

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(For Clinician Records)

By my signature below I, (client name) _____, acknowledge that I received a copy of the Notice of Privacy Practices for Max Stager, MA, LPC, NCC.

X _____
Signature of client (or personal representative) Date

If this acknowledgment is signed by a personal representative, including parent or guardian, on behalf of the client, complete the following:

Personal Representative's Printed Name: _____

Relationship to Client: _____

This form will be retained in your medical record.

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgement
 - An emergency prevented us from obtaining acknowledgement
 - Other: _____
-
-

ICQ - INITIAL CLIENT QUESTIONNAIRE

The purpose of this questionnaire is to obtain information about the client, whether that is you or your family member. In psychotherapy, accurate records are necessary since they permit a more thorough understanding of you or your family member. Completing these questions as fully and as accurately as you can is greatly appreciated. Case records are strictly confidential.

1. CONTACT INFORMATION

Client is child and the name of person completing this form is: _____

Name of Client: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different): _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I give permission for Max Stager:

To leave a message with the person answering the phone To contact me via email

Emergency Contact's Name: _____ Relationship to Client: _____

Phone Numbers: _____

2. REFERRED BY: Professional Clinic Friend Family member Web Site

I give permission for Max Stager to thank referral person. Name: _____

3. DEMOGRAPHICS

Gender: M F Date of Birth: _____ Age: _____ Highest Grade Completed: _____

Marital Status (check one): Single Cohabitation Married Separated Divorced Widowed

Name of & Length of Relationship with Significant Other: _____

If client is adult, number of Children: _____ If client is child, number of siblings: _____

Names and Ages: _____

4. PHYSICAL & HEALTH

(For trauma processing) If client is a female, is the client pregnant? Yes No

Does the client have any current physical health problems and/or is taking medications? If yes, please explain:

5. PSYCHOLOGICAL TREATMENT

Has the client ever been treated for psychological problems? Yes No

Explain: _____

Has the client ever been prescribed psychotropic medications? Yes No

Explain: _____

6. SUBSTANCE USE

Check any of the following that have applied to the client in the past month:

<u>Substance</u>	Never	Rarely	Occasionally	Frequently
Alcohol	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Cannabis	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____
Hallucinogens	_____	_____	_____	_____
Heroin	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Narcotics	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____
Over the Counter Meds	_____	_____	_____	_____
Tranquilizers	_____	_____	_____	_____

7. DEVELOPMENTAL HISTORY (For clients under 18 years old)

Problems during Mother's Pregnancy: _____

Birth: Normal Delivery Difficult Delivery Cesarean Delivery Complications: _____

Infancy Problems: Feeding Sleep Toilet Training Other

Delayed Developmental Milestones: Sitting Rolling Over Standing Walking Feeding Self
 Speaking Words Toilet Training

Childhood Health Issues (Illnesses, Allergies, Significant Injuries, Other): _____

- Emotional/Behavioral Problems:**
- | | |
|---|---|
| <input type="checkbox"/> Abuse—physical, sexual, emotional, neglect | |
| <input type="checkbox"/> Academic Problems | <input type="checkbox"/> Aggression, Breaks Things, Fighting, Hostile, Violent |
| <input type="checkbox"/> Anger, arguing, irritability | <input type="checkbox"/> Animal Cruelty <input type="checkbox"/> Anxious, Nervous, Jittery, Worries |
| <input type="checkbox"/> Attachment Problems | <input type="checkbox"/> Attention, Concentration, Daydreaming, Distractibility |
| <input type="checkbox"/> Authority Conflicts | <input type="checkbox"/> Bizarre Behavior <input type="checkbox"/> Cries frequently and/or easily |
| <input type="checkbox"/> Depression, low mood, sadness, crying | <input type="checkbox"/> Disobedient |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Encopresis (wetting) <input type="checkbox"/> Enuresis (soiling) |
| <input type="checkbox"/> Fire-setting | <input type="checkbox"/> Hyperactive (e.g., cannot sit still) and Impulsive (e.g., blurts out things) |
| <input type="checkbox"/> Immaturity | <input type="checkbox"/> Indecisiveness <input type="checkbox"/> Lying and/or Stealing |
| <input type="checkbox"/> Relationship problems (with friends, with relatives, or at work) | <input type="checkbox"/> Running Away |
| <input type="checkbox"/> School problems (e.g., underachieving) | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Self-Injurious Behavior | <input type="checkbox"/> Separation Anxiety <input type="checkbox"/> Sex Play (Inappropriate) |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Sleep problems <input type="checkbox"/> Social Anxiety |
| <input type="checkbox"/> Spiteful and Vindictive | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Temper problems, Self-control, Low frustration tolerance | |

Current or Highest Education Level: _____

Comments or other developmental problems or issues: _____

FINANCIAL INFORMATION

Client Name: _____ Client Insurance ID #: _____
Client's Date of Birth: _____ Client's Soc Sec #: _____

Please Check Type of Payment: Private Payment or Third-Party Payer: Private Pay

- Aetna Ameriben Blue Cross/Blue Shield Cerdian EAP ComPsych EAP/Beh Health
 Kaiser Permanente MHN/Managed Health Network Multiplan Network Advantage
 Rothenberg Harris International TriCare/Triwest United Behavioral Health
 Value Options Other: _____

Third Party Payer (Insurance Company or EAP) Information:

Policy Holder Name (if different than client): _____
Policy Holder Date of Birth (if different than client): _____
Policy Holder's Social Security # (if different than client): _____
Policy Member ID: _____ Policy Group ID: _____
Company Address: _____
Phone: _____ Fax: _____
Authorization or Certification Number: _____

Must a Primary Care Physician (PCP) or Primary Care Manager (PCM) refer the client? Yes No

If so, have you been referred by your PCP or PCM? Yes No

Credit/Debit Card Information for Missed Appointment Fees

Name on Credit Card: _____ Type: Mastercard VISA Discover
Credit Card Number: _____ Credit Card Security Number: _____

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I/we request that Max Stager, Licensed Professional Counselor (referred to, below, as the "therapist") provide professional services (check all that apply): For me (adult individual) For my child or family

For me and my significant other (marital or couples counseling) For the following person: _____

I/we choose (check and complete one statement below):

I/we agree to pay the therapist fee of \$100 for 60-75 minute of services, which include assessments, psychotherapy, parent/family consults, brief phone consultations, and brief reports (for other professionals) as well as the late cancellation or missed appointment fee of \$100 if necessary.

I/we choose to utilize the **insurance company** or **employee assistance program** identified above in the financial information section. Most sessions are usually 45-50 minutes in length. I/we agree to pay the co-pay of \$ _____, the deductible of \$ _____, and any fee not covered by that third party payer as well as the late cancellation or missed appointment fee, (these vary from \$30 to \$75, depending on the contracted rate this office should have received unless the missed appointment fee is prohibited by the third party payer). I/we give this office permission or authorization to release any information obtained during assessment or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist.

Missed Appointments: I/we agree to pay the missed appointment fee if we fail to cancel an appointment 24 hours in advance. (Please see the missed appointment policy discussed in the Psychotherapy Policies for more information.)

I/we agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I/we inform him, in person or by certified mail, that I/we wish to end therapy. I/we agree to meet with this therapist at least once before stopping therapy. I/we agree to pay for services provided to me/us (or this client) up until the time I end the relationship. Balances not paid within 120 days may be sent to a collection agency unless a payment plan is agreed upon. I/we understand that I/we am/are ultimately responsible for all charges, regardless of insurance coverage or third-party payer.

Client Signature Date

Parent/Guardian Signature Date

Partner/Spouse Signature Date

Max Stager, MA, LPC, NCC Date

CHECKLIST OF CONCERNS (Adults)

Instructions: Check each concern that you currently have from the list below.

- Abuse—physical, sexual, emotional, neglect as child Aggression, hostility, violence
- Alcohol or Drug Use (prescription medications, over-the-counter medications, street drugs)
- Anger, arguing, irritability
- Anxiety, nervousness Attention, concentration, distractibility
- Career concerns, goals, and choices Childhood issues (your own childhood)
- Codependence Confusion Compulsions
- Custody of children Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas) Dependence Depression, low mood, sadness, crying
- Divorce, separation
- Eating problems—overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)
- Emptiness Failure Fatigue, tiredness, low energy
- Fears, phobias Financial or money troubles, debt, impulsive spending, low income
- Friendships Gambling Grieving, mourning, deaths, losses, divorce
- Guilt Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores—quality, schedules, sharing duties
- Inferiority feelings Interpersonal conflicts
- Impulsiveness, loss of control, outbursts Irresponsibility
- Judgment problems, risk taking Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- Memory problems Menstrual problems, PMS, menopause
- Mood swings Motivation, laziness
- Nervousness, tension Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection Panic or anxiety attacks
- Parenting, child management, single parenthood Perfectionism
- Pessimism Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems (see also “Career concerns . . .”)
- Self-centeredness Self-esteem Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion Threats, violence
- Weight and diet issues Withdrawal, isolating
- Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition