The Family Practice
Christopher M. Phillips, Ph.D.
Licensed Psychologist
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info@thefamilypractice.org

Date: _____

This form is subject to the Privacy Act of 1974

This questionnaire is designed to help your provider understand more about you. The primary purpose of asking these questions is to develop a treatment plan that will best suit the reasons you came to this clinic. By completing these questions as completely and honestly as you can, we will be able to offer you treatment most in line with your reasons for coming to this clinic. This form will be included in your mental health record. It will not be included in your medical chart.

NEW PATIENT EVALUATION

Demographics:

Patient Name:		Patient SSN:	
Age:	Rank:	Date of Birth:	Gender (circle one): M F
Ethnic group: American Indian/Alaskan White, Not of Hispanic origin Latino or Hispanic Black, not of Hispanic Origin Asian or Pacific Islander Other:			
Address:			
City: State: Zip code:			
Telephone Numbers: (home):	(work):	(cell):	
May we leave a phone message for you? Yes / No	Marital Status (circle one): Single Married Separated Divorced	If Married, Spouse's Name:	
Email address:			
Children? Yes / No If yes, how many children? _____ boys, ages _____ girls, ages _____			
Emergency Contact: Relation: Phone:			

Employer_____

Occupation (also rank if applicable)_____

Spouse's Employer_____ Occupation_____

Address_____City_____State_____Zip_____

Name of Insured _____ Insured's SS# (aka, Sponsor's SS#)_____

Address of the insured_____City_____State____Zip_____
Insured's I.D. #_____
Insured's Date of Birth __
Health Insurance Co _____
Health Insurance Co Phone_____
Insurance Co Address_____City_____State_____Zip _____
Insured's Policy Group # _____
Insurance Plan Name or Program Name _____
Is there another Health Benefit Plan? Yes No
(please provide Ins. Policy Name & Group #_____

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Primary Concern:

Briefly describe the problems/concerns that brought you here.

_____

_____

What led to your decision to seek help now?

_____

_____

How upsetting is the problem to you? □ Mild □ Moderate □ Severe

What makes the problem worse?

_____

What makes the problem better?

_____

What has changed in your life because of your primary concern? (e.g., relationships with family and friends, your desire to have fun, job difficulties, etc.):

_____

_____

Emotions/Behaviors:

How would you describe your **typical mood** (e.g., happy, sad, mad, depressed, numb, frustrated, etc.):

Over the past month? _____

Over the past year? _____

Today?_____

Please rate the extent to which each item below has been a problem for you over the **past month**.

	No Problem	Mild Problem	Moderate Problem	Extreme Problem
S: Sleeping too much				
Difficulties falling asleep				
Difficulties staying asleep				
Waking earlier than desired				
I: Loss of interest in enjoyable activities				
G: Excessive guilt				
Feeling worthless				
E: Decreased energy				
Increased energy				
C: Difficulties with concentration/memory				
A: Increased appetite				
Decreased appetite				
P: Unable to sit still				
Moving so slowly others notice				
S: Changes in sexual interest				
Mood swings				
Feeling sad or depressed				
Feeling nothing or feeling numb				
Anger				
Anxiety or fear				
Avoiding places, people, or situations				
Seeing things that others may not see				
Hearing things that others may not hear				

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Risk Assessment:

Please check all that apply.	**Currently** (last week)	**Recently** (in last 6 months)	**Previously** (+6months ago)	**Never**
Recurrent thoughts about death				
Recurrent thoughts about killing yourself				
Thinking out a plan to kill yourself				
Active preparation to kill yourself (e.g., writing goodbye letter, purchasing pills, obtaining a weapon)				
Attempting to kill yourself				
Engagement in self-harming behaviors (e.g., cutting or burning yourself)				
Recurrent thoughts about killing others				
Thinking out a plan to kill others				
Active preparation to kill others				
Attempting to kill others				
Believing that others would be "better off" if you die				
Feeling hopeless about your life and future				
A family member or close friend attempting or completing suicide				
Voices telling you to hurt or kill yourself or others				
Being more physically or verbally aggressive than you intended with your spouse or children				
A physical altercation in which you caused injury				
Throwing or breaking things when angry				
Arrest for physical violence				

Physical Symptoms / Medical Issues:

Is your current reason for coming associated with a physical / medical issue? YES NO
(If yes, please explain):

_____
_____

Are you currently being seen or receiving any type of treatment for any physical problems? YES NO
(If yes, please explain):

_____
_____

Do you experience physical pain on a regular basis? YES NO
If yes, what is your usual level of that pain? 0 1 2 3 4 5 6 7 8 9 10
(0 = No pain) (10 = Extreme pain)
Details:

_____
_____

Are you having any difficulties with appetite or eating? YES NO

(If yes, please explain): _____

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Medications:

Please list **any** medications you are currently taking or have taken within the last year

Medication	Dosage	How often?	For what condition?

Mental Health History:

Please check any of the following that apply to you at any time in your life

	Saw a physician for a mental health problem		Had a substance or alcohol abuse evaluation or treatment
	Saw a school counselor for counseling		Saw a psychiatrist, psychologist, social worker, or counselor for treatment or assessment (on or off base)
	Was given medication for a mental health problem		

Please explain any checked items below (e.g., brief details, dates, locations):

_____
_____
_____
_____
_____
_____

Family Mental Health History:

Have any members of your family been affected by a mental health related condition or diagnosis? YES NO
(If yes, please explain):

_____
_____
_____
_____
_____

Is the reason for your visit today related to a family mental health related problem? YES NO
(If yes, please explain):

_____
_____
_____
_____
_____

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Family Background:

Please check any of the following events that applied to you as a child, adolescent, or adult:

	Abusive Relationship		Rape		Happy Childhood
	Experienced physical abuse		Miscarriage		Unhappy Childhood
	Experienced emotional abuse		Abortion		Death of parent
	Experienced sexual abuse		Crime victim		Death of someone close
	Witnessed physical abuse		War		Filed for bankruptcy
	Witnessed emotional abuse		Poverty		Natural disaster
	Witnessed sexual abuse		Divorce		Other:

Where did you grow up? _____
Are your parents married / divorce / separated / other: _____
Do you have step-parents? _____
Do you have any siblings or step-siblings?_____

Quality of relationship with your family of origin? Excellent / Good / Fair / Poor / Other:_____

Are you currently having family of origin-related problems? YES NO
(If yes, please explain):
_____
_____

Is the reason for your visit today related to your childhood or adolescence? YES NO
(If yes, please explain):
_____
_____

Current Living Situation:

Briefly describe your current living situation (e.g., with whom you currently live)
_____
_____

Are you currently having any problems at home and/or in your marriage? YES NO
(If yes, please explain):
_____
_____

Are your relationships physically and emotionally safe? YES NO
(If no, please describe): _____

Are you experiencing any Legal difficulties? YES NO
(If yes, please explain):
_____

Are you experiencing any Financial difficulties? YES NO
(If yes, please explain):
_____

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Relationships (Please complete if you are currently in a significant relationship.)

Are you currently in a significant relationship? YES NO (if no skip to occupation section)

Any problems you want to address within your relationship? YES NO

If yes, what are your concerns_____
_____

How long have you been together?
_____

What initially attracted you to partner?
_____

What do you have in common and/or agree upon?
_____

How are you different and/or what do you disagree about?
_____

What do you do when there is a conflict between you? _____

Do you have children together? YES NO If yes, how many/sexes/ages? _____

Do you have children from another relationship? YES NO _____

Did your partner bring children into the relationship? YES NO _____

Are you experiencing any parenting problems? YES NO Would you like a referral to the New Parent Support Program? YES NO

Is there any emotionally aggressive behavior in the relationship? YES NO
yelling belittling name-calling controlling unjustified jealously

Is there any physically aggressive behavior in the relationship? YES NO
pushing shoving hitting restraining blocking strangling use of weapon hitting inanimate objects throwing thing

Occupation / Duties:

What is your job title? _____

Briefly describe your duties at work:
_____

Are you having any work-related difficulties? YES NO

(If yes, please explain): _____
_____
_____
_____

Is your visit today related to your work? YES NO

(If yes, please explain):
_____
_____
_____
_____

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Learning/Education:

What is the highest education you have completed? (please circle)

GED HS diploma Some College Bachelor's Some Graduate Graduate Degree

Are you currently in school? YES NO Details: _____

Are you experiencing any academic-related difficulties? YES NO
(If yes, please explain):_____

Coping:

Who do you talk to about your problems?_____
What do you do when you're sad? _____
What do you do when you're angry? _____
What do you do when you're afraid/worried?_____
Do you have friends and/or family that are supportive? YES NO
How do you spend your free time?_____
_____
What activities / hobbies are fun for you?_____
_____
Are you doing them?_____
If not, why? _____
Who do you most enjoy spending time with?
_____
Are you spending regular time with friends or family? YES NO

Religion/Spirituality

Do you have a religious affiliation? YES NO Do you utilize a religious higher power? YES NO

Do you have any religious/ spiritual concerns? YES NO

What religion / form of spirituality do you practice (if applicable)? _____

Substance Use:

Tobacco/Caffeine:

Do you use tobacco products? YES NO
If yes, what kind? _____ How much (e.g., packs per day)? _____

Do you use caffeinated products (e.g., coffee, tea, soda, energy drinks)? YES NO
If yes, what kind? _____ How much (e.g., servings per day)? _____

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Drugs:

Have you overused any prescription or over-the-counter drug?	Yes	No
Have you used any illegal drugs now or in the past?	Yes	No
Have you ever taken drugs by IV?	Yes	No
Have you ever been in treatment for drug use?	Yes	No

If yes, list year, type, frequency, and reason:

_____

Alcohol:

Do you drink alcohol now or have you in the past (including beer and wine)? **If yes,** please answer the following:	Yes	No
How many days out of the **month** do you drink? _____		
How much do you usually drink when you do drink? Wine _____ and/or Beer _____ and/or Hard alcohol _____		
How often do you drink to get drunk or to get away from stressors per **month**? _____		
Has your alcohol use increased in the past month?	Yes	No
Have you had problems in your relationships with friends or family due to alcohol use?	Yes	No
Have you had problems at work or at home due to alcohol use?	Yes	No
Have you blacked out in the past from drinking alcohol?	Yes	No
Have you ever been in treatment for use of alcohol (including, AA, Rational Recovery, etc.)?	Yes	No
Have you had trouble with the law due to alcohol use (e.g., DUI, drinking underage, public intoxication, alcohol-related violence)?	Yes	No
Do you drive after drinking alcohol?	Yes	No

DID SOMEONE REFER YOU? IF NOT HOW DID YOU HEAR ABOUT US?

_____

GOALS FOR TREATMENT:

How do you want us to help you (e.g., goals for therapy, behaviors you want to change)?

1. _____

2. _____

3. _____

Please indicate if there is anything else you want us to know about you and/or your visit to us today:

_____

_____

_____

Patient Signature _____ **Date** _____

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NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL (INCLUDING MENTAL HEALTH) INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Christopher M. Phillips, Ph.D. is a licensed Psychologist in the state pf Colorado. His license number is 3346. He earned a PhD in Counseling Psychology from the University of Wisconsin-Madison. His address and phone number is: 6005 Delmonico Drive, Suite 150, Colorado Springs, Colorado, 80919, (719) 266-5244.

During the process of providing services to you, the provider will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as described below.

I. USES AND DISCLOSURES OF PROTECTED INFORMATION

A. General Uses and Disclosures Not Requiring the Client's Consent. The provider will use and disclose protected health information in following ways.

1. *Treatment.* Treatment refers to the provision, coordination, or management of health care (including mental health care) and related services by one or more health care providers. For example, the provider will use your information to plan your course of treatment. As to other examples, the provider may consult with professional colleagues or ask professional colleagues to cover calls of the practices or the provider and will provide the information necessary to complete those tasks.

2. *Payment.* Payment refers to the activities undertaken by a health care provider (including a mental health provider) to obtain or provide reimbursement for the provision of health care. The provider will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company or other third-party payer for services provided. The information provided to insurers and other third-party payers may include information that identifies you, as well as your diagnosis, type of services, provider name/identifier, and other information about your condition and treatment. If you are covered by Medicare, information will be provided to the State of Colorado's Medicare program, including but not limited to your treatment, condition, diagnosis, and services received.

3. *Health Care Operations.* Health Care Operations refer to activities undertaken by the provider that are regular functions of management and administrative activities of the practice. For example, the provider may use or disclose your health information in the monitoring of service quality, staff evaluation, and obtaining legal services.

4. *Contacting the Client.* The provider may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

5. *Required by Law.* The provider will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect, including any past or present sexual contact with a minor; elder abuse or neglect; domestic violence (b) when court ordered to release information (c) when there is a legal duty to warn or take action regarding in imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

6. *Crimes on the premises or observed by the provider.* Crimes that are observed by the provider or the provider's staff, crimes that are directed towards the provider or the provider's staff, or crimes that occur on the premises will be reported to law enforcement.

7. *Business Associates.* Some of the functions of the provider may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

8. *Research.* The provider may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulations are followed. 45 CFR § 164.512(i).

9. *Involuntary Clients.* Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

10. *Family Members.* Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

11. *Emergencies*. In life threatening emergencies the provider will disclose information necessary to avoid serious harm or death.

B. Client Authorization or Releases of Information. The provider may not use or disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent the provider has already taken action in reliance thereon.

II. YOUR RIGHTS AS A CLIENT

A. Access to Protected Health Information. You have the right to inspect and obtain a copy of the protected health information the provider has regarding you, in the designated record set. However, you do not have the right to inspect or obtain a copy of psychotherapy notes. There are other limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask your therapist.

B. Amendment of Your Record. You have the right to request that the provider amend your protected health information. The provider is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask your therapist.

C. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures the provider has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a sign Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask your therapist.

D. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. The provider does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask your therapist.

E. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask your therapist.

F. Copy of this Notice. You have a right to obtain another copy of this Notice upon request.

III. Fees and Payments

A. Fee Rate: The charge for each therapy meeting will be at the rate of $125 per follow up session and $155 for each intake session or at the rate agreed upon your insurance if you have been preapproved for mental health treatment through these carriers. Additional fees will be arranged if you should require me to spend an unusual amount of time on auxiliary services such as consultation with other professionals, preparation for testimony or telephone calls over five minutes. These services will be charged at the standard rate. Fees for psychological testing are based on time with the patient plus time required for scoring and interpreting test data. For sessions conducted anywhere other than the office, travel time plus expenses will be charged at the standard fee.

B. Payment Method: Payment is requested at the time of services unless we agree otherwise or unless you have insurance coverage which requires another arrangement. In these situations, co-payments and non-allowable charges are requested at the time of service. Payment may be made by check, cash, or most major credit cards.

C. Statements: If psychotherapy/consultation is scheduled on a regular and ongoing basis, clients may request monthly statements/payments. When monthly statements are rendered, payment is expected within 10 days of receipt of statement.

D. Past Due Accounts: Processing past due accounts is expensive (supply costs, postage, bookkeeping services, etc.) **A $25 rebilling charge** will be added to all accounts with overdue balances (unpaid charges older than 60 days) unless other arrangements have been made. All overdue accounts **(unpaid after 60 days)** will be submitted to a collection agency. If such action is necessary, its costs will be included in the claim. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Cancellation Policy: If an appointment is cancelled or missed without 24 '<u>business hours'</u> notice, you will be billed $125 for the session, except in extreme emergencies. The missed appointment cannot be billed to your insurance as that is considered insurance fraud.

III. ADDITIONAL INFORMATION

A. Privacy Laws. The provider is required by State and Federal law to maintain the privacy of protected health information. In addition, the provider is required by law to provide clients with notice of the provider's legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. Terms of the Notice and Changes to the Notice. The provider is required to abide by the terms of this Notices, or any amended Notice that may follow. The provider reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted at the provider's service delivery sites and will be available upon request.

C. Complaints Regarding Privacy Rights. If you believe the provider has violated your privacy rights, you have the right to complain to the provider. Your therapist is the person designated within the practice to receive your complaints. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington D.C. 20201. It is the policy of the provider that there will be no retaliation for your filing of such complaints.

D. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Section of the Division of Registrations. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

E. Additional Information. If you desire additional information about your privacy rights, ask your therapist.

F. Effective Date. This Notice is effective January 1, 2018.

G. The following is also required by the Colorado to be noted in

(I) A client is entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure;

(II) The client may seek a second opinion from another therapist or may terminate therapy at any time;

(III) In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder;

(IV) The information provided by the client during therapy sessions is legally confidential in the case of licensed marriage and family therapists, social workers, professional counselors, and psychologists; licensed or certified addiction counselors; and registered psychotherapists, except as provided in section 12-43-218 and except for certain legal exceptions that will be identified by the licensee, registrant, or certificate holder should any such situation arise during therapy; and (e) If the mental health professional is a registered psychotherapist, a statement indicating that a registered psychotherapist is a psychotherapist listed in the state's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state. (2) If the client is a child who is consenting to mental health services pursuant to section 27-65-103, C.R.S., disclosure shall be made to the child. If the client is a child whose parent or legal guardian is consenting to mental health services, disclosure shall be made to the parent or legal guardian.

G. Generally speaking, the information provided by and to you as the client during the therapy sessions is legally confidential. Since the information is legally confidential, I cannot be forced to disclose any of your information without your consent. Information disclosed to me is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

H. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.

I. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

J. You can seek a second opinion from another therapist or terminate therapy at any time.

K. By signing this disclosure, you acknowledge you acknowledge that have read the preceding information and understand your rights as a patient.

Health Information Privacy Notice (HIPAA): By signing this disclosure you acknowledge receipt of the HIPAA policies for your review. You are not required to sign this notice to receive treatment. Please verbally inform me if you elect to not sign the notice.

_____

Patient/Consultant Signature (Parent or Guardian for a Minor) Date

_____

Patient/Consultant PRINTED NAME (Parent or Guardian for a Minor)