BREATHE HOPE
COUNSELING

Beth Griffith
MSW, LCSW

PH: 317-885-1150
FX: 317-885-1070

399 West Main Street
Greenwood, IN 46142

Consent for Mental Health Services

I, the undersigned, agree and consent to participate in the mental health counseling services offered by Beth Griffith, LCSW, a mental health provider.

I understand that I am consenting and agreeing only to those mental health services that the above mentioned provider is qualified to provide within the scope of the provider's licensure and training.

Client's Printed Name: _____

_____

Client's Signature: _____

_____

_____ _____

Witness Signature Date

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here: .

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information”(PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. 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 we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.breathehopecounseling.com, or by calling us at , 317-885-1150 or from Beth Griffith,our privacy officer. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment,or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative’s authority

_____

Signature of authorized representative of this office or practice

Date of NPP: _____ ❑ Copy given to the client/parent/personal representative

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Financial Information and Agreement

A. Patient's name: _____ Birthdate: _____Soc. Sec. #: _____

Address: _____City_____Zip_____

Cell Phone: _____ Other Phone:_____

(If the patient is a dependent) Insured's/policy holder's name: _____

Occupation:_____ Employer: _____ Work phone: _____

Address of employer:_____

B. (If applicable) Spouse's name: _____Birthdate: _____ Soc. Sec. #:_____

Occupation:_____ Employer: _____ Phone: _____

Address of employer:_____

C. If you (or your spouse) have any of these kinds of insurance, please fill in the numbers and names for each one.

1. Blue Cross/Blue Shield

Name of subscriber (if not the patient): _____

Identification/agreement/policy #: _____Group or enrollment #:

_____

Plan #/code or BS #: _____ Effective date: _____

Location of plan: _____ Reciprocity #: _____

Phone: _____ Other information:

_____

2. CIGNA

Name of subscriber: _____

Policy #: _____ Certificate #: _____

Phone: _____ Address to send claims: _____

3. ComPsych

Name of Subscriber:_____

Authorization #:_____

# of Sessions Authorized: _____

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D. If you do not have insurance, how will you pay for services from this office? Check and cash are preferred. Credit Card is accepted ($25.00 minimum) _____

E. I give this office permission to release any information obtained during examinations 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.

F. I understand the following: I am responsible for all charges, regardless of insurance coverage. A statement of benefits is not a guarantee of payment. Payment is due at the time of service. A full session fee ($125.00 for an intake; 115.00 for a regular session) will be charged for appointments missed or cancelled without 24-hours'notice. If a check is returned for non-sufficient funds, the bank fee will be charged to my account. Bank charges and fees incurred for missed appointments are not billable to insurance.

G. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above.. A photocopy of this assignment is to be considered as good as the original.

_____ _____
Client's (or parent/guardian's) signature, indicating agreement to all of the statements above — Date

_____
Printed name

_____
Witness

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Client Information Form

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: ____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____Home Phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you? _____

_____

C. Chief concern

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

_____

_____

_____

D. Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____

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G. Your medical care:
From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____

Address: _____

H. Your current employer
Employer: _____ Address:

_____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

I. Emergency information
If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: _____ Phone: _____ Relationship: _____

Address:

_____

Significant other/nearest friend or relative not residing with you: _____

J. Your education and training

Dates From	To	Schools	Special classes?	Adjustment to school	Did you graduate?

K. Treatment
1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

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2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:
When? From whom? Which medications? For what? With what results?

L. Employment and military experiences

Dates From	To	Name of employers	Job title or duties	Reason for leaving

M. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Brothers					
Sisters					
Stepparents					
Grandparents					
Uncles/aunts					
Others					

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N. Marital/relationship history

	Spouse's name	Spouse's age	Your age	Your age when	Has spouse remarried?
First					
Second					
Third					

O. Significant nonmarital relationships

	Name of other person	Person's age	Your age	Your age	Reasons for ending
First					
Second					
Third					
Current					

P. Children

Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

Q. Present relationships

1. How do you get along with your present spouse or partner? _____
_____
_____
_____

2. How do you get along with your children? _____
_____
_____
_____

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R. Chemical use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____. How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____ How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .
2. How much tobacco do you smoke or chew each week?_____
3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes
4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes
5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes
6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes
7. How much beer, wine, or hard liquor do you consume each week, on the average? _____
8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ No ❑ Yes
9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____

_____

_____

S. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain:

_____

_____

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain: _____

_____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes. If yes, please explain:

_____

_____

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_____

4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: F = federal, S = state, Co = county, Ci = city.
Under "Sentence," write in the time and the type of sentence you served or have to serve (AR = accelerated or alternate resolution, CS = commu-nity service, F = fine, I = incarceration, Pr = probation, Po = parole, O = other, R = restitution).

Date	Charge(s)	Jurisdiction (F,S,C,Ci)	Sentence (AR, I, Pr, Pa)	Probation/parole officer's name	Your attorney's name

5. Your current attorney's name: _____ Phone: _____

6. Are there any other legal involvements I should know about?_____

_____

I. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: _____

_____

_____

_____

_____

_____

_____

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Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ❑ I have no problem or concern bringing me here
- ❑ Abuse–physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, 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
- ❑ Drug use–prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems–overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy

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- ❑ 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
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism

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- ❑ 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, distrust
- ❑ 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
- ❑ Other concerns or issues: _____

_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: