TJ Walsh Counseling & Psychotherapy Services

Client Information Form

Identification

Name: Today's Date:

DOB: Phone: Email:

Address:

Please describe the main difficulty that has brought you to see me:

Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

◯ Yes ◯ No

Have you ever taken medications for psychiatric or emotional problems?

◯ Yes ◯ No

When (Years)	Medications	Dosage	Prescribing M.D.	For What?	Results?

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Client Information Form (Continued)

Relationships in your family of origin

Please describe the following:

Your parents are:

◯ Married ◯ Never Married ◯ Separated ◯ Divorced

◯ Father is Remarried ◯ Mother is Remarried

Your parents' medical problems, drug/alcohol use, and mental or emotional difficulties:

Father: ◯ Major Medical Complication ◯ History of Substance Use
◯ History of Mental Health Issues

Mother: ◯ Major Medical Complication ◯ History of Substance Use
◯ History of Mental Health Issues

Abuse History

◯ I was not abused in any way. ◯ I was abused.

If you were abused, please indicate the following:

◯ P = Physical, such as beatings
◯ S = Sexual, such as touching/molesting, fondling, or intercourse
◯ N = Neglect, such as failure to feed, shelter, or protect
◯ E = Emotional, such as humiliation, etc.

Present Relationships

Current relationship status:

◯ Married ◯ Divorced/Separated ◯ Single ◯ In a relationship

Number of children:

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Client Information Form (Continued)

Chemical Use

How much tabacco do smoke or chew each week?

Have you ever used drugs or medication that was not prescribed to you?

◯ Yes ◯ No

How often do you consume alcoholic beverages?

◯ Daily ◯ Weekly ◯ Monthly ◯ Rarely ◯ Not at all

How many alcoholic beverages do you typically consume when drinking?

Have you ever used inhalents (“huffing”), such as glue, gasoline, or paint thinner?

◯ Yes ◯ No

Which drugs (not medications prescribed for you) have you used in the last month?

Legal History

Are you required by court, the police, or a probation/parole officer to have this appointment?

◯ No ◯ Yes

If yes, continue:

County holding your case:

Name of probation/parole or court personnel supervising your case:

TJ Walsh Counseling & Psychotherapy Services

Consent to Use and Disclose Your Health Information

Therapist Signature: Date:

This form is an agreement between you, and me. If you are completing this form for someone else, please write their name here: _____. When I use the words “you” and “your” below that will refer to yourself, or the name written above. When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls “protected health information”(PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. By signing this form you also comply with your PHI being used for clinical supervision purposes. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, and to help provide other treatment to you, this would include software used for appointment reminders and other communication. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information. If you do not sign this form agreeing to our privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change our notice of privacy practices. If I do change it, you can get a copy from the office, or by calling me at (484) 928-0082. If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, supervision, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if we do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it by informing me in writing. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

_____ _____

Signature of client or his/her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to client

☐ Copy accepted by client/representative

TJ Walsh Counseling & Psychotherapy Services

Notice of Privacy Practices

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.

Therapist Signature:

☐ Copy refused by client/representative

My commitment to your privacy
TJ Walsh Counseling & Psycotherapy Services is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information.

How I use and disclose your protected health information with your consent
I will use the information I collect about you mainly to provide you with treatment, to arrange payment for my services, and for some other business activities that are called, in the law, health care operations. After you have read this notice I will ask you to sign a consent form to let me use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent
There are some times when the laws require me to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. I will only share information with persons who are able to help prevent or reduce the threat.

2. When I am required to do so by lawsuits and other legal or court proceedings.

3. If there is a report of Child Abuse.

4. In case of a medical emergency.

Your rights regarding your health information

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.

2. You can ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records upon request.

4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation.

5. You have the right to a copy of this notice. If I change this notice, I will be sure to inform you of this change.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a com plaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writ ing. Filing a complaint will not change the health care I provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I will be happy to discuss these situations with you now or as they arise. If you have any ques tions regarding this notice or my health information privacy policies please feel free to ask at any time.

TJ Walsh Counseling & Psychotherapy Services

Emergency Consent

The effective date of this notice is:

This form will expire on

This form is an agreement between you, and me. If you are completing this form for someone else, please write their name here: _____. When I use the words "you" and "your" below, that will refer to yourself, or the name written above.

In the instance of an emergency I, _____, permit TJ Walsh Counseling and Psychotherapy Services to contact:

Name: _____ Relationship to Client: _____

Address: _____

Phone number: _____

For the purposes of: **Notification of a medical or psychiatric emergency**

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, supervision, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if we do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it by informing me in writing. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

_____ _____

Signature of client or his/her personal representative | Date

_____ _____

Printed name of client or personal representative | Relationship to client

_____

Signature of clinician

☐ Copy accepted by client/representative

☐ Copy refused by client/representative

TJ Walsh Counseling & Psychotherapy Services

Financial Information Form

Printed name of client/P.R.: Relationship to client:

_____

Signature of clinician

☐ Copy accepted by client/representative
☐ Copy refused by client/representative

I truly appreciate your choosing to come to me for counseling. As a part of providing high-quality services, we need to be clear about our financial arrangements. TJ Walsh Counseling & Psychotherapy Services does not accept insurance payments. Thus, cash, check or credit card payments are the only acceptable forms of payment. If this is acceptable with your financial situation please complete the form below.

Client's Name:

Address:

Primary Phone: **Email:**

Occupation: **Employer:**

Work Phone:

(If applicable) Spouse's/Parent's Name:

Occupation: **Employer:**

Work Phone:

Address of Employer:

I, _____ agree to remit a _____ (amount) payment for service at the time the service is rendered. I understand that failure to pay for services in a timely fashion will result in a suspension of services being offered. I also understand I am responsible for the full session fee for missed sessions in which I fail to give a 24hr. notice. In the event that a check would be returned, I understand that I am responsible for a $15.00 processing fee.

Thank you for making this agreement official, for that now allows us to get to the part of building an effective counseling relationship.

_____ _____

Signature of clinician Date