

Heritage Behavioral Health Consultants

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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 8:00am to 5:00pm Monday through Friday. Each clinician sets his or her own schedule and will work with you to schedule a mutually agreeable time.

SESSIONS

Full sessions are 45 minutes and half sessions are 25 minutes long. 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 ASSESMENTS

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

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

Adult Patient Information

Date: _____ Clinician 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 alright 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: _____

<u>Please complete if patient is female:</u>			
Menstrual History:			
Age at onset: _____	Date of last period: _____	Cycle: _____ days	Duration: _____ days
Regular: Yes No	Pains/Cramps: Yes No	PMS: Yes No	
Pregnancies: Total # of pregnancies: _____	Miscarriages: _____	Terminations: _____	
Age of youngest living child: _____ yrs			

Credit Card Billing Address: _____

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

Signature: _____

Diet and Exercise:

Weight: Current ___ 1 year ago ___ Desired ___ Are you on a special diet? _____

Indicate which of the following symptoms you have experienced

- | | | |
|--|---|--|
| <input type="checkbox"/> Fatigue/ lack of energy | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Increase/decrease in sex drive |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Aggressive/violent behavior | <input type="checkbox"/> Fear of going crazy |
| <input type="checkbox"/> Lack of Sleep | <input type="checkbox"/> Seeing things that are not real | <input type="checkbox"/> Fear of dying |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Hearing things that are not real | <input type="checkbox"/> Feeling of unreality |
| <input type="checkbox"/> Increase/Decrease of appetite | <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Feeling in dream-like state |
| <input type="checkbox"/> Increase/Decrease in weight | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Isolation/withdrawal |
| <input type="checkbox"/> Repetitive/senseless thoughts | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Repetitive/senseless behavior | <input type="checkbox"/> Worthless feelings | <input type="checkbox"/> Difficulty in focusing vision |
| <input type="checkbox"/> Sad/down in the dumps | <input type="checkbox"/> Excessive guilt feelings | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Helplessness | <input type="checkbox"/> Eye discomfort in bright light |
| <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Hopeless feelings | <input type="checkbox"/> Sinus pain or congestion |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Sweating | <input type="checkbox"/> Increase/decrease in tearing |
| <input type="checkbox"/> Fearful feelings | <input type="checkbox"/> Dizziness/light headedness | <input type="checkbox"/> Increase in sensitivity to sounds |
| <input type="checkbox"/> Frequent crying | <input type="checkbox"/> Unsteady feelings | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Frequent negative thinking | <input type="checkbox"/> Jumpiness | <input type="checkbox"/> Joint pains or stiffness |
| <input type="checkbox"/> Frequent thoughts of death | <input type="checkbox"/> Keyed up/ on edge | <input type="checkbox"/> Backache |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Muscle tension |
| <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Constant worry | <input type="checkbox"/> Muscle pain/soreness |
| <input type="checkbox"/> Fainting/ feeling faint | <input type="checkbox"/> Panic | <input type="checkbox"/> Swelling of hands/feet/ankles |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Feeling life not worth living | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Trembling/shakiness | | |
| <input type="checkbox"/> Seizure/convulsions | | |

- | | | |
|---|---|---|
| <input type="checkbox"/> Numbness/tingling in limbs | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Inability to control urine |
| <input type="checkbox"/> Foot problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Penile/vaginal sores |
| <input type="checkbox"/> Trouble walking | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Penile/vaginal discharge |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Difficulty in sexual frustration |
| <input type="checkbox"/> Cold/clammy hands | <input type="checkbox"/> Fear of losing bowel control | <input type="checkbox"/> Breast discharge |
| <input type="checkbox"/> Unable to sit still | <input type="checkbox"/> Inability to control bowels | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chest pain/discomfort | <input type="checkbox"/> Shortness of breath | _____ |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Dry mouth | |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Unusual taste sensation | |
| <input type="checkbox"/> Nausea | | |

Chief Concern: Please describe the main reason that you here today: _____

Educational History:

High School(s): _____

College(s): _____

Treatment History:

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

- Yes No

When	From whom	For what problem	With what results
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Have you ever taken medications for psychiatric or emotional problems? Yes No

When	From whom	For what problem	With what results
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Personal History:

What is your marital status? Married Divorced Separated Single Dating

Do you have children, and if so, how many? _____

How many times have you been married? _____ # of Years Married _____

Please describe the following relationships in your family of origin:

Your parents' relation ship with each other: _____

You relationship with each parent and with other adults present: _____

Your relationship to your brothers and sisters, in the past and present: _____

Family History:

In either side of biological parents, is there any history of the following

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Bowel Disease _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> ADHD _____ | <input type="checkbox"/> Compulsions _____ |

- Depression _____
- Diabetes _____
- Drug Abuse _____
- Emphysema _____
- Epilepsy _____
- Heart Disease _____
- HIV _____
- Hormone Disorders _____
- Learning Disabilities _____
- Suicide/ Attempts _____
- High Blood Pressure _____
- Kidney Disease _____
- Liver Disease _____

- Physical Abuse _____
- Phobias _____
- Physical Abuse _____
- Psychiatric Hospitalization _____
- Rage _____
- Schizophrenia _____
- Sexual Abuse _____
- Suicide/Attempts _____
- Thyroid Disease _____
- Tremors or tics _____
- Ulcers _____
- Other _____

Present Relationships:

How do you get along with your present spouse or partner if you have one? _____

Please list your spouse/partner's physical health problems, chemical use, and mental or emotional difficulties if any: _____

How do you get along with your children if you have any? _____

Please list your children's physical health problems, chemical use, and mental or emotional difficulties if any: _____

Your most important friends, past and present:

Name	Good Parts of Relationship	Bad Parts of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal Abuse History:

- I was not abused in any way I was abused I am not sure if I was abused

If you know you were abused, please list all incidents below using the following letters:

P = physical, such as being shoved, hit, or beaten.

S = Sexual, such as touching/molesting, fondling, or intercourse

N = Neglect, such as failure to feed, shelter, or protect you

E = emotional, such as humiliation, verbal attacks

Your age	Kind of abuse	Effects on you	Did you tell anyone?	Consequences of telling
_____	_____	_____	_____	_____

Substance Use:

Have you ever felt the need to cut down on your drinking? Yes No

Have you ever felt annoyed by criticism of your drinking? Yes No

Have you ever felt guilty about your criticism of your drinking? Yes No

Have you ever taken a morning "eye-opener"? Yes No

How many drinks (beer, wine, or hard liquor) do you consume each week, on average? _____

How much tobacco do you smoke or chew each week? _____

What medications are you currently on: _____

Reason for medication: _____

Which drugs (not including prescription medications) 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 do you use them, their effects, and so forth: _____

Legal History:

Are you presently suing anyone or thinking of suing anyone? Yes No

Is your reason for coming to see us related to an accident or injury? Yes No

Is your appointment required by a court/police/probation/office/parole? Yes No

If you answered yes to any of the above questions, please explain: _____

Your current attorney's name: _____ Phone: _____

Please list all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones using the following letters.

Jurisdiction: (F=Federal, S = State, Co = County, Ci = City)

Sentence: Time served and type of sentence (AR = accelerated or alternate resolution, CS = community service, F = fine, I = incarceration, Pr = probation, Po = parole, O = other, R = restitution)

Date	Charge	Jurisdiction	Sentence	Probation/Parole Officer	Your Atty's Name
<hr/>					
<hr/>					
<hr/>					

Are there any other legal involvements that we should know about? _____

Current medications:	Name	Dosage	Reason for taking
<hr/>			
<hr/>			
<hr/>			

Other:
Is there anything else you feel is important for your therapist to know that we have not asked about on these forms? _

Patient Signature: _____ **Date:** _____