

Date: \_\_\_\_\_

**PSI Client Information Form**



**Client Name:** \_\_\_\_\_ Sex: M F Date of Birth: \_\_\_\_\_

Client Address: \_\_\_\_\_  
Street City State Zip Code

May we correspond by email? Y N Email address: \_\_\_\_\_

Client Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status: Single Married Divorced Domestic Partner Widowed

Client SSN: \_\_\_\_\_

Person filling out form, if not client: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

*Please fill out all of the following information even if a copy of your insurance card is attached:*

**Primary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_

Authorization #: \_\_\_\_\_ Policy Holder SSN: \_\_\_\_\_

Insurance Billing Address: \_\_\_\_\_  
Name of Policy Holder Exactly as It  
Appears on the Card: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy Holder I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Policy Holder Mailing Address (if different from client's): \_\_\_\_\_

Policy Holder Phone: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

**Cash Pay:** Yes No **EAP:** \_\_\_\_\_ EAP Authorization #: \_\_\_\_\_

Are you involved in any legal proceedings (e.g. Worker's Compensation Claim, child custody dispute, etc) which may involve your therapist? Yes No If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

How did you hear about PsychStrategies, or who referred you to us? \_\_\_\_\_

I authorize my insurance carrier to pay PsychStrategies (please sign):

\_\_\_\_\_  
**For Clinician use Only (please print)**

Clinician Name: \_\_\_\_\_ # \_\_\_\_\_ Dx: \_\_\_\_\_ Copay due/session: \_\_\_\_\_

***PsychStrategies***  
**Client History, Concerns and Goals**

Name of Client: \_\_\_\_\_ Date: \_\_\_\_\_  
(If you have come for Couples Therapy, please fill out one form for each partner.)

Filled out by: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Please fill in the following information as completely as possible. All information is covered by our confidentiality policy (see attached office policies). **Use the back of form as necessary.**

1) Describe what has happened recently that led you to seek counseling now. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Describe current concerns and symptoms. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Check the one response which best applies:

(A) My current concerns and symptoms are:

- the continuation of a long-standing condition
- a recent worsening of an on-going condition
- the reoccurrence of a previous condition
- significantly different from any previous condition
- my first occurrence of any condition

(B) My current symptoms developed:

- suddenly (less than four weeks)
- gradually (one to several months)
- very gradually (one to several years)

4) **Medical History.** Please list major injuries, illnesses or surgeries.

<u>Condition</u>	<u>Dates</u>	<u>Treatment</u>

5) Are you currently on any medication?  yes  no

<u>Medication</u>	<u>Dosage</u>	<u>Prescribing Physician</u>	<u>Date Started</u>

Allergies/Sensitivities to medications \_\_\_\_\_

6) Any psychiatric medications you have taken in the past (and are not currently taking):

<u>Medication</u>	<u>Dosage</u>	<u>Prescribing Physician</u>	<u>Date Started</u>

7) Please indicate any significant prenatal events and developmental history. \_\_\_\_\_  
\_\_\_\_\_

8) Please list other substances that you use. *Include amount and frequency.*

Alcohol \_\_\_\_\_  
Marijuana \_\_\_\_\_  
Caffeine \_\_\_\_\_  
Tobacco (cigarettes, etc.) \_\_\_\_\_

Heroin \_\_\_\_\_  
Psychedelics \_\_\_\_\_  
Methamphetamine \_\_\_\_\_  
Other \_\_\_\_\_

9) Have you been in psychotherapy or been hospitalized in a psychiatric facility? (Please list names of past therapists and hospitalizations, dates, and reason for treatment.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10) Has anyone in your immediate or extended family had a psychiatric illness? Please list relationship and nature of illness. \_\_\_\_\_  
\_\_\_\_\_

11) Spouse/Significant Other: \_\_\_\_\_ Age: \_\_\_\_\_  
Children (Please list names and ages): \_\_\_\_\_  
Parents (Please list names and ages): \_\_\_\_\_  
Describe your current family situation and relationship history.  
\_\_\_\_\_  
\_\_\_\_\_

12) Education: \_\_\_\_\_

13) Current employment and work history (summary). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14) Describe your relationship within your family of origin. Include parental substance abuse issues as well as other relevant life events. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15) Briefly describe your current support system (family, friends, organizations, self). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16) Briefly describe your strengths and weaknesses.  
\_\_\_\_\_  
\_\_\_\_\_

17) Please describe your goals for therapy.

A. \_\_\_\_\_  
B. \_\_\_\_\_  
C. \_\_\_\_\_

18) Do you have thoughts about hurting yourself or others?  yes  no  
Please describe. \_\_\_\_\_  
\_\_\_\_\_



**Legal and Ethical Policies** - Without pressure or coercion, I, the client/guardian, consent to treatment for myself and/or my legal dependent. All information disclosed in sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my, the client/guardian's, written permission, except where disclosure is required by law.

The reporting of information disclosed in session is *required by law* under the following circumstances:

- If a client presents an imminent danger to self or others or is gravely disabled (severely disoriented or in danger due to a psychiatric condition) authorities must be notified.
- If a client expresses a serious threat of harm to an identifiable person, that person must be warned and the police must be notified.
- If there is *reasonable suspicion* of child, dependent, or elder abuse or neglect, authorities must be notified.

The reporting of information disclosed in session *may be required*:

- If the client's mental status is placed at issue in litigation initiated by me, the client/guardian.
- In the event of a court order or subpoena, information, records, or testimony about the client may have to be produced.

I, the client/guardian, have the right to review and/or receive a copy of the client's protected health information. If the treating clinician deems that releasing such information might be harmful in any way, the clinician will either deny my request or provide the records to an appropriate and licensed mental health professional of the client/guardian's choice.

I, the client/guardian, may end treatment at any time by notifying the therapist in person or by telephone.

**Financial Policies** – I, the client/guardian, assume primary financial responsibility for all professional services rendered and understand that any balance due will be billed to me on a monthly basis. I, the client/guardian, am responsible for the standard fee of \$\_\_\_\_\_ per session. Payment is due at the time that services are provided. An additional charge may be added for payments received after the date of service.

Insurance co-payment per session is \$\_\_\_\_\_.

**Cancellation Policy** - If the client misses an appointment or cancels an appointment without giving 24 hours notice I, the client/guardian, will be charged \$\_\_\_\_\_for the missed session. Missed appointments and late cancellations are not covered by insurance.

Services provided outside of the client's usual scheduled session (i.e., telephone consultations, site visits, travel time, longer sessions, etc.) may be charged to me, the client/guardian, at the clinician's standard fee unless otherwise agreed upon.

If payment of the client's account is over 120 days late, or if it goes to collection, all fees including collection and attorney fees will be my, the client/guardian's, responsibility.

**Insurance Policies** - I, the client/guardian, consent to have claims submitted to the client's insurance company. Yes \_\_\_\_\_ No \_\_\_\_\_

I, the client/guardian, am *ultimately* responsible for charges incurred even though services will be billed to the client's insurance. PsychStrategies will bill the client's primary insurance only. PsychStrategies will not bill a secondary insurance (except when MediCare is the primary insurance). A receipt for services can be provided upon request. I, the client/guardian, understand that not all issues/conditions/problems that may be the focus of treatment are reimbursed by insurance companies. I understand that the client's insurance benefit may only provide for crisis intervention, and that, therefore, a brief therapy model with solution-focused therapy or problem-solving techniques may be used by the clinician.

I, the client/guardian, consent to have PsychStrategies release the client's protected health information to the client's insurance company in order to receive payment for claims. I understand that the client's protected health information will include diagnostic information, dates of service, and other information as requested by the client's insurance company for payment. I, the client/guardian, understand that PsychStrategies has no control over or knowledge of what insurance companies do with the submitted information or who has access to this information after it is released.

**It is my, the client/guardian's, responsibility to verify the specifics of the client's insurance coverage and be aware of and inform PsychStrategies of any changes that may occur to the client's insurance coverage. It is my, the client/guardian's, responsibility to be aware of the amount of the client's insurance co-payment and any changes to the amount of the client's co-payment.**

**General PsychStrategies Policies** - I, the client/guardian, consent to release the client's protected health information to all PsychStrategies clinicians who participate in the client's treatment.

**EMERGENCY PROCEDURES**

- **Non-emergency:** To contact my clinician between sessions, I, the client/guardian, can leave a message on the voice mail number provided. Clinicians check messages regularly during the week.
- **Urgent:** If I am unable to reach my clinician by phone about an urgent situation, I, the client/guardian, may call 526-8300 (ext 4) between 6PM and 9AM and on weekends and holidays. The PsychStrategies On-Call clinician returns calls within one hour.
- **Emergency:** If I(the client/guardian) think I or the client is having an emergency, I will call 911 or go to the nearest Emergency Room with the client.

**Satisfaction Survey** – I agree to allow PsychStrategies to mail a Satisfaction Survey to my mailing address. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ The Satisfaction Survey may be mailed within one year of your first appointment.

**Appeals and Grievances** - If the client's insurance company denies additional sessions, I, the client/guardian, may appeal for additional sessions.

If I, the client/guardian, am dissatisfied with any action taken by PsychStrategies, I must notify PsychStrategies in writing within ten (10) business days. The letter should be addressed to:

PsychStrategies  
1160 N Dutton Ste 230  
Santa Rosa, CA 95401

Appeals to decisions made by PsychStrategies may be made directly to my insurance company. I, the client/guardian, may submit a grievance to the client's insurance company to register a complaint about services. Grievances regarding your insurance company can be made to the Department of Managed Healthcare at 800-400-0815.

**Yes**\_\_\_ **No**\_\_\_ **I, the client/guardian, request a copy of this form.**

*If requested, a copy of this form was provided to the client/guardian. Date:\_\_\_\_\_ Staff Initials:\_\_\_\_\_*

**I have read the above statements, understand them, and agree to comply with them:**

Client/Legal Dependent Name (Print)	Date	Signature
Client/Legal Guardian Name (Print)	Date	Signature
Clinician Name (Print)	Date	Signature



# PSYCHSTRATEGIES, INC.

## Acknowledgment of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that PsychStrategies, Inc. has given you. The *Notice of Privacy Practices* provides information about how PsychStrategies, Inc. may use and disclose your protected health information. You are encouraged to read it in full.

The *Notice of Privacy Practices* is subject to change. If PsychStrategies, Inc. changes its *Notice of Privacy Practices*, you may obtain a copy of the revised form from your clinician, from our web site at [www.PsychStrategies.com](http://www.PsychStrategies.com) or by contacting our main office at (707) 526-8300.

Please discuss any questions about the *Notice of Privacy Practices* of PsychStrategies, Inc. with your clinician.

I acknowledge receipt of the Notice of Privacy Practices of PsychStrategies, Inc.

\_\_\_\_\_  
Signature of Client/Guardian

\_\_\_\_\_  
Date

## Inability to Obtain Acknowledgment of Receipt of Notice of Privacy Practices

I made good faith attempts to obtain my client's acknowledgment of his/her receipt of the *Notice of Privacy Practices* of PsychStrategies, Inc., including \_\_\_\_\_  
(describe good faith attempts)

However, because of \_\_\_\_\_  
(reason(s) why acknowledgment was not obtained)

\_\_\_\_\_ I was unable to obtain my client's  
acknowledgement.

\_\_\_\_\_  
Signature of Clinician

\_\_\_\_\_  
Date