Baytree Behavioral Health — Louise Peters, Psy.D.

NEW CLIENT INFORMATION Date: _____

PERSONAL

Name: Last _____ First _____

SSN: _____ Date of Birth: _____

Who referred you to our practice? _____

ADDRESS

Street Address _____

City _____ State _____ ZIP _____

EMAIL _____

May we contact you by email? Yes No

Home phone: _____ Cell phone: _____

Work phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ cell phone: _____

Relationship: _____ work phone: _____

MARITAL STATUS

Married__ Widowed__ Single__ Separated__ Divorced__ Partnered__

If married or partnered, how would you rate your relationship? (Circle)

Bad Fair Good Excellent

Comments: _____

EMPLOYMENT INFORMATION

Occupation: _____

Employer: _____

Do you enjoy your work? _____

CLINICAL INFORMATION

Chief complaint and brief description of current problem?

_____

_____

_____

_____

Recent changes or losses?

_____

_____

Any history of counseling? _____

When and with whom? _____

HABITS

___Smoking Packs/Day _____

___Alcohol Drinks/Week _____

___Coffee/Caffeine Drinks Cups/Day _____

___Marijuana or other drugs List: _____

___shopping, porn, gambling, overeating… Specify:_____

___poor sleep hygiene Describe: _____

___High Stress Level? Reason? _____

_____

Please list medical conditions:

_____

_____

_____

List medications:

_____

_____

Have you had any psychiatric hospitalizations?

_____

FAMILY (List names and ages of all family members)

Parents_____

Siblings_____

Children_____

How would you describe your childhood?

_____

What were the major family stressors?

_____

Any physical, sexual or emotional abuse or bullying by peers?

_____

MOOD

What is your predominant mood? You can check more than one

___angry ___anxious ___blunt/ flat ___ depressed ___frustrated

___hopeless / helpless ___hostile ___intense ___irritable

___joyful ___labile (quickly changing) ___stable ___worthless

Comments _____

_____

THOUGHT CONTENT

___no suicidal ideation ___suicidal ideation ___suicidal plan ___homicidal ideation

TRAITS & BELIEFS

What are your dominant personality traits that you feel you exhibit on a consistent basis?

(Check all that apply)

___ ruminating / worrying ___ obsessive ___ controlling ___ perfectionist

___ pleasing others ___ striving ___ competitive ___ passive

___ aggressive ___ self-critical ___ inadequacy ___ shame

___ low self-esteem ___ self-conscious ___difficulty expressing feelings

Any other traits or personal patterns or relational patterns that concern you?

_____

1. Do you have a Spiritual Practice? Do you believe in God, the Divine or other Spiritual beliefs?

2. Do you have a social support system (family, friends, church group…?)

3. We all have strengths and limitations. What are your strengths, capabilities, inner qualities you feel you can rely on?

4. Are you concerned about any limitations?

5. What helps you get through difficult times?

6. What is going well in your life?

7. What are your hopes for counseling?

8. Anything else that would be important and helpful for your therapist to know?

Baytree Behavioral Health
Orientation to Clinical Services

Following is an outline of items and issues which will be discussed in our first clinical meeting. These issues are discussed early in the therapeutic process to facilitate a clear understanding of the many factors which influence the clinical work we do together. They are established to ensure the highest quality of care. Any time you have questions regarding these policies and procedures, please feel free to discuss them in therapy. All of our administrative practices are in compliance with the Health Insurance Portability and Privacy Act (HIPPA).

1. CONFIDENTIALITY: Some exceptions to maintaining confidentiality include:
    - Insurance processing (limited information necessary to process claim)
    - Discussions with other clinical professionals in private anonymous consultation
    - In the case of child abuse
    - Suicidal or homicidal plan, action, or intent
    - Disclosure of violent crimes or of threat or intent to harm others
    - Other individuals, only with your written consent

2. EMERGENCIES:
    - Contact the clinic during normal business hours
    - The clinic or answering service will contact your therapist
    - Go to the nearest Emergency Room

3. APPOINTMENTS:
    A clinical therapy appointment can be expected to be 45 minutes in length and I make every attempt to start the appointment on time. From time to time, clinical needs may dictate adjustments, but every effort will be made to avoid delays.

4. CANCELLATIONS:
    Many times there are patients on a waiting list to see a therapist. Subsequently, there is a $50 charge for appointments missed or appointments not canceled within 24 hours of the appointed time. This fee cannot be charged to insurance and is the responsibility of the patient.

5. INSURANCE:
    If financial conditions make it necessary to adjust service fees or co-pays, the insurance company must be notified of such an adjustment. It is unethical and constitutes insurance fraud if a co-pay is waived without the insurance company's awareness. Patients are responsible for the payment of their co-pays and deductibles at the time the service is rendered. If the insurance company refuses to pay, the patient is responsible for the cost related to the services. Baytree Behavioral Health will not bill tertiary insurance for patients. Costs not covered by primary or second insurance will be the patient's responsibility.

6. TRAINING INSTITUTE:
    Periodically, we may supervise mental health professionals in training who may be involved in various aspects of the therapeutic process. Their clinical participation is critical to the development of quality clinicians. They, of course, follow the same rigorous rules regarding confidentiality and your permission is always requested.

Please read and sign:

I hereby fully understand that I enter into treatment having discussed the nature of the therapeutic relationship, the therapeutic course, and techniques to be used, to include therapeutic risks and benefits. I am aware of issues relating to confidentiality and its exceptions, patient's rights and responsibilities, the established fees, insurance company requirements, and policies related to “no shows” and cancellations. I have had the opportunity to review the Privacy Act Policies of the clinic and I am also aware that I may discuss these issues at any time.

_____ _____

(Patient Signature) (Date) (Print Name)

Baytree Behavioral Health Notices of Privacy Practices

I have read and understand Baytree Behavioral Health HIPAA Practices and my rights and responsibilities as they pertain to my treatment record at Baytree Behavioral Health. I am also aware that upon request I may receive a hardcopy of this Privacy Notice.

Patient Signature:

Patient Representative:

Witness:

Date:

Date: _____

Patient Name: _____

I have been provided information on the following:

Patient Privacy Statement (HIPAA)

I Accept _____
(Patient Signature)

Benefits & Release: I authorize the billing of my insurance company for services provided.
*(For Medicare/Tricare patients: Your plans are **almost always secondary to any other commercial insurance**. Failure to disclose other insurance is illegal and could result in charges not being covered by either insurance, becoming patient responsibility.)*

I Accept _____
(Patient Signature)

Patient Financial Policy

Note: No-shows or cancellations with less than 24 hours notice are subject to a $50 fee

I Accept _____
(Patient Signature)

For Tricare Patients Only

Baytree Behavioral Health
Office: 321-253-8887 / Fax: 321-253-8878
CONSENT TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

I, _____ (DOB_____), hereby authorize
Baytree Behavioral Health, located at 1370 Bedford Dr., Suite 106, Melbourne, Florida 32940,
_____ **to release to** _____**to receive from** (check appropriate line)

Person/facility/agency: **45th Medical Group Patrick AFB**
Fax/Phone: **P: 321-494-7599 F: 321-494-8334**
Address if known: _____
The specific information indicated below with regard to the services provided to me for the period of treatment from _____(all dates included)_____ for the following purposes:
____For coordination of care
____For treatment at this facility
____For processing of my insurance claim
____For peer review/third party payer
____Other (specify): _____
Information to be furnished (this section must be completed)
Check/Initials

_____Progress reports throughout treatment
_____Report of psychological/psychiatric evaluation
_____History and Physical
_____Medical Discharge Summary
_____Psychosocial Assessment
_____Continuing Care Plan
_____Progress Notes
_____Neuropsychological Assessment
_____Lab and Radiographic results
_____Consultations
_____Legal
_____Other: Specify_____

I understand that the above consent is subject to revocation by me at any time except to the extent that action has been taken in reliance on this consent prior to revocation. The Federal Regulations regarding the confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR part 2) have been explained to me as applicable.

_____ or _____
Patient Signature Parent/Legal Guardian

_____ _____
Witness Date

****

I do not want my records released to Patrick Airforce Base.

_____ or _____
Patient Signature Parent/Legal Guardian

_____ _____
Witness Date