Demographic Form

NAME: _____ _____ _____
First name **Middle Initial** **Last Name**

PREFERRED NAME:_____

DOB:_____**AGE:**_____ **ADMINISTRATIVE SEX:** ☐**MALE** ☐**FEMALE**

GENDER IDENTITY: ☐**FEMALE** ☐**MALE** ☐**OTHER**_____

PRONOUNS:_____

ADDRESS: _____**APT.#:**_____

CITY:_____ **STATE:**_____ **ZIP:**_____**COUNTY:**_____

PHONE NUMBER: _____ _____ _____
Cell **Other** **Email Address**

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED**

RACE/ETHNICITY:

☐ Caucasian/White	☐ Japanese	☐ Hispanic	
☐ African American/Black	☐ Chinese	☐ Native American	☐ Biracial
☐ Asian	☐ Hawaiian	☐ Vietnamese	☐ Other

Others residing in the household: _____

If client is under 18 years old:

Mother's Name:_____ Father's Name_____

Are the parents divorced? _____ Parenting Time_____

Custody Arrangements:_____

Does the other parent agree with minor being placed in therapy?_____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT?

_____

_____

_____

IS TREATMENT COURT ORDERED? ☐ Yes ☐ No

EMPLOYMENT INFORMATION: ☐ Full-time Student ☐ Part-time Student ☐Employed ☐ N/A

LEGAL HISTORY: Have you even been charged with a crime? ☐ Yes ☐ No

Are you currently on probation? ☐ Yes ☐ No

If yes, please explain: _____

LIST HOBBIES OR RECREATIONAL INTERESTS:

_____

_____

FAMILY, CULTURE AND RELIGION: Describe any cultural and/or religious connections.

_____

_____

BEREAVEMENT AND GRIEF: Have you experienced grief or loss? If so, please describe how you are supported socially, spiritually and culturally.

_____

_____

PRIMARY CARE PHYSICIAN (PCP):

NAME: _____ **PHONE:**_____

ADDRESS: _____

Visit/Checkup with PCP within the past 12 months: ☐ YES ☐ NO

Regular preventative health screens: ☐ YES ☐ NO

CURRENTLY PRESCRIBED MEDICATIONS: (Medication, dosage and prescribing physician)

_____

_____

Have you been consistently taking these medications as prescribed ☐ YES ☐ NO

NUTRITION: (Please check all that apply – past or current)

	PAST	CURRENT	N/A		PAST	CURRENT	N/A
INCREASED APPETITE	☐	☐	☐	BINGE EATING	☐	☐	☐
DECREASED APPETITE	☐	☐	☐	HOARDING	☐	☐	☐
OTHER _____	☐	☐	☐				

Are you currently being seen for any of the above? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE_____

_____

Food Allergies _____

I have made myself throw-up after eating ☐ YES ☐ NO

I do not eat a wide variety of healthy foods ☐ YES ☐ NO

PSYCHIATRIC HISTORY:

	PAST	CURRENT	N/A		PAST	CURRENT	N/A
ADHD	☐	☐	☐	ABUSE: SEXUAL	☐	☐	☐
ANXIETY	☐	☐	☐	ABUSE: PHYSICAL	☐	☐	☐
DEPRESSION	☐	☐	☐	EATING DISORDER	☐	☐	☐
OTHER_____	☐	☐	☐				

MENTAL HEALTH HISTORY:

☐ No previous therapy

☐ Outpatient Treatment

Type of treatment: (Circle all that apply) Individual therapy family therapy group therapy

Provider: _____

Dates of treatment: _____

Reason for treatment: _____

Please document additional treatment episodes on a separate sheet

INPATIENT PSYCHIATRIC HOSPITALIZATION:

Previously hospitalized: ☐ Yes ☐ No ☐ N/A Multiple Hospitalizations: ☐ Yes _____

Last psychiatric facility _____ Date Admitted_____Date Dismissed_____

Please document additional hospitalizations on a separate sheet

HAVE YOU EVER RECEIVED A MENTAL HEALTH DIAGNOSIS (i.e. depression, bipolar disorder, schizophrenia)

_____

SUBSTANCE USE HISTORY: ☐ NONE

☐ ALCOHOL ☐ WITH BLACK OUTS ☐ WITH LEGAL PROBLEMS ☐ COURT ORDERED TREATMENT

☐ OTHER SUBSTANCE USE _____

Have you attended alcohol/drug abuse treatment: ☐Yes ☐No

Have you been told that you have an alcohol/drug problem: ☐Yes ☐No

FAMILY MEDICAL HISTORY: (Please mark each that apply with "1" for immediate family "2" for extended family)

☐ Diabetes ☐ Depression ☐ Anxiety ☐ Psychiatric hospitalizations

☐ Heart Disease ☐ Schizophrenia ☐ Suicide attempts ☐ Alcohol/drugs ☐ Other:_____

☐ ADHD ☐ Bipolar disorder ☐ Antisocial behavior (difficulties – police/violence)

GENERAL FUNCTIONING:

- ☐ Sad or tearful most of the time
- ☐ Decrease in interests / activities
- ☐ Feelings of guilt
- ☐ Down most days
- ☐ No energy
- ☐ Difficulty thinking
- ☐ Feel rested after 3-4 hours sleep/night
- ☐ Under active/sluggish behavior
- ☐ Takes more than an hour to fall asleep
- ☐ Night waking for longer than 30 minutes
- ☐ Sleep too much
- ☐ Hard to wake up in the morning
- ☐ Feelings of hopelessness
- ☐ Intentional self harm
- ☐ Nightmares
- ☐ Sexual concerns
- ☐ Irritability/anger
- ☐ Extreme ups and downs in mood
- ☐ Distinct periods of nonstop activity
- ☐ Fast/rapid speech
- ☐ Fearless/engaging in reckless activities
- ☐ Exaggerated view of abilities
- ☐ Cheerful/happy most of the time
- ☐ Inability to sustain attention
- ☐ Difficulty concentrating
- ☐ Inability to complete tasks
- ☐ Restless
- ☐ Easily distracted
- ☐ Worries about _____
- ☐ Verbal threats of harm to others
- ☐ Physical aggression
- ☐ Fearful of places, situations or people
- ☐ Poor memory
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Weight loss / gain
- ☐ Intentional vomiting/purging
- ☐ Overly fatigued during the day
- ☐ Tense
- ☐ History of abuse as a child
- ☐ History of abuse as an adult
- ☐ Problems with work/school performance
- ☐ Problems with relationships at home
- ☐ Extreme conflict with others
- ☐ threatened to hurt someone w/ intent
- ☐ Suicidal thoughts
- ☐ Suicidal attempts

HOW LONG HAVE YOU HAD THESE CONCERNS? _____

HOW OFTEN DO THESE OCCUR? _____

WHAT ARE 3 OF YOUR STRENGTHS?

_____

_____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOURSELF?

_____

_____

_____

_____

_____

Fee Agreement

The following are the fees charged by *Center Point Counseling LLC*:

Initial Session $200 (roughly 60-90 minutes)

Individual/Family Counseling $180.00/hr

Court Appearance $150.00/hour

Clients are responsible for payment of all fees. We will be happy to submit a claim to your insurance company or provide you with a receipt for submitting your insurance claim. However, clients are ultimately responsible for payment of their bill.

Once a recurring appointment has been set, plan to meet at that time unless you or your therapist alerts the other of a need to cancel or reschedule. Cancellations happen from time to time due to sickness, vacation and personal emergencies but in general you are agreeing to attend every scheduled session. You will be responsible for a cancellation fee of **$75** if you cancel your session/No Show with less than 24 hours notice and it is not possible to find an alternative time to meet that same week. Please be aware that insurance companies will not reimburse you for missed session fees.

If you missed 2 consecutive sessions without being in contact, unless other arrangements have been made in advance, your therapist will assume that you've decided to end treatment and will discharge you from therapy.

All copays and deductibles will be sent out at the end of each month. We are willing to work with you regarding your bill if you have trouble paying your portion. However, if you fail to communicate with us or do not follow through on making some sort of payment plan, we do reserve the right to turn your account in to collections.

In case we need to do so, you agree to give us the right to report any unpaid amounts to a credit reporting agency, to obtain a copy of your credit report to help us or our agent to collect any amounts not paid by you. You also agree that you may be held liable for attorney fees, court costs, collection fees or other costs involve in collecting any unpaid amounts.

I have read and agree to the terms of the above fee policy.

_____

Client Name (please print)

_____ _____

Client /Parent/Legal Guardian Signatures Date

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (client name), acknowledge that I have received a copy of *Center Point Counseling LLC* Notice of Privacy Practices.

My signature below indicates that I have received the notice and that I have been provided an opportunity at ask questions about the agency's privacy practices as they pertain to my protected health information.

_____

Signature Date

_____

Witness Date

Assignment of Insurance Benefits

Client Name:_____
Insurance Holder Name:_____
Insurance Holder Birthdate:_____
Insurance Company:_____
Policy Number:_____
Group Number:_____

I hereby authorize the direct payment of all insurance benefits to *Center Point Counseling LLC* for all mental health services rendered.

_____
Client/Guardian Signature Date

_____
Center Point Counseling LLC Representative Date

Consent for Treatment

I agree to receive mental health services at *Center Point Counseling LLC*. These services may include, but not limited to; individual counseling, group counseling, family counseling, relationship counseling, and psychological/vocational testing. I understand that if *Center Point Counseling LLC* does not provide a service which is requested or necessary, I will be referred to an appropriate provider of that service.

I understand that all information that I share with my counselor will be kept confidential and will not be released without my written consent. I understand that the clinicians of *Center Point Counseling LLC* regularly consult with one another in order to provide me with the highest quality service possible, and may share information about my case for purposes of consultation. Information may also be shared with my insurance company to the extent necessary to secure payment for services.

I understand that confidentiality is not absolute, that in some circumstances my counselor may be required by law or by the ethical standards to share information about my case. Information may be released without my consent in situations where there is reason to believe that I might harm myself or others, or in the case of actual or suspected child abuse or neglect.

I understand that although participation in counseling will likely result in significant benefit, there are also risks involved. I understand that talking about personal issues in counseling may be upsetting, and in the short term may increase my level of discomfort. However, despite these risks, I understand that the process of counseling is often helpful in making positive changes in my life and my relationships with others.

I hereby certify that I have read and fully understand the above authorization and agree to participate in services at *Center Point Counseling LLC*. I further understand that I can withdraw from services at any time.

_____

Client Name (please print)

_____

Client Signature Date

_____

Parent / Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical, mental health and substance abuse information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Center Point Counseling LLC is committed to protecting the privacy of your medical, mental health and substance abuse information. We create a record of the care and services that you receive from us. This information is needed to provide you with quality care and to comply with certain legal requirements. We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices. We are also required to comply with the terms of this notice.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care options and for other purposes that are permitted or required by law. This notice also describes your rights regarding the information that we maintain about you and a brief description of how you may exercise those rights.

"Protected Health Information" means medical, mental health and substance abuse information, including identifying information about you that we have collected from you or received from others.

The privacy practices in this notice apply to all *Center Point Counseling LLC* staff, contract workers, students and volunteers.

Your Rights: You have the following rights regarding your protected health information.

- **Confidential Communications**: You may ask that we communicate with you in a particular way, or at a certain location, such as calling you at work rather than at home, to maintain your confidentiality.
- **Inspect and Copy**: You have the right to review and/or receive a copy of the information in your record. Under certain limited circumstances, we may have to deny your request. If we deny your request, you may ask for a review by contacting your therapist at *Center Point Counseling LLC*.
- **Addendum:** You may ask us to add an addendum to the information in your records if you feel that the information is incorrect or incomplete. Your request may be denied if we did not create the information. You may prepare a statement that will be included in our clinical record if you do not agree with information in your record.
- **Accounting of Disclosures**: You may request a list of disclosures that we have made of your protected health information with the exception of treatment, payment and healthcare operations described in this notice, or information that was released with your authorization.
- **Requesting Restrictions**: You may ask us to limit our use or disclosure of your protected health information. We are not required to agree to your request, but if we do, we will honor your request unless the information is needed to provide emergency treatment for you.
- Receiving a Copy of this Notice You may receive a paper copy of this notice at any time upon request.

How We Will Use and Disclose Your Protected Health Information

Uses and Disclosures that may be Made for Treatment, Payment, and Healthcare Operations

- **For Treatment:** We may use and disclose your protected health information to provide, coordinate, and manage your care and services. Information about you may be shared with *Center Point Counseling LLC* staff, contract workers, students, or volunteers who are involved in your care or services. This information will be shared on a "need to know" basis.

We also may use your health information in order to remind you about an appointment at *Center Point Counseling LLC* or to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

Business Associates: There may be some services provided through contracts with "business associates." We may need to share information about you with our "business associate" in order to coordinate and manage your services. To protect the privacy of your health information, "business associates" are required to abide by all aspects of this Notice of Privacy Practices.

- **For Payment**: Your protected health information will be used and disclosed, as needed, to obtain payment for your services. For example, a bill for services sent to you or to a third party payer such as a Medicaid HMO, might include identifying information about you such as your name, your diagnosis and services received.

- **For Health Care Operations:** We will use or disclose, as needed, your protected health information to support and improve the activities of *Center Point Counseling LLC*. For example, *Center Point Counseling LLC* staff may use information in your clinical record to evaluate the care that you received. This information would then be used in efforts to improve the quality and effectiveness of services provided by *Center Point Counseling LLC.*

- Uses and Disclosures That May Be Made Only With Your Specific Authorization

- Other uses and disclosures of your protected health information will be made only with your specific written authorization, unless otherwise permitted or required by law as described below. For example, your written authorization would be required for us to share your confidential information with a member of your family or with your family doctor except in circumstances specified in this notice. You may revoke this authorization at any time, in writing, except to the extent that we have already taken an action to use or disclose your information, relying upon our authorization.

Uses and Disclosures That May Be Made Without Your Authorization

- **As Required by Law:** We may be required by federal, state, or local law to disclose your protected health information. For example, if you have threatened to harm another person, we may be required to notify the local police department and the threatened person.
- **For Public Health Activities:** We may need to disclose your protected health information to a public health authority that is required by law to receive the information. Such disclosures would be made for the purpose of controlling disease, injury, or disability. For example, a disclosure regarding HIV/AIDS status would be made to the local Department of Public Health if necessary to protect the health of an individual, diagnose and care for the mental health consumer or to prevent further transmission of the virus.
- **Abuse or Neglect:** We may be required to disclose your protected health information if we suspect that you or another person has been abused or neglected.

- Health Oversight: We may be required to disclose your protected health information for an audit, inspection, investigation or other health care oversight activity.
- **Judicial and Administrative Proceedings**: We may have to disclose your protected health information if we receive a court order or subpoena or for risk management purposes.
- **Law Enforcement:** We may have to disclose your protected health information in connection with a criminal investigation by a federal, state, or local law enforcement agency, or to authorize federal officials who provide protective services for the President or other persons.
- **Serious Threat to Health of Safety**: We may be required to disclose information about you when it is necessary to prevent a serious threat to your health and safety or that of another person or of the public.

- **Coroner or Medical Examiner:** We may need to disclose your protected health information to help identify a deceased person or to determine a cause of death.
- **Research:** We may disclose your protected health information to researchers if their research proposal includes protocols to insure the privacy of your health information and has been approved by the appropriate research review board.

If you believe that your rights have been violated, contact the *Center Point Counseling LLC* Director or the Office of Civil Rights. Your services will not be affected in any way if you file a complaint.
To file a complaint with *Center Point Counseling LLC* or if you have any questions or want more information, call or write:

Center Point Counseling LLC
102 W. Chicago Blvd. Ste.204
Tecumseh, MI 49206
(517) 295-5377

To file a complaint with the Office of Civil Rights, call or write:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201
1-877-696-6775 (toll free)