Pattison Professional Counseling Center

259 East Oakdale Avenue, Crestview, FL 32539
7 Vine Avenue, NE, Fort Walton Beach, FL 32548

Name _____ Date: _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Birth Date _____

Marital Status:

____ Single
____ Married
____ Divorced
____ Separated
____ Widowed
____ Other

Employment Status:

____ Employed
____ Part Time Student
____ Full Time Student

Condition Related To:

Employment ____Yes ____ No
Auto Accident ____Yes ____ No
Other Accident ____Yes ____ No
Which State: _____

Responsible Party (if client is a minor, please indicate parent information):

Name _____ Date: _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Birth Date _____

Relationship to Client: _____

Provider you will be seeing: _____

Thank you for choosing Pattison Professional Counseling Center. We are interested in knowing how we were selected to serve you. How were you referred to us?

____ Yellow Pages ____ Talking Phone Book ____ Friend/Relative
____ Internet ____ Television/Radio ____ DUI School/Probation/Parole
____ Doctor (_____) ____ Other
____ Another Therapist (_____)

Pattison Professional Counseling Center

Primary Insurance Information

Please provide your insurance card so we may have a copy on file.

Insurance Company _____ ID Number _____

Policy Holder's Name _____ Policy Number _____

Policy Holder's Date of Birth _____

Policy Holder's Social Security Number _____

Employer or Company Name _____ Group Number _____

If Tricare: ___Standard ___Prime ___Active Duty ___Retired ___Deceased ___Other

Sponsor's Name _____

Sponsor's Date of Birth _____ Sponsor's Social Security No. _____

Secondary or Supplemental Insurance Information

Please provide your insurance card so we may have a copy on file.

Insurance Company _____ ID Number _____

Policy Holder's Name _____ Policy Number _____

Policy Holder's Date of Birth _____

Policy Holder's Social Security Number _____

Employee Assistance Program (EAP) Information

Name of EAP _____ ID Number _____

Name of Employee _____ Relationship to Client _____

Name of Employer or Company _____

If you do not have insurance, please indicate your annual income so that an appropriate sliding scale fee may be determined: _____

Medical History

This medical information is used to detect possible medical problems that may require a doctor's attention. Responses may result in the recommendation that you see your doctor for a physical examination.

Your Physician's Name _____ Allergies _____

Current Medications _____

Please check the symptoms or conditions that have applied to you at any time:

__ Alcoholism
__ Allergies
__ Anemia
__ Cancer/Tumors
__ Diabetes
__ Drug abuse
__ Epilepsy
__ High blood pressure
__ Eating problems
__ Hearing problems
__ Kidney disease
__ Head trauma
__ Seizures
__ Stroke
__ Heart disease

Please check the symptoms or conditions that frequently apply:

__ Abdominal pain
__ Bed wetting
__ Breathing difficulty
__ Chest pain
__ Colds
__ Constipation
__ Decreased appetite
__ Diarrhea
__ Fainting
__ Frequent urination
__ Headaches
__ Menstrual pain
__ Nausea
__ Numbness
__ Sleep disturbance
__ Stomachaches
__ Vision changes
__ Chills/Hot flashes
__ Sweating
__ Heart pounding
__ Rapid heart beat
__ Shortness of breath
__ Dizziness
__ Fatigue
__ Skin problems
__ Stuttering
__ Blackouts
__ Choking sensations
__ Trembling/shaking
__ Tic/Twitches
__ Muscle tension
__ Muscle spasms
__ Jaw pain
__ Muscle or joint pain
__ Sexual problems
__ Other: _____

Chief Concern

Please describe the primary problem/concern for which you have come to the office:

_____

_____

_____

_____

_____

_____

_____

What do you consider to be the top three stressors in your life?

1) _____

2) _____

3) _____

Do you have problems with your work performance or boss? ___ Yes ___ No

If yes, explain: _____

_____

Do you have any legal problems? ___ Yes ___ No

If so, please state: _____

_____

Who/what is your support system? _____

Psychological Symptoms

Emotions: *(Select any of the following emotions that you find troublesome and/or apply to you in the last month.)*

__ Hopeless	__ Happy	__ Fearful	__ Confused
__ Tense	__ Contented	__ Anxious	__ Angry
__ Distrustful	__ Lonely	__ Jealous	__ Guilty
__ Sad	__ Helpless	__ Bored	__ Frustrated
__ Excited	__ Energetic	Relaxed	Restless
__ Suspicious	__ Other: _____		

Behaviors: *(Select any of the following behaviors that you find troublesome and/or apply to you in the last month.)*

__ Under eating	__ Temper outburst	__ Impulsiveness
__ Vomiting	__ Aggressive	__ Hurting others
__ Over eating	__ Nightmares	__ Spending sprees
__ Crying	__ Decreased interest	__ Odd behavior
__ Sleeping problems	__ Increased drinking	__ Hurting self
__ Impulsiveness	__ Isolation	__ Social withdrawal
__ Increased energy	__ Increased smoking	__ Flashbacks
__ Loss of control	__ Fears	__ Unable to keep job
__ Decreased energy	__ Taking too many risks	Concentration problems
__ Avoiding activities, places, people	__ Mood altering with drugs	

__ Other: _____

Mental Health History

Have you previously been seen for a mental health reason, in an office, clinic, or hospital? ___ Yes ___ No

If yes, please indicate below the date(s), location(s), Inpatient/Outpatient, and the diagnosis:

Date	Facility	Inpatient/Outpatient	Diagnosis

Do you currently have trouble with alcohol and/or drugs? ___Yes ___No
If yes, explain: _____
Have you had trouble with alcohol and/or drugs in the past? ___Yes ___No
If yes, explain: _____
Have you been treated in the past for substance abuse? ___Yes ___No
If yes, explain: _____
If yes, are you actively working a recovery program? ___Yes ___No

Family History

Please state which family members may have had any of the following:

Mental illness _____ Alcoholism _____
Mental retardation _____ Other substances _____
Cancer/Tumors_____ Heart disease _____

Any history of physical, sexual, emotional, or mental abuse? ___Yes ___No

Educational History

What is the highest grade / level of education you have completed? _____

Did you have any conduct or behavioral problems in school? ___ Yes ___ No

If yes, explain: _____

_____

Did you have a learning disability or need for special educational services?
___ Yes ___ No

If yes, explain: _____

_____

Goals for Treatment

What are your goals for treatment and what would you like to see change or be different? _____

_____

_____

Informed Consent / Treatment Agreement

I agree to make a commitment to the treatment process. I understand this means I agree to active involvement in all aspects of treatment, including:

- Attending sessions (or letting my provider know when I cannot make it)
- Voicing my opinions, thoughts, and feelings honestly and openly, whether negative or positive
- Being actively involved during sessions
- Completing homework assignments
- Experimenting with new behaviors and new ways of doing things
- Taking medication as prescribed
- Implementing my crisis response plan

I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. If it is not working, I will discuss it with my provider.

Patient's Signature _____ Date: _____

Substance Abuse/Alcohol Screening

1. At what age did you first drink alcohol? _____
2. Who introduced you to alcohol? _____
3. How much do you drink?_____
4. What do you drink? _____
5. Date of last drink: _____
6. Are any members of your family heavy drinkers or alcoholics? _____
7. What is your drinking pattern?
   ___alone ___daily ___weekly ___ binges ___other _____
8. Has your drinking been problematic with any of the following?
   ___ spouse ___children ___extended family ___ friends ___work ___other_____
9. Have you ever been arrested related to drinking?
   ___DWI/DUI ___drunken fights ___disorderly behavior ___underage drinking ___other_____
10. Have you ever been hospitalized for alcohol use? _____
11. What are your symptoms?
    ___blackouts ___tremors ___D.T.s ___seizures ___hallucinations
    ___other _____
12. Have you ever taken Dilantin or any other drugs for seizures? _____
13. Are you aware of changes in the amount of alcohol required to get the effect you want?_____
14. Do you have, or were you treated for:
    ___ pancreatitis ___cirrhosis ___hepatitis ___esophagitis
15. Have you had previous treatment?
    ___detoxification ___rehabilitation ___halfway house ___outpatient ___other _____
16. Have you experienced tingling, pain, or numbness in your hands or feet (neuropathy)? _____
17. Have you ever attended AA meetings? _____
18. Have you ever had a sponsor?_____

Drug History

1. At what age did you first use drugs?_____
2. Who introduced you to drugs? _____
3. Have you ever been arrested for using and/or selling drugs? _____
4. Do you expect to benefit from this program? _____
   If so, how?_____
   If not, why not? _____
5. Have you received any other type of mental health treatment or counseling?_____
   If so, why, when, and where? _____
6. Have you ever attempted suicide? _____ If so, when and how? _____
   _____

Drug History, continued

Have you used any of the following drugs?

___marijuana	age at 1st use_____	frequency_____	last used _____
___inhalants	age at 1st use_____	frequency_____	last used _____
___cocaine	age at 1st use_____	frequency_____	last used _____
___crack	age at 1st use_____	frequency_____	last used _____
___heroin	age at 1st use_____	frequency_____	last used _____
___methadone	age at 1st use_____	frequency_____	last used _____
___tranquilizers	age at 1st use_____	frequency_____	last used _____
___Valium	age at 1st use_____	frequency_____	last used _____
___Librium	age at 1st use_____	frequency_____	last used _____
___Quaaludes	age at 1st use_____	frequency_____	last used _____
___pills	age at 1st use_____	frequency_____	last used _____
___dust	age at 1st use_____	frequency_____	last used _____
___LSD/PCP	age at 1st use_____	frequency_____	last used _____
___black tar	age at 1st use_____	frequency_____	last used _____
___prescription	age at 1st use_____	frequency_____	last used _____
___over the counter	age at 1st use_____	frequency_____	last used _____
___other	age at 1st use_____	frequency_____	last used _____

Analysis of Current Problems

1. Circle any of the current behaviors that apply to you:

weight gain/loss	suicide attempts	lazy	frequent crying	drinking too much
self harm	loss of control	withdrawal	smoking	working too hard
can't keep a job	sleep problems	using drugs	extreme fears	outbursts of temper
hyperactive behavior	working too much	other _____		

2. Circle any of the feelings that often apply to you:

anger	bored	content	jealous	optimistic
unhappy	guilty	hopeless	relaxed	helpless
energetic	confused	sad	lonely	restless
hopeful	tense	rested	happy	depressed
panic	joyful	ashamed	other _____	

3. Circle any of the physical symptoms that apply to you:

headaches	tiredness	blackouts	sexual problems	fainting spells
stomachaches	chest pain	tensions	tremors	forgetfulness
dry mouth	twitches	back pain	numbness	hearing things
dizziness	rapid heart beat	tingling	spasms	excessive sweating

other _____

4. Identify any serious health problems that you have (include dates). _____

_____

Domestic Violence Report

Physical Abuse: Have you done the following to your partner?

	Yes	No	How Often	Comments
Slapped	____	____	_____	_____
Punched	____	____	_____	_____
Choked	____	____	_____	_____
Pulled hair	____	____	_____	_____
Pushed	____	____	_____	_____
Restrained	____	____	_____	_____
Kicked	____	____	_____	_____
Used weapon	____	____	_____	_____
Thrown things	____	____	_____	_____
Other	____	____	_____	_____

	Yes	No
Coercion and Threats: Have you?		
Threatened to take the children away from your partner?	____	____
Threatened suicide?	____	____
Threatened to injure your partner or children?	____	____
Threatened to hurt your partner's friends or family?	____	____
Threatened to destroy property?	____	____
Threatened to leave your partner?	____	____
Insist your partner take part in illegal activities?	____	____
Threatened your partner if she didn't drop charges against you?	____	____
Using Intimidation: Have you?		
Made your partner afraid by looks, actions, or gestures?	____	____
Yelled, pounded your fist, or punched walls?	____	____
Smashed things in front of your partner?	____	____
Driven recklessly with her in the vehicle?	____	____
Hit or mistreated pets?	____	____

Domestic Violence Report, continued

	Yes	No
Emotional Abuse: Have you?		
Put down your partner or called her names?	_____	_____
Told your partner not to feel a certain feeling (sad, hurt, angry)?	_____	_____
Humiliated your partner?	_____	_____
Using Isolation: Have you?		
Kept your partner from going to work, school, out with friends?	_____	_____
Listened to your partner's phone calls?	_____	_____
Followed your partner around?	_____	_____
Told your partner that she is not spending enough time at home?	_____	_____
Asked your partner what was said and done while she was out?	_____	_____
Minimizing, Denying, and Blaming: Have you?		
Made light of the abuse and did not take seriously your partners' concerns?	_____	_____
Told others that the abuse didn't happen?	_____	_____
Told your partner that she was the cause of the abuse?	_____	_____
Blamed alcohol or drug use for the cause of the abuse?	_____	_____
Using Children: Have you?		
Tried to make your partner feel guilty about the children?	_____	_____
Used the children to relay messages?	_____	_____
Used visitation to harass your partner?	_____	_____
Threatened to take the children away?	_____	_____

Notice of Privacy Policies and Communications

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

Pattison Professional Counseling Center (PPCC) discloses patient information relating to treatment, payment, and health care operations. This information is shared with other health care providers, insurance companies, managed care companies, and other professionals.

Your health care information may be used to obtain an explanation of your health benefits and to obtain authorizations to continue treatment. Insurance/managed care companies receive treatment reports and clinical information upon request. Patient information may be disclosed for utilization reviews and for quality assurances.

Patient information is exchanged among health care providers. For example, patient information regarding diagnosis, symptoms, treatment recommendations, medication, family history, medical conditions, drug or alcohol use, and other clinical information provided by the patient is discussed among the clinician, medical doctor, psychologist, and/or other health care professionals who are involved in the patient's treatment.

PPCC may call your home or work to discuss treatment or scheduling of appointments. We may leave a message on your answering machine to remind you of your appointment or request that you return our call. The clinician's name, phone number, the office of affiliation, and the time of your appointment may be left on the answering machine. If any individual other than you answers the home telephone, the information will be given to that individual. If we call your work and you are not the individual taking the call, we will state the name of our company and our phone number to the individual answering the phone and request that you return our call.

Federal and state laws obligate PPCC to protect and safeguard all patient information. Protected health information consists of, but is not limited to, a client's name, address, phone number, and medical treatment information. The law states that our clients have the right to confidentiality, and therefore, we are obligated to insure that their protected health information remains private and confidential. If you become aware of the inappropriate disclosure of your or another client's protected health information, please report the disclosure to: Pattison Professional Counseling Center, Attn: Susan Page, 7 Vine Avenue, NE, Fort Walton Beach, FL 32548.

Upon request you may receive an accounting of all disclosures regarding your health care information. You have the right to place restrictions on the patient information that is released by PPCC. Furthermore, PPCC is required to maintain a designated record set, which includes patient medical information and billing information. You have the right to inspect, copy, and amend the patient health care information maintained in your designated record set. In order to inspect, copy, amend, or request restrictions on our health care information, please call your clinician at our office at (850) 226-4098 (Fort Walton Beach) or (850) 398-5255 (Crestview), or mail your request to Pattison Professional Counseling Center, 7 Vine Avenue, NE, Fort Walton Beach, FL 32548.

There are exceptions regarding your right to amend, copy, inspect, and restrict the release of protected health information. Information that is accurate and complete cannot be amended. Documents that are not created by PPCC may not be amended, copied, or inspected. Documents that are included in litigation may not be inspected, copied, amended, or restricted from release. Psychotherapy notes are not a part of the designated record set and, therefore, are excluded. Furthermore, other state, federal, or governmental laws may overrule your right to inspect, amend, and restrict the release of your protected health information.

_____ _____

Signature of Client/Guardian Date

Pattison Professional Counseling Center

Finanical Policy

Thank you for choosing Pattison Professional Counseling Center. We are committed to your successful treatment. The following is our financial policy, which we request you read, understand, and sign prior to treatment.

Insurance: Your insurance policy is between you and your insurance company. We are not a party to that contract. If services are not covered by your insurance policy, you are responsible for all session fees. We do accept assignment of benefits from insurance companies with which we are participating providers. All Tricare/Champus clients must obtain a doctor's referral in order to file the insurance claims. If the client does not obtain a referral and insurance cannot be filed, the client is responsible for the entire session charge. We will file your insurance claims for you, either by paper claim or electronically, unless otherwise specified by you.

Assignment of Benefits: I assign my insurance benefits to Pattison Professional Counseling Center for the duration of my treatment.

Payments: All payments, co-payments or deductibles are due after each session. If your co-payment is not known on the first date of service, a co-payment of $20.00 will be collected at the time of each session until your correct co-payment can be determined. We accept cash, checks, money orders, Visa, MasterCard, and American Express for payments. We can also keep your credit card number on file and charge your card with your cost share after each visit.

Missed or Cancelled Appointments: 24-hour notification is required if you need to cancel or reschedule your appointment. A minimum of $30.00 will be charged to your account if you do not show for your scheduled appointment or give us 24-hour notification. For psychiatric patients, a minimum of $50.00 will be charged. If calling to cancel or reschedule your appointment after business hours, please leave your name, appointment date and time, and a brief message on our voice mail. We appreciate your assistance in helping us serve you better by keeping scheduled appointments.

Billing: Payment for all client statements is due in full upon receipt. A divorce decree cannot assign responsibility for an adult or child's account. Failure to pay your bill could result in your account being turned over to a collection agency. Only your name and account status will be discussed with the collection agency.

Returned Checks: A $30.00 service fee will be added to your account for each returned check from your bank. Only cash payments will be accepted if two NSF checks are received.

My signature acknowledges that I have read, understand, and agree to all parts of the financial policy of Pattison Professional Counseling Center. I also understand that my account will be turned over to a collection agency if it becomes delinquent.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Witness Date

Client Rights

I have the right to efficient and effective care individualized to my needs. My treatment provider will work with me to develop a treatment plan best suited to me. We will use this plan to help us deal with my problems as quickly and effectively as possible.

I have the right to be treated with dignity and respect. I will be treated with respect at all times. I will report any misconduct by my treatment provider, including social invitations, suggestive remarks, or unwanted touching, to PPCC management. I may call PPCC any time with questions, comments, or complaints.

My treatment provider will make every effort to meet me at our scheduled appointment time. If my treatment provider is late, he or she will extend our session, if I am willing, or we will make other arrangements by mutual agreement.

I have a right to privacy and confidentiality. All records and communications will be treated with confidentiality in compliance with applicable state and federal laws. These laws may obligate PPCC to report suspected abuse or neglect, domestic violence, and those who pose a danger to themselves or others, or when ordered to by a court of law.

Client Responsibilities

Scheduled appointments are commitments. I will make every effort to be on time for my appointment(s). I understand that time will be lost from my session if I am late for my appointment.

I am responsible to pay for services received. I am aware my insurance plan typically requires me to pay a co-payment (a dollar amount) or co-insurance (a percentage of my treatment provider's fee) at the time services are provided. My insurance plan may also have a deductible (an initial dollar amount) that is my responsibility. Additionally, certain services may be limited and/or not covered at all by my insurance plan. I understand I am financially responsible for co-payments, co-insurance, deductibles, and all services not covered by my insurance plan. My treatment provider and my insurance plan's representative will help me determine what services my insurance plan covers.

I have read this list of rights and responsibilities or had them read to me. I understand and agree to them.

_____ _____

Print Name Date

_____

Signature