ADULT INFORMATION SHEET

Provider: Judith Allston, LCSW

Today's Date: _____

Full Name (first, middle initial, last):_____

Street Address:_____

City/State/Zip:_____

Home Phone:(___)_____ Work Phone:(___)_____

Cellular Phone:(___)_____ Pager:(___)_____

Age:____ Birthdate:_____ Sex:____ Social Security #:_____

Occupation:_____ Employer:_____

Marital Status:_____ Date Married:_____ Previous Marriages?:_____

Education:_____ Religion:_____

Spouse's/Partner's Name:_____

Street Address:_____

City/State/Zip:_____

Home Phone:(___)_____ Work Phone:(___)_____

Cellular Phone:(___)_____ Pager:(___)_____

Age:____ Birthdate:_____ Sex:____ Social Security #:_____

Occupation:_____ Employer:_____

Education:_____ Religion:_____

In case of emergency, call_____

Phone: (___)_____ Relationship to you:_____

There may be occasions in which our office needs to contact you concerning your appointments, billing problems, or any other situation relating to your visit at our office. Please indicate if you give our office permission to leave messages (on an answering machine or with anyone that answers the phone) at the following locations:

Home Phone:	Yes	No
Work Phone:	Yes	No
Cell Phone:	Yes	No

Other numbers we may use to contact you:_____

_____

List children:

Name _____ Age Education Occupation Resides _____

_____

_____

_____

List parents/siblings:

Name _____ Relationship Age Education Occupation Resides _____

_____

_____

_____

Who referred you? _____ Phone:(___) _____ May I contact him/her to acknowledge the referral? YES NO

Briefly describe your reason for seeking help now: _____

_____

How long has this been a problem for you? _____

Primary Care Physician: _____ Phone ( ) _____

Do you want this office to file insurance claims for you? YES NO
If "YES," complete this section. If "NO," skip this section.

Have you called your insurance company to pre-authorize these services? YES NO

Primary Insurance: _____ Policyholder: _____

Relationship to Policyholder: _____ Policyholder's Date of Birth: _____

Policy/ID#: _____ Group #: _____

Claims Address: _____

_____

Secondary Insurance: _____ Policyholder: _____

Relationship to Policyholder: _____ Policyholder's Date of Birth: _____

Policy/ID#: _____ Group #: _____

Claims Address: _____

_____

Are you experiencing any legal problems? YES NO (If YES, please explain) _____

_____

Who is responsible for the bill? _____

Will you be paying today by: Check_____ Cash_____ Credit Card_____

THANK YOU for completing this questionnaire. *PLEASE* let me know if any of the above information changes.

PROFESSIONAL PSYCHOTHERAPY ASSOCIATES
1002 Bradford Way Kingston, TN 37763
Phone (865) 376-1585 FAX (865) 376-1587

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Judith A. Allston, LCSW to release to my insurance company and/or insurance plan management company information requested on the HCFA-1500 claim form and/or the plan management company's outpatient treatment report for the purpose of pre-authorizing services and/or processing claims for reimbursement of services rendered by above-named therapist. I also authorize above-named therapist to release the information necessary to secure full payment of my account through other parties, such as a collection agency/credit bureau or court of law, if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and direct my Insurance Company and/or insurance plan management company to pay Judith A. Allston, LCSW such amount as may be payable pursuant to the provision of my contract.

I also authorize above-named therapist to initiate a complaint to the Insurance Commissioner on my behalf if my insurance company fails to respond to a claim or to pay a claim in a timely fashion.

Date:_____ Patient or Guardian's Signature:_____

PAYMENT AGREEMENT

I accept responsibility for payment of fees for services provided to myself and/or my dependent by Judith A. Allston, LCSW. I understand and agree that having health insurance coverage does not relieve me of full responsibility for all charges, even when the therapist agrees to accept direct payment of benefits from the insurance and/or the plan management company. I understand that my insurance benefits may not pay for all charges incurred by my dependent or myself. I understand that I may be charged for appointments not canceled 24 hours in advance and agree to pay those charges. I further agree to pay all charges (such as collection agency commissions, attorney's fees, court costs, returned check charges) incurred by above-named therapist in the pursuit of payment for my delinquent account balance in addition to the full balance of my account. I also understand that interest charges may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information . Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Judith Allston, LCSW
Licensed Clinical Social Worker

I, _____, understand and have been provided a copy of Ms. Allston's Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Patient Signature or Parent if Minor or Legal Charge Date
If Legal Charge, describe representative authority: _____

PSYCHOSOCIAL HISTORY-ADULT

Thank you for taking the time to fill out this information. It will be helpful to your therapist in giving you the best treatment. Professional Psychotherapy Associates does not discriminate against any individual based on race, creed, religion sex, age, handicap, or national origin. If you need help filling this out, please tell the receptionist.

Client Name:_____

Marital Status: ____Single ____Separated ____Divorced ____Married
____Widowed ____Remarried ____Living Together ____Partnered

Number of Marriages and Dates:_____
Previous Marriages of Spouse:_____

Name of Children	Date of Birth	Living with you? ___Yes ___No
_____	_____	___ ___
_____	_____	___ ___
_____	_____	___ ___
_____	_____	___ ___

Others in your household
_____
Emergency contact person and phone:_____

Briefly describe your reason for contacting us_____
_____
How long has this been a problem for you?_____
Why did you decide to seek help now?_____
_____
Have you had counseling or treatment before?_____Was it helpful?____
What others ways have you tried to handle this problem?_____
_____
Please list with phone number any other persons it might be helpful for us to contact in order to assist you. (We will not contact anyone without a specific written Release of Information._____
_____
_____

	Does not Apply	Not Very Serious >>>>>>>>>>>>				Very Serious
Please circle how serious this problem is for you		1	2	3	4	5
How has this problem affected your:						
Marriage/Partner	_____	1	2	3	4	5
Family	_____	1	2	3	4	5
Job or School Performance	_____	1	2	3	4	5
Friendships	_____	1	2	3	4	5
Financial situation	_____	1	2	3	4	5
Legal situation	_____	1	2	3	4	5
Health	_____	1	2	3	4	5
Anxiety level/ Nerves	_____	1	2	3	4	5
Mood	_____	1	2	3	4	5
Eating habits	_____	1	2	3	4	5
Sleeping habits	_____	1	2	3	4	5
Ability to concentrate	_____	1	2	3	4	5
Child rearing	_____	1	2	3	4	5
Ability to control temper	_____	1	2	3	4	5
Spirituality	_____	1	2	3	4	5

What is your religious/spiritual orientation?_____

If you have one, which church or group do you attend?_____

What are your beliefs?_____

How do they impact your life?_____

Have they helped you or hurt you and in what ways?_____

Will your beliefs facilitate or be a barrier to your treatment?_____

Therapist's observations regarding this-is this a source of strength for the client?_____
_____

Have you ever or do you now attend a 12 step or other support group?____
_____

What are your hobbies or leisure activities?_____
_____

How far did you go in school?_____

Where are you employed now, or recently?_____

What is your occupation?_____

If you are on disability, for what reason?_____
_____

Have you applied for disability, or do you plan to?_____

Health History

Family Physician_____ Phone No._____
Address_____
Date of last medical exam_____ Future Appointment?_____
Specify any physical limitations_____
Allergies_____
Pharmacies used_____
Do you have a living will?_____If so, who has a copy?_____

Mark any of the following health problems you have ever experienced with a check. Mark an "O" if it has been a health problem for others in your family.

____Heart Disease	____Pneumonia	____Sexually Transmitted Disease
____Cancer	____Bronchitis	____PMS/Menstral
____Diabetes	____Arthritis	____No. of Pregnancies
____Stroke	____Asthma	____AIDS/HIV Positive
____Seizures	____Hepatitis	____Kidney Problems
____Ulcers	____Cirrhosis	____Stomach/Intestinal Disease
____Head Injury	____Broken Bones	____Emphysema
____Rheumatic Fever		

Other conditions:_____
Surgeries and date:_____
Have you been in the hospital in the past year?_____ If so, please describe
_____
If your parents or brothers and sisters are deceased, please list how they died:
_____
If you are on any medication, please indicate name and dosage:_____
_____
Do you regularly take any over-the-counter medication?_____
Do you use tobacco?_____What type and how often?_____
How much caffeine do you consume on an average day?(coffee, some soft drinks, tea, chocolate)_____
How much do you use alcohol and/or drugs?_____
Has alcohol or drugs ever been a problem in your life?_____
Is alcohol or drugs a problem with your spouse/partner _____
Has alcohol or drugs been a problem in your family?_____
Do you exercise regularly?_____What type?_____

Client Name_____Date_____

Symptom Check List
(Adult)

Sleep problems_____
Appetite problems_____
Weight gain_____
Weight loss_____
Sad Mood/crying_____
Trouble concentrating_____
Isolation_____
Loss of interest/pleasure_____
Nightmares_____
Confusion_____
Indecisive_____
Flashbacks_____
Loses time_____
Troubled relationships_____
Mood swings_____
Elated mood_____
Accident prone_____
Self-mutilation_____
Short attention span_____
Fainting/dizziness_____

Panic attacks_____
Worrying_____
Restlessness_____
Obsessions & type_____
Compulsive behavior_____
Angry outbursts_____
Physical violence_____
Irritability_____
Argumentative_____
Phobias/fears_____
Forgetfulness_____
Blackouts_____
Increased drinking_____
Increased smoking_____
Increase other substances_____
Hypervigilant_____
Hallucinations_____
Intrusive thoughts_____
Paranoia/suspiciousness_____
Delusions_____

Somatic problems:_____
Other problems:_____
_____
Comments on the above:_____
_____

Signature:_____Date_____

JUDITH A. ALLSTON, L.C.S.W., B.C.D.
CLINICAL SOCIAL WORKER

In preparation for your first appointment, I would like to provide you with answers to some common questions you might have about our office procedures and what to expect from your initial consultation.

People seek counseling or psychotherapy for many different reasons – marriage or family problems, job or financial stress, depression, anxiety, or traumatic events in the past or present to name a few. The appropriate course of treatment depends on the nature and history o your personal concerns, so today's session will focus on obtaining information about your reasons for seeking therapy and relevant background information. Please try to be as frank and direct as you can in expressing your concerns, as this will allow us to be more effective in working together to formulate a helpful treatment approach. Also, please do not hesitate to ask any questions you have about office or billing procedures or the process of therapy itself.

The confidentiality of therapy is protected by state law. This means that anything discussed or disclosed in the course of treatment is held in the strictest confidence. Should you wish me to release information to a third party, I will obtain your written consent to do so. That consent may be revoked by you at any time.

There are three circumstances under which a psychotherapist may be required to release information without client consent: 1) if the psychotherapist has clear reason to believe that a client poses imminent bodily danger to him or herself or to a specific third person; 2) if the psychotherapist has reason to believe that a minor child is being or has been abused or neglected; and 3) if a judge specifically orders the release of records.

If you wish to use insurance to assist with treatment costs, please note that many insurance and managed care organizations require either limited or full release of clinical information to authorize payment of claims and to document medical necessity for services provided. Th information required may be limited to diagnosis and dates of service or may be as extensive as an on-site review of all records relating to the case. Please feel free to speak with me or to contact your insurance carrier or managed care organization if you have questions about these procedures. Your sense of privacy is very important for successful treatment, so I strongly encourage you to raise any concerns you have about confidentiality or its limitations.

For routine messages, you may leave a message for me on **my voice mail (376-1585 extension 104)**. For an urgent message, please leave a message on my voice mail and follow the prompts so that I may be paged. In the event that I am out of town or otherwise unavailable, my voice mail greeting will advise you of the name and number of the clinician who is providing emergency coverage. You may also seek emergency treatment at any time by dialing 911 or consulting your area hospital Emergency Room.

Fees will be discussed in your initial session. If you wish to pay for sessions on a fee-for-service basis, full payment is expected at the time of the appointment unless other arrangements are made. Mastercard and Visa payment options are also available. If you wish to use your health insurance to help with the cost, co-pay and deductible payments are expected at the time of the appointment. You will be responsible for any unpaid balance with the exception of circumstances or fees specified in provider agreements with your insurance or managed care company. Statements are issued once monthly. Should you have any questions regarding your statement or insurance claim, please contact Ms. Debra Patterson, office manager, at 376-1585.

Appointment times are reserved specifically for you, and 24 **hour notice is requested if you are unable to keep a scheduled appointment.** You may leave a message at 376-1585 if you must cancel a scheduled appointment. **Should you fail to give such notice, a $40 fee will be charged, which will not be reimbursed by insurance.**

I recognize that from time to time circumstances may arise which impact one's capacity to meet payments on the agreed upon schedule. Should this occur, let me know. I will be happy to work with you on a payment plan which is manageable for you. However, in the event a good faith effort is not made toward payment of services, I reserve the right to turn delinquent accounts over for collection.

I hope this information is useful in explaining basic policies. Please keep a copy of this document for your records. Your signature below indicates that you have read this document, agree to the client responsibilities outlined, and have received a copy.

Patient Signature _____ Date _____

Custodial Parent or Guardian _____ Date _____

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