Adult Intake Form

Today's Date _____

Name _____ **Date of Birth** _____
Last First M. I. Maiden Name

Address _____ **Email** _____
Nbr & Street City State Zip Code

Phone: Home (____) _____ Work (____) _____ Soc. Sec. #_____

Cell Ph. (____) _____ Other (____) _____ Drivers Lic. #_____

Relationship Status

☐ Single ☐ Dating ☐ Live-in Partner ☐ Married Date _____ ☐ Divorced Date _____ ☐ Widowed Date _____ ☐ Separated Date _____

Whom may we contact in an emergency? _____
Name Phone Relationship

Employment Information

Currently Employed? ☐yes ☐no May We Leave A Message For You? ☐yes ☐no

Occupation _____ Employer's Name _____

Address _____
Street City State Zip Code

Areas of Training _____ Areas of Interest _____

Seeking Employment? ☐yes ☐no Type of Position Sought _____

Family of Origin

Cultural Background _____ Religious Background _____

Members (Mother, Father, Brothers, Sisters, Step-Family Members) If needed, continue on back.

Name	Relationship	Age	Health	Current Occupation	Living/ Deceased

Current Living Situation Please list everyone in the home where you live today. (If needed, continue on back.)

Name	Relationship	Age	Date of Birth	Gender

Medical Background

Family Physician _____ Clinic Name _____ Phone (___)_____

Address _____
Street City State Zip Code

Date of Last Visit _____ Reason _____

Date of Last Complete Physical _____ Results _____

Current Illnesses/Injuries _____

Current Medications _____

Substance Use

Do you smoke? ☐Yes ☐No Do you drink coffee? ☐Yes ☐No

If Yes, Cigarettes per day _____ Cups per day of Regular_____ Cups per day of Decaf_____

How often do you drink alcohol?

☐ Never ☐1-10 times a year ☐1-3 times a month ☐1-3 times a week ☐4+ times a week

Typical Amount per Occasion (1 drink = 1 shot = 12 oz. beer = 1 glass wine = 1 wine cooler)

☐1-2 drinks ☐3-4 drinks ☐5-6 drinks ☐ 7-10 drinks ☐more than 10 drinks

How often do you consume drugs (prescription or recreational)?

☐Seldom/Never ☐1-3 times a month ☐1-3 times a week ☐1-3 times a day

Please list / describe recent drugs & purpose. _____

_____

Please list any drugs previously used on a regular basis. _____

Educational Background

High School Completed? ☐Yes ☐No College Completed? ☐Yes ☐No Degree _____

Veteran Information

Are You A Veteran? ☐Yes ☐No Branch of Service and Dates _____

Legal Information

Have You Been or Are You Involved in Any Legal Cases (Civil, Traffic, Other)? ☐Yes ☐No If Yes, Please Explain on back.

Who referred you? _____

Name Address Phone

May we thank them? ☐Yes ☐No

Please ___✓___ as many as you have experienced within the Past 6 Months.

Circle the appropriate choice where applicable; ***example,*** ___✓___ family/work/school conflict

_____recent physical changes incl. weight Gain / Loss (which - ?)

_____confusion & / or spaciness

_____family / work / school conflict (which - ?)

_____forgetfulness (intentional / unintentional) (which - ?)

_____miss social cues

_____low self-confidence or self-esteem

_____emotional control

_____superiority

_____inferiority

_____isolation &/or loneliness

_____frustration / irritation / anger

_____abandonment

_____communication problems_____ (Hearing Speaking Reading Writing)

_____restlessness

_____sleep problems:_____ (indicate types of problems)

_____hopelessness

_____overwhelmed

_____anxiety or panic

_____hyperactivity or impulsivity

_____other_____

_____mood swings

_____destructive tendencies

_____suicidal threats / attempts

_____homicidal threats / attempts

_____fearfulness

_____spiritual / religious concerns

_____helplessness

_____depression

_____unattractiveness

_____sexual issues

_____disorganized

_____some difficulty being on time

_____guilt or shame

_____boredom

_____obsessiveness & / or compulsiveness

_____unwanted thoughts, voices or images

_____crisis or trauma

_____dissociation (lost time – 'checking out')

_____unusual or inappropriate behavior

_____other_____

(Use back for more space.)

Have you ever been hospitalized for psychiatric reasons? ☐Yes ☐No

Previous therapy or counseling ☐ No ☐ Yes If 'yes,' please give dates and names of therapist:

_____

Are you currently involved in treatment elsewhere? ☐Yes ☐No

If so, _____

Name Address City Zip Phone

Client Signature _____ Date _____

Witness _____ Date _____

Jennifer Heretick, P.A.

125 5th Street South Suite 201

St. Petersburg, FL 33701 (727) 386-8231

INFORMED CONSENT TO PSYCHOTHERAPY / COUNSELING

This form is to document that I, _____, give my permission
(client or parent name)

and consent to Dr. Jennifer Massa to provide psychotherapy to:
(clinician name)

☐me; ☐spouse; ☐child:_____.
(please mark one) (name)

While I expect benefits from this treatment, I fully understand that because of factors beyond our control, such benefits and particular outcomes cannot be guaranteed.

I understand that because of the counseling or therapy, I may experience emotional strain at times. I may feel worse during treatment and make life changes that could be distressing.

I understand that this clinician is not providing an emergency service and I have been informed of whom to call upon in an emergency or during weekend and unavailable hours.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the clinician at least two weeks in advance so that effective planning for continued care can be implemented.

As stated in the American Psychological Association Code of Ethics:

(a) Psychologists disclose confidential information without the consent of that individual only as mandated by law, or where permitted by law for a valid purpose, such as (1) to provide needed professional services to the patient or the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the patient or client or others from harm, or (4) to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

(b) Psychologist also may disclose confidential information with the appropriate consent of the patient or the individual or organizational client (or of another legally authorized person on behalf of the patient or client), unless prohibited by law.

I know of no reasons why I should not undertake this therapy and I agree to participate fully and voluntarily.

Signature_____ Date_____
(Client or person authorized to consent for client)

Witness_____ Date_____

Jennifer Heretick, P.A.

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St. Petersburg, FL 33701 (727) 386-8231

AUTHORIZATION FOR TREATMENT AND BILLING

FEE SCHEDULE:

Full Session -- $185 per 50-minute session.
Payment is due at the time service is provided.

THIRD PARTY PAYMENT:

I authorize direct payments of any third party insurance benefits to Jennifer Heretick, P.A. for services rendered. If the third party payment benefits are not paid directly to Jennifer Heretick, P.A. or are paid in an amount which is less than the agreed upon charge, or insurer refuses to acknowledge the obligation for the payment of charges for services rendered, I acknowledge my personal responsibility and agree to pay the amount of any charges for which Jennifer Heretick, P.A. has not been paid through third party insurance benefits. I am aware that it is then my choice and my responsibility to seek resolution of any dispute with my insurer.

I acknowledge that I have been informed and am aware of Jennifer Heretick, P.A. charges for services rendered and agree to pay or authorize the third party insurer to pay those rates or their contracted portion.

In the event that the client is a minor, I represent that I have the right and authority to authorize treatment and hereby authorize Jennifer Heretick, P.A. to provide services to that minor.

NO-SHOW AGREEMENT:

There is a charge for scheduled appointments that are not kept or are canceled less than 24 hours before the appointment time, (other than for emergencies). I understand and acknowledge that I am personally responsible for this charge and that it is not covered by any third party insurance benefits. For a no-show, I agree to pay for the missed session.

Signature of Responsible Party _____ Date _____

Signature of Witness _____ Date _____

Jennifer Heretick, P.A.

125 5th Street South Suite 201

St. Petersburg, FL 33701 (727) 386-8231

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose y*our Protected Health Information (PHI),* for treatment, payment, and health care operations purposes with your *consent. To* help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*

  - *Treatment refers to* when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.

  - *Payment refers to* when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within our offices, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure "* applies to activities outside of our offices, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization" is* written permission beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes we have made about our conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the

authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* -If there is reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.

- *Adult and Domestic Abuse* -If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.

- *Health Oversight Activities* -If we receive a subpoena or other lawful request from the Department of Health or the Florida Board of Psychology, we must disclose the relevant PHI pursuant to that subpoena or lawful request.

- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when a third party is evaluating you or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* - If you communicate a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm on yourself, we may disclose information in order to protect you.

- *Worker's Compensation* - We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in therapy. On your request, we will send your bills to another address.)
- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the

record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- Right to Amend-, You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- Right to a Paper Copy - You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you either in person or by mail.

V. Complaints

If you are concerned that one of us has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact the office at 125 5th Street South Suite 201, St. Petersburg, FL 33707 telephone number (727) 386-8231 and if the situation cannot be resolved, you will be given further information about how to proceed with your complaint under the laws of the State of Florida.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. A person listed at the above location can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on February 22, 2013

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in person or by mail.

I further acknowledge that I have received the first three pages of this notice and may keep them for my records.

Signature: _____ Date _____

Witness: _____ Date _____