General Information

Suzanne M. James, PSY.D., LLC
Licensed Psychologist
305 Artillery Park Dr. Ste. 102
Fort Mitchell, KY 41017
(859) 426-0200

ADULT

Patient Information: Date:___________________________

Patient Name:____
Last First Middle

Address:____

City:____ State:_____________ Zip:__________________

Phone Home:(______)_______-___________Cell:(______)_______-___________ Work:(______)_______-___________

OK to leave message at this number? (Y/N) Home:_______ Cell:_______ Work:_______

Email: ____ OK so send email to this address? Y/N: _________

Patient Social Security #: __________________________ Date of Birth:______-_______-__________

Gender: [ ] Male [ ] Female

Marital Status: [ ] Married [ ] Single [ ] Divorced
[ ] Separated [ ] Widowed [ ] NA (children)

Employment Status: [ ] Employed [ ] Student [ ] Unemployed

Primary Care Physician:__________________________________ Phone:________________________

Insured's Information:
If the insurance you are using is provided to you through a family member you must complete the following for us to bill the insurance on your behalf.

Insured's Name: ____

Insured's Social Sercurity #: __________________________ Date of Birth:______-_______-________

Insured's place of employment: ____

If different from above:
Address:____

City:____ State:_____________ Zip:_________________

Home Phone:(_______)________-______________ Employer: ______________________________

In Case of Emergency, Contact:

Name:_________________________________ Relationship:_________________________

Phone:_________________________________

Insurance Authorization Number: __________________________________ (If known)

Who referred you to our practice? ________________________________ May we thank them: [ ] Yes [ ] No

Are you seeking counseling related to a court order or legal proceedings? [ ] Yes [ ] No

Informed Consent for Receipt of Psychological Services (Adult)

This form is to document that I, ____ give voluntary permission and consent to receiving psychological services from Dr. Suzanne James.

______ **Purpose and Background:**

The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of KY to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise.

While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Dr. Suzanne James. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

______ **Confidentiality:**

I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

______ **HIPAA**

I understand that this consent form acknowledges my right to privacy and the limitations on my privacy, I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of Dr. Suzanne James' "Notice of Privacy Practices", that were effective of as their start of business on March 1st, 2004. I acknowledge I was offered this policy statement on the date indicated by my signature below.

______ **Attendance:**

I understand that regular attendance, a willingness to be open and honest and follow-through on treatment suggestions will produce maximum benefits, but that the final decision on what to do is always up to me. In addition, I understand that I am free to discontinue treatment at any time. A termination session may be requested in order to provide for any continuing areas of concern.

I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the rate of $60 per missed appointment. Further, I understand that my insurance will not cover these charges in any way, and I will be liable for all charges that result from a missed appointment without sufficient (24 hour) notice.

______ **Emails, texing, letters, and phone messages outside of session:**

Please note that emails, letters, phone messages and texting are not appropriate ways of communicating therapeutic issues. If an email or text is received regarding a therapy issue, it will be discussed in the following session. Texting,

emailing, and phone messages are appropriate only to cancel or reschedule an appointment. A phone call is appropriate also in case of emergency.

______ **Telepsychology:**
If at any time during treatment, the use of phone or skype is utilized, it is important to understand that there are limitations. This is an innovative method of treatment and as changes occur, this consent will be updated. Current risks include:

1. Risks of confidentiality of information due to technology. Please note that rules of confidentiality outside of technology related issues will remain in effect.
2. Reporting of self-harm, suicidal and homicidal behavior will continue to remain in effect and local authorities to the client will be called.
3. Risk of disruption of service due to technology problems. If this occurs, this therapist will contact client as soon as possible. If the problem persists, this therapist will use an alternative method for rescheduling the appointment.
4. If this therapist determines that treatment through telepsychology is not effective and face-to-face needs to occur, a referral will be made.
5. Please note that emails and texting are not appropriate ways of communicating therapeutic issues. If an email or text is received regarding psychological concerns, thoughts, or feelings, these will be discussed in the following session.

______ **Contact Information:**
The office address for Suzanne James, Psy. D., LLC is 305 Artillery Park Dr Ste 102, Ft. Mitchell, KY 41017. I understand that for routine appointments and information I may call (859) 426-0200. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned as soon as possible by my therapist. If I have an after-hours crisis or need assistance more quickly I can call my therapist at the crisis contact number provided in their regular voicemail box, however, I understand this number is for crises only. If I feel I need immediate psychiatric admission to a hospital for stabilization, I understand that I may be referred to the nearest hospital emergency room.

______ **Complaints Procedure:**
If I am dissatisfied with any aspect of the services I receive, I understand that I can and am encouraged to raise my concerns with my therapist immediately. Dissatisfactions will make working together slower and more difficult if not resolved. If I feel that I have been treated unfairly or unethically and cannot resolve this problem directly, a complaint procedure is available through your therapist's state licensing agency, which may be contacted in Frankfort, KY 40602.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.

I release and hold harmless Suzanne James, PSY. D., LLC., and its staff and agents from any action or liability arising out of my participation in treatment.

____ ______________________________

Signature of client Date

____ ______________________________

Signature of Witness Date

Consent To Bill Third Party Payer

Use of Insurance:
As a part of receiving psychological services through Dr. Suzanne James, I understand that I will be responsible for the financial expenses incurred as the result of my participation in treatment. I further understand that I may elect to use a third party payer, i.e. medical insurance, to help cover the cost associated with treatment. However, I understand that if I elect to use a third party payer to help offset the cost of my treatment, I will be required to consent to the release of information for billing purposes. This will definitely mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and at times may constitute the release of treatment planning information.

Charges for Services:

Diagnostic Assessment	$140.00
Psychotherapy Session (45-50 min)	$125.00
Psychological Testing (Per unit)	$150.00
Case Management (per 15 minute)	$ 35.00
Missed Appointment/Late Cancellation	$ 60.00

Payment:
I understand that payment is expected at time of service. If I wish to pay for services out of pocket, or for the purposes of making my co-payment, should I elect to use my insurance, I may make payments via cash or check. I understand all checks returned unpaid will be subject to a $25.00 service fee, and if they remain unpaid for more than three months, may be turned over to a collection agency for the purpose of recovering lost funds.

Use of Insurance and Authorization for Treatment:
If I chose to use medical insurance, it is important that I be aware of my coverage and limits. I am responsible for amounts and/or services not covered by my insurance. I am also responsible for payment of amounts not covered because of failure to obtain a referral or not following necessary guidelines set by my insurance company for accessing mental health benefits. I understand I will be charged $60.00 for missed or cancelled appointments unless prior notification is given 24 hours prior to the time of the appointment, I understand that insurance companies do not cover the costs of missed appointments and I will be billed directly.

I, ____,

☐ wish to use my medical insurance to off-set the cost of treatment, and in so doing give Dr. Suzanne James permission to release any information necessary to process this claim and collect payment for the services rendered. I permit direct payment to my therapist any benefits due me for services rendered. I understand I am financially responsible for all services rendered, if not otherwise satisfied through my medical insurance.

☐ do not wish to use any medical insurance benefit to cover services I receive through Dr. Suzanne James. I understand that I am financially responsible for all expenses incurred for my treatment, and will make all payments at the time of service.

____ ______________________________

Signature of Client/Responsible Party Date

____ ______________________________

Signature of Witness Date

ADULT INTAKE

Name: ______________________________

Date: ______________________________

Date of Birth: _______________ Age: ____________

1. Why have you come to Suzanne James, PSY.D., LLC (Presenting issue for Client)?

____

____

____

2. How long has this been an issue? ____

3. What have you tried to do to resolve this issue?

____

____

4. What are your goals for counseling?

____

____

5. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems, and chemical dependency/use):

____

____

____

6. Has any other member of your family (including extended family) been diagnosed or had significant problems with mental health issues and/or alcohol use or chemical dependency? Please explain:

____

____

7. Who resides with you in your home?

Name and Relationship:	Age:
__________________________	________
__________________________	________
__________________________	________
__________________________	________
__________________________	________
__________________________	________

8. Children (names, ages, gender, problems, strengths):

____

____

____

9. Educational History

Highest grade actually completed: _____________ Did you obtain a GED? (circle) Yes No

How would you describe your usual performance (grades) in school?

____ A & B ____ B & C ____ C & D ____ D & F

Academic Strengths: ________________________ Academic Weaknesses: _____________________________

Did you repeat any grades? (circle) Yes No Which grade(s)? __________________________

Reason: ____

Were you in any special classes or receive any special services? (circle): Yes No

Describe: ____

Describe any problems you may have had learning to read, write or do math?

____

____

Did you have any attentional or behavioral problems? (circle): Yes No

Describe: ____

10. Work History

Current work status: (circle) Full-time Part-time Not Working Retired Disabled

Employment Dates	Company	Job Title
________________________	_______________________	___________________________
________________________	_______________________	___________________________
________________________	_______________________	___________________________

Any work-related problems? (circle): Yes No Describe: ____

____

Have you or are you considering applying for disability benefits? (circle) Yes No

11. Legal History

Current/Past Legal Problems? (circle): Yes No Describe: ____

____

Any pending litigation? (circle): Yes No Describe: ____

____

Attorney name: ____ Phone #: ______________________________
Attorney address: ____

Durable Power of Attorney? (circle) Yes No Name: ____

Do you have a will? (circle) Yes No Living Will? (circle) Yes No

12. Alcohol/Drug History

Have you or anyone who has known you ever been concerned about your use of alcohol or drugs (either prescribed or illicit)? (circle): Yes No

Chemical Used	Age Started	Amount	Frequency	Last use

Do you consider yourself dependent on any of the above drugs? (circle): Yes No

If yes, which ones: ____

Do you consider yourself dependent on any prescription medications? (circle): Yes No

If yes, which ones: ____

Has use of drugs/alcohol affected your work performance or relationships? (circle): Yes No

Describe: ____

Have you had any legal problems related to your drugs/alcohol use? (circle): Yes No

Describe: ____

Have you ever experienced any of the following due to the use of alcohol or drugs?

____ Increased tolerance

____ Withdrawal symptoms

____ Used more than had intended

____ Difficulty controlling use

____ Guilty about use

____ Dangerous behaviors (e.g., physical fights, Driving when intoxicated)

____ Used first thing in the morning

____ Used excessively when alone

____ Trouble with or lost relationships

____ Trouble at or lost jobs

____ Legal problems

Have you ever attended Alcoholics Anonymous or similar support groups? (circle): Yes No

Have you ever been hospitalized for drug/alcohol related problems? (circle): Yes No

Describe: ____

Do you drink alcohol? Yes____ No_____ If yes, how often?______________________________

When was the last time you had a drink? ____

How much did you drink at that time? ____

Do you have any history of using or abusing drugs/medications? Yes____ No____

Do you currently abuse any drugs/medications? Yes____ No____

What substances have you used in the last 6 months? (check all that apply)

[ ] Marijuana/ "Pot" [ ] Cocaine [ ] Inhalants/ "Huffing"
[ ] LSD/ "Acid" [ ] Amphetamines/ "Speed" [ ] Other
[ ] Pain Killers [ ] Sedatives/ "Downers" [ ] None of Above

If "Other" is checked, explain below:

____

____

____

Check any of the following that has occurred as a result of your drinking or drug use:

[ ] Arrest [ ] DUI [ ] Family Problems
[ ] Public Intoxication [ ] Financial Problems [ ] Arguments
[ ] Work Problems [ ] Health Problems [ ] Relationship Problems

Do you use Nicotine? Yes [ ] No [ ] Amount? ___________________________________

Do you use Caffeine? Yes [ ] No [ ] Amount? ___________________________________

13. Medical History

Health (describe your general health as well as any chronic conditions including pain)

____

____

14. Describe any history of head trauma? ____

15. Who is your primary care physician? ____

When was your last complete physical exam by an M.D.? ____________________________

Are you currently under the care of an M.D. for any condition? Yes____ No____

If yes, please explain: ____

Please list all current medications including over-the-counter and prescription medications:

Name of Medication:	Dosage:	Date Started:
____________________	________	________________
____________________	________	________________
____________________	________	________________
____________________	________	________________

Please prior medication for mental health issues, chemical dependency or alcohol use:

Name of Medication:	Dosage:	Date Started:
____________________	________	________________
____________________	________	________________
____________________	________	________________

16. Health Concerns

Please check any of the following that apply:

[ ] Significant weight gain/loss in the last six months
[ ] Food/drug allergies
[ ] Problems chewing or swallowing
[ ] Dieting
[ ] Overeating or eating too little

If any box is checked, please explain:

____

____

Do you have any functional limitations that affect your daily living (ex: physical impairments, problems with self care, speech, vision, or hearing)? Yes_____ No_____

If yes, please explain: ____

17. Family History:

Among your family, did any have significant problems with:

Mental health? ____

Neurological Disorders (e.g., dementia, stroke, genetic disorders)? _____________________

Medical Disorders? ____

Substance/ Alcohol Abuse? ____

18. Developmental History:

Were you born? (circle) On time Prematurely Late

Describe any problems with your birth or immediately afterward (oxygen deprivation, illness):

____

Describe anything that was unusual about your early developmental history (e.g. meeting developmental milestones as infant/child): ____

____

Describe significant developmental events in your life (e.g., marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.): ____

____

19. Legal History:

Please place an **"N"** for none, **"C"** for currently experiencing, or **"P"** for experienced in the past.

DUI	________	Bankruptcy	______	Divorce	________
Unemployment	________	Domestic Violence	______	Custody Dispute	________
Disability Claim	________	Workman's Compensation	______		

20. Financial Problems: ____

21. Educational Background (highest grade completed): ______________________________

22. Employment History (Please describe current job briefly):

____

23. Military Service: ____

24. History of Abuse:
Please place an **"N"** for none, **"C"** for currently experiencing, or **"P"** for experienced in the past.

Verbal Abuse _______ Emotional Abuse _______ Childhood Abuse _______
Physical Abuse _______ Spouse Abuse _______
Sexual Abuse _______ Elder Abuse _______

25. Sexual/Affectionate History:
Are you satisfied with your sex life? Yes_____ No_____
Do you have any concerns or question about your sexual orientation or experiences? (If so, please explain)
____
____

26. Religious/Spiritual History:
Do you have an identified religious preference?
____

27. History of Harm to Self or Others:
Do you currently have any urges/thoughts of hurting yourself? Yes_____ No_____
Any current urges/thoughts of hurting another? Yes_____ No_____
Any history of hurting self or suicide attempt? Yes_____ No_____
Any history of physical aggression toward another Yes_____ No_____
If yes on any of these questions, please describe in the space below:
____
____

28. Current Life Stressors
Please describe any stressors including anything that *is* currently stressful for you such as relationships, job, school, finances, children, etc.: ____

____

29. Goals of Consultation/ Treatment
What are your goals in seeking this consultation? What do you hope to gain?

____

____