of Years Together: _____

NAME _____

Last

First

EMERGENCY CONTACT

Name	Contact #	RELATIONSHIP TO THE CLIENT

CHILDREN

Name	Sex	Age	Deceased?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRESENTING PROBLEM

What brings you to counseling at this time?

Have you (or your family members) ever been involved in counseling? Yes No

If yes, with whom? _____ When? _____

Reason(s): _____

Is the client in treatment with another counselor at this time? Yes No If yes, with whom? _____
Reason _____

Check which of the following you use, and please note the amount and frequency of each:

- Caffeine _____
 - Coffee Sodas Other drinks Pills/Supplements
- Alcohol/Adult Beverages _____ Tobacco _____

Notice of Privacy Practices

Client Name _____

This notice describes how Medical/Mental Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective 01/01/2014, Amy Ray, LLC will only release information in accordance with state and federal laws and the ethics of the counseling profession. The following describes policies related to the disclosure of client’s healthcare information. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality of care. State and Federal Laws allow Amy Ray, LLC to use and disclose health information for these purposes.

USES and DISCLOSURES

- *Help manage the health care treatment you receive* – Example: A psychiatrist sends information about your diagnosis and treatment plan so additions or changes in your care can be provided
- *Payment* – Example: Verifying your insurance coverage or processing claims to collect fees
- *Healthcare operations* – Example: Site review for compliance
- *Other uses and disclosures without your consent* – Example: Mandated reporting to a suspected crime or abuse

CLIENT RIGHTS

- Right to request where to contact or notify you Number or email to use:
- | | | | |
|------------|---------|--------|--|
| Home | ___ YES | ___ NO | |
| Work | ___ YES | ___ NO | |
| Cell | ___ YES | ___ NO | |
| Email | ___ YES | ___ NO | |
| Voice Mail | ___ YES | ___ NO | |

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask to limit the information shared
- Get a list of those with whom your information has been shared
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You can complain if you feel we have violated your rights by contacting Amy Ray with Amy Ray, LLC. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting

www.hhs.gov/ocr/privacy/hipaa/complaints/. I will not retaliate against you for filing a complaint.

Amy Ray, LLC responsibilities include: 1. Required to maintain the privacy and security of your protected health information. 2. Let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3. Follow the duties and privacy practices described in this notice and give you a copy of it. 4. Not use or share your information other than as described here unless you inform Amy Ray, LLC in writing. If you inform in writing, you may change your mind at any time. Inform Amy Ray, LLC in writing if you change your mind.

Client Signature (age 14 & up) _____ Date ____/____/____

Guardian Signature _____ Date ____/____/____

Checklist of Concerns

(please check any relevant concerns)

THOUGHTS/FEELINGS/MOOD

- Anger/frustration/hostility
- Anxiety, nervousness
- Attention, concentration, distractibility
- Confusion
- Depression
- Disliking others
- Emptiness
- Euphoria
- Excessive worry
- Failure
- Fatigue
- Fear
- Grieving (death, loss, divorce, etc)
- Guilt
- Hearing things other people don't
- Homicidal thoughts
- Intrusive thoughts
- Judgment problems
- Memory difficulties
- Negative thoughts
- Obsessive thoughts
- Oversensitivity to criticism
- Oversensitivity to rejection
- Panic attacks
- Perfectionism
- Sadness
- Seeing things other people don't
- Self-centeredness
- Self-esteem (low)
- Shyness
- Spiritual, religious, or moral issues
- Stress
- Sudden mood changes
- Suicidal thoughts
- Suspiciousness
- Temper problems
- Thoughts of hurting self or others

BEHAVIOR

- Aggression, violence
- Alcohol use
- Argumentative
- Avoidant
- Compulsive behavior/rituals
- Controlling
- Decreased/lack of sexual interest
- Dependency
- Destruction of property
- Drug use: prescription, over-the-counter, street
- Eating problems
- Financial problems, debt
- Gambling
- Hyperactivity
- Internet problems
- Irresponsibility
- Isolation
- Legal problems
- Letting others take advantage of you
- Lying
- Not able to relax
- Preoccupation with sex
- Procrastination
- Purging
- History of running away
- Self destruction/sabotaging
- Self-neglect
- Sexual dysfunction
- Smoking
- Stealing
- Threats
- Weight, gain/loss
- Withdrawal from others
- Loss of interest in what I used to like
- Sleep difficulty
- Loss of appetite
- Overeating

FAMILY & RELATIONSHIPS

- Affair
- Childhood issues (client's childhood)
- Divorce
- Friendships
- Housework/chores
- Interpersonal conflicts
- Parenting
- Problems w/ child(ren)
- Problems w/ parents
- Problems w/ spouse/partner
- Separation

ABUSE

- Abuse of alcohol
- Abuse of drugs
- Physical abuse by another
- Physical abuse of another
- Sexual abuse by another
- Sexual abuse of another

WORK & SCHOOL

- Absenteeism
- Career concerns, goals, choices
- Difficulty with coworkers
- Difficulty with supervisor
- Performance
- Tardiness
- Procrastination
- School problems

OTHER CONCERNS

I have no problems or concerns bringing me here.

MEDICAL HISTORY/HEALTH CONDITIONS

Date of Last Physical _____ Date of Last Visit _____

Please indicate if the client have now or have had any of the following conditions:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chronic Lung Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Stomachaches | <input type="checkbox"/> Ulcer/Gastrointestinal Problems | <input type="checkbox"/> Sexual Functioning Problems | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Changes in Appetite |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Self-Harm | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> PMS | | | |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Other _____ | | | |



Consent for Counseling

Thank you for choosing Amy Ray, LLC for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with the procedures and policies, I am providing the following information regarding services and limitations.

COUNSELOR'S CREDENTIALS: I received a Master of Education with a concentration in Agency Counseling from the University of Montevallo in 2004. I am a Licensed Professional Counselor (LPC), a National Certified Counselor (NCC), and a Registered Play Therapist. Play therapy is a counseling method that can be helpful to use when children are involved in the counseling process.

PURPOSE & METHODS: My purpose is to work with you to determine what goals you have for personal growth explore possible ways to achieve those goals. The frequency and method vary depending on your individual circumstances. Counseling sessions are typically fifty-five minutes. You always have the right to decline participation in or the use of certain therapeutic techniques. Please feel free to ask questions about any approaches or techniques used in sessions.

CONFIDENTIALITY: An essential aspect of counseling is confidentiality. I strive to maintain privacy and uphold the ethics of confidentiality. This includes all verbal, written, and recorded data concerning your treatment, which may not be released without your written consent. Limitations to these rights are: 1) I have a legal duty to warn and protect persons threatening harm to self or others; 2) I have a legal duty to report to proper authorities any indication that abuse to a child or vulnerable adult may have occurred. 3) I am required to comply with Alabama State Laws in regard to court ordered subpoenas/court testimony. 4) If you request services to be covered by your insurance company or your Employee Assistance Program, they will require the counselor provide information and may request further information about the counseling sessions to authorize reimbursement for services. Amy Ray, LLC is affiliated with Shelby Psychological Services and utilizes their services to manage billing and administrative needs. If you choose to keep a third-party informed of your progress in counseling, it will be necessary to complete an "Authorization to Release Information" form that will be kept on file.

Your client record is the property of Amy Ray, LLC and shall be treated as confidential. To comply with state and federal laws regarding client confidentiality, your records will not be released without properly executed written consent. Amy Ray, LLC will maintain your record for at least 7 years past the date of your last appointment at which that point in time the records will be erased. Any paper records will be scanned for electronic storage and the paper copy will be shredded. In signing this consent, you are agreeing that any electronic signatures or scanned copies of original signatures are as binding as an ink signature. In the event of my death, a custodian of records has been assigned. Currently, the assigned custodian of records is: Paul Johnson, Life Practical Counseling, 5520 Hwy 280 Suite 4 Birmingham, AL 35242, (205) 807-6645.

CONSULTATION AND SUPERVISION: It is common practice for counselors to consult with other professionals or colleagues about issues that arise within therapy. The minimum amount of information needed for consultation is given to continue to protect confidentiality.

REGARDING DIVORCE AND CUSTODY LITIGATION: If you are involved in divorce of custody litigation, my role as a counselor is not to make recommendations to the court concerning custody or parenting issues. By signing this consent form, you agree to not have me subpoenaed to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney making recommendations. The court can appoint professionals, who have no prior relationship with family members to conduct an investigation or evaluation and to make recommendations to the court.

RISK: Counseling comes with potential risks and benefits. Counseling can be emotionally painful at times. Counseling also involves change. Processing areas of your life and learning new ways of thinking, feeling, and behaving can cause discomfort for you and others around you. While there is hope that improvement will occur as part of the therapeutic process, this is not a guarantee. Commitment to the counseling process increases the opportunity for benefits from counseling to occur. Please ask for any clarification that may help you feel more comfortable.

REFERRALS: The counselor reserves the right to terminate the counseling relationship for any reason deemed to be in the client's best interest. If the counselor or the client believes continued counseling is needed, the counselor will provide other referrals. If a client expresses a desire to find another counselor, the counselor can provide a referral and can be contracted to provide a summary of work to the new counselor at the current hourly rate, with a minimum of one hour and a maximum of two.

EMERGENCY SERVICES AND AFTER HOURS CONTACT: Amy Ray, LLC does not provide emergency services. In the event of an emergency, call 911 or go to the closest emergency department. For urgent concerns after hours, please contact the Crisis Center at 205-323-7777.

COMMUNICATION: Phone calls are typically returned during the hours of 8:00 am to 3:00 pm Monday through Friday. Telephone sessions lasting over 20 minutes will be charged at a rate of current hourly fees. The use of emailing and texting may be used at times if you agree to this. Please be aware that emailing and texting as forms of communication may compromise confidentiality. Communication through text or email is not a requirement of this consent.

I have read the preceding information. By signing below, I acknowledge my understanding and agree to all the terms discussed in this consent for treatment form.

Client Signature

Date

Amy Ray M.Ed., LPC

Date

Shelby Psychological Services Adult Client Registration Form

CLIENT INFORMATION					
Name		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	
Street Address		City		State	Zip Code
School (if applicable)	Grade	Employer		Work Phone ()	
Email Address				Home Phone ()	
Primary Care Physician Name:				Cell Phone ()	
How Did you Hear About Us? <input type="checkbox"/> Physician <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Other _____					
INSURANCE INFORMATION (Please provide your insurance card for office to copy)					
Primary Insurance			Primary Policyholder's (PP's) Name		
Primary Policyholder's Social Security #	PP's Birth Date	PP's Employer		Group number	
Policy Number		Client's Relationship to Primary Policyholder			
Secondary Insurance					
Primary Policyholder's Name		PP's Birth Date	PP's Employer		Group number
Policy Number		Client's Relationship to Primary Policyholder			
Person Responsible for Bill and address if different					
Your Signature					

- Acknowledges:
- ✦ Accuracy of above information and financial responsibility to pay any balance and attorney if required for account collection
 - ✦ Notice of HIPAA and State of Alabama policy and practices to protect your health information
 - ✦ Consent for client to be evaluated and/or treated by Shelby Psychological Services (SPS)
 - ✦ Dr. Vance has a small therapy-dog-in-training at SPS – I understand it is my responsibility to inform SPS staff if I do not want to interact with the dog.

- Authorizes:
- ✦ SPS to release information required to process my insurance claim and for insurance benefits to be paid to SPS
 - ✦ Consent to release treatment information to other SPS providers only in the event of an interoffice referral
 - ✦ Consent to release requested information to the referring physician/source
 - ✦ Consent to release information for insurance purposes, when required, with supervising providers.

I have read, understand and acknowledge/authorize the above.

Printed Name of Client/Guardian _____

Signature of Client/Guardian

Date

**Shelby Psychological Services
FINANCIAL AGREEMENT**

Patient/Guardian/Responsible Party Name:

Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF THE VISIT. APPOINTMENTS NOT CANCELED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED AT THE REGULAR RATE. Automated reminder calls are sent out as a courtesy. However, computers do sometimes malfunction and phone numbers change etc. **YOU ARE STILL RESPONSIBLE TO KEEP YOUR APPOINTMENTS OR CANCEL ON A TIMELY BASIS** even if the reminder system does not work.

_____ Please initial

If a provider receives a subpoena with an order to appear for court proceedings regarding this case, it is the client/guardian's responsibility to reimburse the provider for their time. This includes preparation time, travel time and actual time at court at the cost of \$200/hour. A retainer fee of \$1000 is required at the time of the request. _____ Please initial

If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include any major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and/or other health plans to Shelby Psychological Services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Responsible Party Signature _____ Date _____