

Heritage Behavioral Health Consultants

Julie Summers, M.A., L.P.C.-S.

Brittany Senseman M.A., L.P.C.

Jennifer Hofman, M.A., L.P.C.-I.

Annie Higgins, M.A., L.P.C.

Sharon Carroll, M.A., L.P.C.

Patrick Lucas, LAT, ATC, CSCS, NSCA-CPT, EMT

Jerry Duncan, M.Div., L.M.F.T.

V. Shannon Burkett, Ph.D.

Julie Ottosen, M.A., L.P.C.

Shaun Lester, Ph.D., L.P.C.-S.

Beth Flinn, M.A., L.P.C.

Danielle McGee, R.D., L.D.

Welcome to the practice of Heritage Behavioral Health Consultants. We are pleased you have chosen our office and will assure you that we are working with you in a caring and professional manner. Please take a few moments to read our office policies and do not hesitate to ask any questions you may have. These policies are further detailed in the Notice of Privacy Practices following this form.

OFFICE HOURS

Regular support staff hours are from 9:00am to 5:00pm Monday through Thursday. Each clinician sets his or her own schedule and will work with you to schedule a mutually agreeable time.

SESSIONS

Initial nutrition consultations are 75-90 minutes and follow-up nutrition consultations are 45-60 minutes long. Weekly follow-up sessions are 30 minutes each. In order to ensure that your time is respected and waiting time does not interrupt your schedule or ours, every effort is made to start and stop on time. Extended sessions can be arranged when necessary, that will include an additional fee.

CANCELLATIONS

There is no charge for missed appointments IF APPOINTMENT IS CANCELLED AT LEAST 24 HOURS IN ADVANCE. If the appointment is for Monday, the cancellation may be made-by leaving a message with the answering service. WE DO CHARGE FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE.

EMERGENCY SERVICES

Emergency consultation is provided 24 hours each day, seven days a week. Your clinician usually will be available to assist you personally: however, at times, a colleague may cover calls. You may reach us at (713)365-9015. If we do not answer the page in 30 minutes, please page a second time and let the service know this is an emergency. If the consultation requires more than 15 minutes, you may be billed for time.

NOTICE OF PRIVACY PROCEDURES

In accordance with the Health Insurance Portability and Accountability Act (HIPPA), Heritage Behavioral Health Consultants is required to: 1) maintain the privacy of your health information, 2)

provide you with a Notice to our legal duties and privacy practices with respect to the information that we collect and maintain on you, 3) abide by the terms of the Notice, 4) notify you if we are unable to agree to a requested restriction, 5) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. Please refer to our Notice of Privacy Practices for detailed information.

FEES

Payment is due at the time of service rendered in the form of cash, check or credit card. We do not file insurance in this office; however for those clients that belong to an insurance company that wish to file, we will give you an itemized statement so that you can file it with your insurance company in order to have them reimburse you directly.

It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 10% charge to the outstanding balance.

TYPES OF THERAPY AND ASSESSMENTS

A variety of therapies are available depending on your needs and wishes. During your first visit, you and one of our clinicians will evaluate together what issues you wish to address and the type of therapy that would be most appropriate for you.

Please check each type of therapy or assessment you feel may be appropriate.

- Marriage or Relationships Counseling
- Individual Counseling
- Parent Consultation
- Family Therapy
- Attention Deficit Disorder Assessment
- Psychological Testing
- Nutrition Consultation

PERSONAL RELATIONSHIPS

Our goal is that we will develop a positive, rewarding relationship. At this time, please take a few minutes to fill out the enclosed information so that we may better help you achieve your goals.

I HAVE READ AND FULLY UNDERSTAND THE PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT AND AGREE TO ITS TERMS.

Patient's Full Name (please print) : _____

Signature: _____ Date: _____

I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES AND AGREE TO ITS TERMS.

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

Heritage Behavioral Health Consultants

Client Information

Date: _____ Dietitian Name: _____

Patient's Name: _____

D.O.B.: _____ Sex: M _____ F _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Business Address: _____

Wk Phone: _____ Email: _____

Emergency contact: _____ Phone: _____

Referred by: _____

Would you like an invoice after every visit? : Yes No

Is it all right to leave a voicemail on your answering device? : Yes No

At which phone number? Home Cell Work

Would you like to keep your credit card info on file for ease of payment: Yes No

Card Holder Name: _____

Credit Card No.: _____

Exp. Date: _____

Credit Card Billing Address: _____

CVV Code: _____ (3 digit code on back of card)

Signature: _____

Health Assessment Patient Questionnaire

Name: _____ Date: _____

Background Information

Age: _____ Birth date: _____ Preferred phone number: _____

E-mail: _____ Occupation: _____

Work hours: _____ Marital status: _____

Highest level of education: _____

Please list the people in your household and their relationships to you: _____

General Health Information

Physician's name: _____ Physician's phone: _____

Physician's address: _____

Date of most recent physical exam: _____ Date of most recent blood tests: _____

How do you rate your health? _____ Poor _____ Fair _____ Good _____ Excellent

Height: _____ Weight: _____

Review of Systems (circle all that you currently have or are concerned about)

Respiratory

Shortness of breath

Emphysema

Disturbed sleep

Coughing

Snoring

Sleep apnea

Asthma or wheezing

Daytime sleepiness

History of pneumonia, chronic
bronchitis, or COPD

Cardiovascular

High blood pressure

Heart murmur

Ankle or feet swelling

Heart disease/heart attack

Irregular heartbeat or palpitations

Varicose veins

Congestive heart failure

Chest pain or discomfort

Blood clots or clotting disorders

Gastrointestinal

Nausea/vomiting	Ulcer disease	Diarrhea
Abdominal/stomach pain	Rectal bleeding or blood in stools	Gallbladder disease/gallstones
Heartburn/acid reflux	Hemorrhoids	Celiac disease
Belching/burping	Constipation	Hernia

Genitourinary

Difficulty urinating	Inability to empty bladder fully	Sexual problems
Urinary incontinence (leaking urine)	Recurrent urinary tract infections (UTIs)	Abnormal menstrual periods
	Infertility	Enlarged prostate

Musculoskeletal

Aching muscles or joints	Lower back pain/disc problems	Arthritis
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Endocrine

Diabetes mellitus	Thyroid disease	High triglycerides
High cholesterol	Gout	

Skin and Hair

Skin sores or infections (boils, ulcers, skin fold irritations)	Chronic rashes or dermatitis or eczema	Excessive facial/ body hair (women only)
Bruises easily		

Other

Low energy level	Obsessive-compulsive disorder (OCD)	Binge eating
Depression		Bulimia
Bipolar disorder	Psychological or psychiatric care	Anorexia
Attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD)	History of child abuse, rape, or molestation	Anemia
Anxiety disorder or panic attacks	History of being subjected to any physical or verbal abuse	Headaches or migraines

Cancer (list type): _____

Other serious medical conditions (list types): _____

Do you have a family history of any of the following? (Circle all that apply)

High blood pressure, high blood cholesterol, diabetes, thyroid disease, obesity, heart disease, cancer,
other (list):

List the types of surgeries you have had: _____

How often do you use tobacco? _____ How often do you drink alcohol? _____

How many hours of sleep do you average per night? _____ Is your sleep restful? Yes No

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life? _____

Please list any religious practices that affect your health care or diet:

List all prescription and over-the-counter medications that you currently take (include the dosages):

List all vitamins, minerals, supplements, and herbs that you take:

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes?

1 2 3 4 5

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What makes it hard for you to lose weight and keep it off? _____

Nutrition Information

What one or two things would you like to change about your diet? _____

In the following chart, describe when and what you usually eat in a typical day. (Write "None" if you do not eat that meal or snack.)

Meal	Time	Foods Eaten/Amount
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Physical Activity Information

What is the most physically active thing you do in an average day? _____

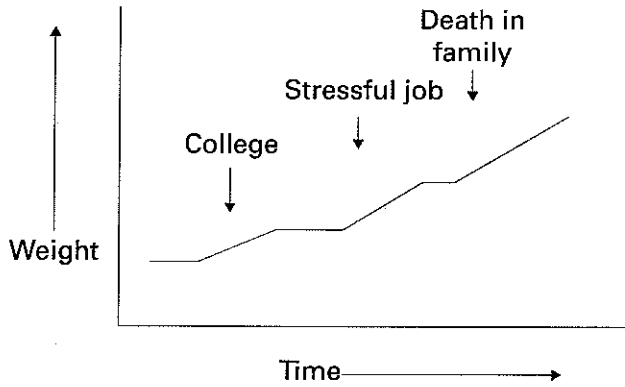
What, if any, regular exercises do you do? How often and for how long do you participate? _____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain the reasons.

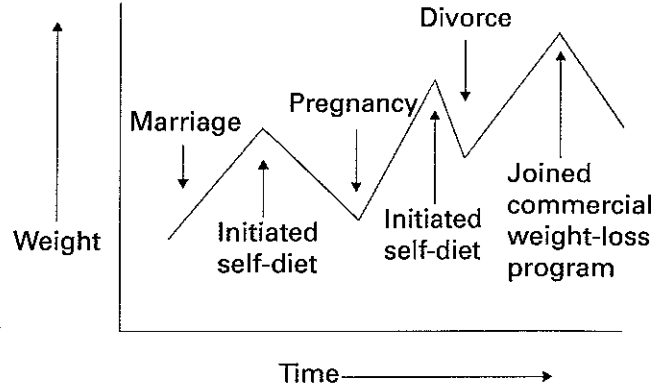
Weight History Graph

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.

Progressive (or Ratcheting) Weight Gain



Weight Cycling or "Yo-Yo" Weight Gain



Please draw a graph of your weight gain. Mark *life events* and *diet attempts* that have contributed to your current weight.

