KOVNER CENTER FOR BEHAVIORAL HEALTH AND PSYCHOLOGICAL TESTING

CLIENT INFORMATION FORM

Today's Date:					
Presenting Problem:					
	CLIENT'S INFORMATION		**SPOUSE OR PARTNER'S INFORMATION**		
Client's Name:			**Spouse or Partner's Name:**		
Date of Birth:		**Age:**	**Date of Birth:**		**Age:**
Cell Phone:			**Cell Phone:**		
Employer/ Occupation:			**Home Phone:**		
E-Mail:			**E-Mail:**		
Address:			**Employer's Name:**		
City and Zip Code:			**Occupation:**		
Emergency Contact and Phone:					
Physician's Name:			**Young Adult's Parents' Names:**		
Physician's Phone Number:			**Young Adults Parent's Phone:**		
Childrens': Names/Ages:					

INSURED'S INFORMATION IF USING INSURANCE			
Primary Insurance Company:		**Secondary Insurance Company:**	
Insured's Name:		**Insured's Name:**	
Insured's Employer:		**Insured's Employer:**	
Insured's Date of Birth:		**Insured's Date of Birth:**	
Address:		**Address:**	
State/Zip Code:		**State/Zip Code:**	
Ins. Co. Tel. #:		**Ins. Co. Tel. #:**	
Employer:		**Employer:**	
Policy Number:		**Policy Number:**	
Group Number:		**Group Number:**	
Effective Date:		**Effective Date:**	
Deductible:		**Deductible:**	
Amount Met:		**Amount Met:**	
# of Sess. Per Cal. Yr.:		**# of Sess. Per Cal. Yr.:**	
Co-Pay:		**Co-Pay:**	
Precert? Auth. #:		**Initial Diagnostic Impression:**	

OFFICE POLICIES AND PSYCHOLOGICAL SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. The law requires that I obtain your signature acknowledging that I have provided you with this information at or before the end of the first meeting. Although these documents are long and sometimes complex, it is very important that you read them carefully. I can discuss any questions you have about the procedures during the first meeting. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Under Dr. Kovner's supervision, I provide assessment, diagnosis and treatment of learning, relationship, psychological, and some neuropsychological disorders. By signing this agreement, you are giving consent for yourself and/or your child/to undergo psychological evaluation and/or treatment.

Psychological Testing

A psychological evaluation is a comprehensive assessment of cognitive, educational, and social/emotional functioning. Over a period of 4 to 8 hours, standard testing procedures assess various abilities that relate to cognition, learning, memory, problem solving and critical thinking. The evaluation also measures psychological dimensions relating to social and emotional functioning. The evaluation may also be used to procure public school or college classroom/teaching accommodations for you or your child in order to obtain more effective learning experiences. Also, psychological testing may be used to provide medical clearance, fitness for duty to return to work, or parental competence in a court of law. If you have further questions about the purpose and potential benefits of a psychological evaluation, I will be happy to provide additional information.

Psychotherapy

Psychotherapy, or mental health counseling, is a complex array of many activities that serve to build a trusting relationship between the client and their therapist. This array of activities may consist of play, dance or movement, physical exercise, education, learning, application and practice of that learning, assimilation of learning into behavior and integration of what is learned and practiced into ethical, morally mature, socially responsible and healthy personality functioning. The transformation that occurs through this complex array of activities with the therapist involves easing of personal defense mechanisms that permit insight into one's own emotional life and habitual ways of behaving socially.

Self-control and improved social and moral functioning comes through the development of self-awareness, rational thought, appropriate expression of emotions, planning, anticipation of consequences, mental flexibility, self-acceptance, genuine regard for others' feelings, beliefs, and opinions, and capitalizing on one's existing strengths and resources. By forming a therapeutic alliance with me, we will work to improve your chances of success in achieving the goals of emotional stability, personal and interpersonal growth, occupational and educational satisfaction and social responsibility. Furthermore, research has shown that improvement in mental health can have a beneficial affect on your physical health.

CONTACT INFORMATION AND EMERGENCY PROCEDURES

Often I am not available immediately by telephone. I do not answer the phone when I am in a meeting with a client. On days that I am not in the office, I check voice mail frequently. When I am unavailable, the telephone is answered by the office manager or an answering machine. I will try to return your call within one business day of receiving it, with the exception of holidays and vacations.

If you are difficult to reach, please inform us of some times when you will be available. My practice does not have 24 hour crisis availability, support staff, or a psychiatrist. If it is possible you will need crisis services over the course of treatment it is important that you discuss this point with me as soon as possible. I may recommend that you seek services with a provider who can offer more crisis coverage than can be provided by mye.

In case of an emergency, this is the protocol I follow. In an emergency, you may try to reach me at the office number. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. In a situation where serious harm may occur, call 911 or get safe transportation to the nearest hospital emergency room. If you are able to wait for a return call, clients with life-threatening emergencies will be seen immediately, or directed to emergency care. Clients with non-life threatening urgent needs will be seen within 24 hours or be directed to emergency care.

If I will be unavailable for an extended time and you provide me with a written request I will provide you with the name of a colleague to contact.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in a Clinical Record. Except in unusual circumstances where that disclosure would physically or emotionally endanger you and/or others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. In most circumstances, I am allowed to charge a copying fee and charge for certain other expenses such as postage and envelopes.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

You also may add information to your records when I review them with you if you believe they contain inaccurate or incomplete information.

It is my office policy to retain clients' records for seven years after the end of our therapy.

Please note that in some cases your files may include information from other treatment providers that clients have given me written permission to obtain. If you have given me permission to obtain such records, I cannot provide them to you if you ask to review your files. Instead, I would ask for you to contact the provider who created the records and obtain copies directly from her or him.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. I are happy to discuss any of these rights with you.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about you or your child's treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Georgia law. However, in the following situations, no authorization is required: Disclosures required by health insurers or to collect overdue fees; if you are involved in a court proceeding and a judge waives your privilege to confidentiality. Generally, I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. In the case of suspected child abuse, the privilege is waived because all psychologists are mandated court reporters of child abuse.

Additionally, I would not need authorization to disclose your records under the following circumstances:

1. If a you file a complaint or lawsuit against me, I may disclose relevant information regarding you and your treatment in order to defend myself.

2. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of a client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.

3. You should be aware that I practice with other mental health professionals and that I occasionally employ administrative staff. In some cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations in which we are legally obligated to take actions where your confidentiality privileges are waived. These situations include instances where we believe it is necessary to attempt to protect others from harm. Under such circumstances, I may have to reveal some information about a patient's treatment. These situations are unusual in our practice, and include:

4. If I know or have reasonable cause to suspect that a child under 18 has been or is likely to be abused or neglected or that a disabled person has been abused, neglected or exploited, the law requires that I file a report with the appropriate government agency, usually the Georgia Department of Child Protective Services. Once such a report is filed, I may be required to provide additional information.

5. If I determine that the patient poses a direct threat of imminent harm to the health or safety of any individual, including himself/herself, I may be required to disclose information in order to take protective action(s). These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can assist in providing protection.

6. If you have filed a worker's compensation claim and I are being compensated for your treatment by your employer or its insurance company as a result of that claim, I must provide, upon appropriate request, legally required reports and other information related to your condition.

FEE FOR SERVICES

Your fee per session is based on income. You will need to bring a pay stub and your last 1040 tax return to prove your income.

Sliding Scale

- **If your yearly income is between $35,000 and $50,000, sessions will be charged at $50 per session.**
- **If your yearly income is between $25,000 and $34,000, sessions will be charged at $35 per session.**
- **If your yearly income is below $25,000, your sessions will be charged at $25 per session.**
- **If you are unemployed and not collecting unemployment, your sessions will be charged at $20 per session.**

Payment by cash or credit/debit card must be made at the time you make the appointment.

I also charge my session rate for other services including:

- Psychological Testing
- Report Writing
- Telephone consultations lasting longer than 10 minutes
- Consultations with other professionals
- Preparing records or treatment summaries for court

It may be helpful to keep your credit card on file to make your payments. If so, please fill out the form below.

CREDIT CARD AND AUTHORIZATION FORM

Credit Card Number		**Expirations Date**	/	**Security Code**	
Authorizing Signature _____ **Date** _____		**The services rendered are checked below.** ( ) Diagnostic Interview ( ) Psychotherapy 50-60 Min. ( ) Psychological Evaluation ( ) Court Testimony ( ) Two-Day Couples Retreat ( ) Written Correspondence ( ) Test Results Feedback ( ) School Board, IEP or Tribunal Hearing ( ) Phone Consultations greater than 10 minutes			

CANCELLATION POLICY AND RESCHEDULING APPOINTMENTS

When you schedule an appointment you will be asked to pay for the session at that time. If you cannot keep your appointment, we require a 48 hour advanced notice of your cancellation or else you forfeit your session fee. We refer to this as the ***Cancelation Fee***. The fee may be waived at Ms. Deragon's discretion if you were unable to attend due to circumstances beyond your control.

Your will need to pay for your next appointment at the time you schedule it.

RETURNED CHECK FEES

There will be a $35.00 charge for each returned check to cover all of the expenses involved in paying bank fees and other resulting insufficient funds charges.

EATING OR SMOKING

No Eating or Smoking is permitted in the Building. If you smoke outside, please throw your used cigarette into the plastic receptacle out front. Children are to wait quietly in the waiting room. Parents must accompany young children to the bathroom and make sure all doors are closed and the facilities are left clean. Do not leave children unsupervised in or outside of the office.

THE WAITING AREA

Clients are to wait quietly in the waiting room. Please be courteous and turn your cell phones to vibrate. Please use ear buds to listen to music and voices down to a whisper if you talk on your cell phone. We use the radio to provide the Office Manager privacy. She has limited time. Please respect her time and privacy.

All clinical information is to be presented ***in therapy sessions by appointment***.

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICES OF PRIVACY PRACTICES, OFFICE AND CANCELLATION POLICIES

A summary of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules is available for you to read on line at your-psychologist.com or in the office on the credenza in the waiting room. A paper copy of your HIPAA rights is available to you upon request. The entire privacy rule, as well as guidelines and additional materials may be found on the government website at http//: www.hhs.gov/ocr/hipaa.

By signing below, I acknowledge that I have been provided information about Ms. Deragon's and Dr. Kovner's privacy practices, made the HIPAA information available to read in detail and have therefore been advised of how health information about me may be used and disclosed and how you may obtain access to and control this information according to law; and I have been informed of and agree to their Office Policies and financial agreements.

_____
Client or Parent's Signature

1. Please list who you want to have access to your pertinent medical information?
(i.e.: family member, spouse, significant other)

_____ _____

_____ _____

_____ _____

2. May we leave a message on your phone or answering machine? YES __ NO__

3. Preferred method of contact?

Email _____

Home #_____ Cell #_____ Work #_____

.....

Having read Ms. Deragon's and Dr . Kovner's office policies, I consent to treatment.

X_____

SK Symptoms Checklist © 2009

By Steven Kovner, Ph.D.

Name: _____ Age:_____ Gender:_____ Date:_____

D

- ☐ Persistent, sad, anxious or "empty" feelings
- ☐ Feelings of hopelessness and/or pessimism
- ☐ Feelings of guilt, worthlessness and/or helplessness
- ☐ Irritability, restlessness
- ☐ Loss of interest in activities or hobbies once pleasurable, including sex
- ☐ Fatigue and decreased energy
- ☐ Difficulty concentrating, remembering details and making decisions
- ☐ Insomnia, early-morning wakefulness, or excessive sleeping
- ☐ Overeating, or appetite loss
- ☐ Thoughts of suicide, suicide attempts
- ☐ Persistent aches or pains, headaches, cramps or digestive problems that do not ease even with treatment

GAD

- ☐ Worry very much about everyday things for at least six months, even if there is little or no reason to worry about them
- ☐ Can't control the constant worries
- ☐ Worry much more than I should
- ☐ Can't relax.
- ☐ Have a hard time concentrating
- ☐ Am easily startled
- ☐ Have trouble falling asleep or staying asleep.
- ☐ Feeling tired for no reason
- ☐ Headaches
- ☐ Muscle tension and aches
- ☐ Having a hard time swallowing
- ☐ Trembling or twitching
- ☐ Being irritable
- ☐ Sweating
- ☐ Nausea
- ☐ Feeling lightheaded
- ☐ Feeling out of breath
- ☐ Having to go to the bathroom a lot
- ☐ Hot flashes.

PA

- ☐ Rapid heart rate
- ☐ Sweating
- ☐ Trembling
- ☐ Shortness of breath
- ☐ Hyperventilation
- ☐ Chills
- ☐ Hot flashes
- ☐ Nausea
- ☐ Abdorninal cramping
- ☐ Chest pain

- [ ] Headache
- [ ] Dizziness
- [ ] Faintness
- [ ] Tightness in your throat
- [ ] Trouble swallowing
- [ ] A sense of impending death

PTSD

- [ ] Bad dreams
- [ ] Flashbacks, or feeling like the scary event is happening again
- [ ] Scary thoughts you can't control
- [ ] Staying away from places and things that remind you of what happened
- [ ] Feeling worried, guilty, or sad
- [ ] Thoughts of hurting yourself or others

Ph

- [ ] Fear of places or situations where getting help or escape might be difficult., such as in a crowd or on a bridge?
- [ ] Persistent and unreasonable fear of an object or situation, such as flying, heights, animals, blood, etc.?
- [ ] Being unable to travel alone?
- [ ] Very anxious about being with other people
- [ ] Very self-conscious in front of other people
- [ ] Very worried about how they themselves will act
- [ ] Very afraid of being embarrassed in front of other people
- [ ] Very afraid that other people will judge you
- [ ] Worries for days or weeks before an event where other people will be
- [ ] Stays away from places where there are other people
- [ ] Has a hard time making friends and keeping friends

May have body symptoms when they are with other people, such as:

- [ ] Blushing
- [ ] Heavy sweating
- [ ] Trembling
- [ ] Nausea
- [ ] Has a hard time talking

OCD

- [ ] Has unwanted thoughts, ideas, images, or impulses that seem silly, nasty, or horrible
- [ ] Worries excessively about dirt, germs, or chemicals
- [ ] Constantly worries that something bad will happen because you may not have locked the door or turned off appliances
- [ ] Afraid you will act or speak aggressively when you really don't want to
- [ ] Must do things excessively or must repeat thoughts to feel comfortable
- [ ] Washes self or items excessively
- [ ] Check things over and over again or repeat things many times to be sure they are done properly
- [ ] Avoids situations or people you worry about hurting through aggressive words or deeds
- [ ] Keeps many useless things because you feel you can't throw them away

ASD

As an infant:

- [ ] Did not babble, point, or make meaningful gestures by 1 year of age
- [ ] Did not speak one word by 16 months

- [ ] Did not combine two words by 2 years
- [ ] Did not respond to name
- [ ] Loses language or social skills
- [ ] Poor eye contact
- [ ] Did not seem to know how to play with toys
- [ ] Excessively lines up toys or other objects
- [ ] Is attached to one particular toy or object
- [ ] Did not smile
- [ ] At times seems to be hearing impaired
- [ ] Communication Difficulties
- [ ] Repetitive Behaviors
- [ ] Sensory problems
- [ ] Seizures

ED

- [ ] Emaciation
- [ ] A relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight
- [ ] A distortion of body image and intense fear of gaining weight
- [ ] A lack of menstruation among girls and women
- [ ] Extremely disturbed eating behavior
- [ ] Loses weight by dieting and exercising excessively
- [ ] Loses weight by self-induced vomiting, or misusing laxatives, diuretics or enemas
- [ ] See self as overweight
- [ ] Recurrent and frequent episodes of eating unusually large amounts of food
- [ ] Feeling a lack of control over the eating
- [ ] Fasting
- [ ] Overweight or obese
- [ ] Experience guilt, shame and/or distress about the binge-eating

Sz

- [ ] I see, hear, smell, or feel things that no one else can see, hear, or smell
- [ ] Invisible fingers touch my body when no one is near
- [ ] I can smell odors that no one else detects
- [ ] I see people or objects that others cannot see
- [ ] Neighbors can control my behavior with magnetic wave
- [ ] Trouble organizing thoughts or connecting them logically
- [ ] Thought blocking
- [ ] agitated, repetitive or frozen in body movements
- [ ] Flat affect
- [ ] Talks in a dull or monotonous voice
- [ ] Lack of pleasure in everyday life
- [ ] Lack of ability to begin and sustain planned activities
- [ ] Speaking little, even when forced to interact
- [ ] Poor "executive functioning" (the ability to understand information and use it to make decisions
- [ ] Trouble focusing or paying attention
- [ ] Problems with "working memory" (the ability to use information immediately after learning

BiPD

- [ ] Feel very "up" or "high"
- [ ] Feel "jumpy" or "wired"
- [ ] Talk really fast about a lot of different things

- [ ] Agitated, irritable, or "touchy"
- [ ] Trouble relaxing or sleeping
- [ ] Think they can do a lot of things at once and are more active than usual
- [ ] Do risky things, like spend a lot of money or have reckless sex.
- [ ] Feel very "down" or sad
- [ ] Feel worried and empty
- [ ] Have trouble concentrating
- [ ] Forgets things a lot
- [ ] Lose interest in fun activities and become less active
- [ ] Feel tired or "slowed down"
- [ ] Have trouble sleeping
- [ ] Think about death or suicide.

BoPD

- [ ] Intense bouts of anger, depression and anxiety that may last only hours, or at most a day associated with episodes of impulsive aggression, self-injury, and drug or alcohol abuse
- [ ] Distortions in cognition and sense of self leading to frequent changes in long-term goals, career plans, jobs, friendships, gender identity, and values.
- [ ] Views self as fundamentally bad, or unworthy.
- [ ] Feels unfairly misunderstood or mistreated, bored, empty, and has little idea who they are.
- [ ] Feels isolated and lacking in social support, and may result in frantic efforts to avoid being alone.
- [ ] Often has highly unstable patterns of social relation
- [ ] Develops intense but stormy attachments
- [ ] Attitudes towards family, friends, and loved ones may suddenly shift from idealization (great admiration and love) to devaluation (intense anger and dislike)
- [ ] Fears of abandonment
- [ ] Excessive spending, binge eating and risky sex

ACE

Did a parent or other adult in the household often or very often swear at you, insult you, or put you down?

[ ] YES [ ] NO

Did one of your parents often or very often push, grab, slap or throw something at you?

[ ] YES [ ] NO

Did one of your parents often or very often hit you so hard that you had marks or were injured?

[ ] YES [ ] NO

Did an adult or person at least 5 years older ever have you touch their body in a sexual way?

[ ] YES [ ] NO

Did an adult or perosn at least 5 years older ever attempt oral, anal, or vaginal intercourse with you?

[ ] YES [ ] NO

As a child, did you witness your mother sometimes, often , or very often pushed, grabbed, slapped, or had something thrown at her?

[ ] YES [ ] NO

As a child, did you witness your mother sometimes, often , or very often kicked, bitten, hit with a fist, or hit with something hard?

[ ] YES [ ] NO

SA1. Have you used drugs other than those required for medical reasons? Y[ ] N[ ]

2. Have you abused prescription drugs? Y[ ] N[ ]

3. Do you abuse more than one drug at a time? Y[ ] N[ ]

4. Can you get through the week without using drugs Y N
(other than those required for medical reasons)? Y N
5. Are you always able to stop using drugs when you want to? Y N
6. Do you abuse drugs on a continuous basis? Y N
7. Do you try to limit your drug use to certain situations? Y N
8. Have you had "blackouts" or "flashbacks" as a result of drug use? Y N
9. Do you ever feel bad about your drug abuse? Y N
10. Does your spouse (or parents) ever complain about your involvement with drugs? Y N
11. Do your friends or relatives know or suspect you abuse drugs? Y N
12. Has drug abuse ever created problems between you and your spouse? Y N
13. Has any family member ever sought help for problems related to your drug use? Y N
14. Have you ever lost friends because of your use of drugs? Y N
15. Have you ever neglected your family or missed work because of your use of drugs? Y N
16. Have you ever been in trouble at work because of drug abuse? Y N
17. Have you ever lost a job because of drug abuse? Y N
18. Have you gotten into fights when under the influence of drugs? Y N
19. Have you ever been arrested because of unusual behavior while under the influence of drugs? Y N
20. Have you ever been arrested for driving while under the influence of drugs? Y N
21. Have you engaged in illegal activities in order to obtain drug? Y N
22. Have you ever been arrested for possession of illegal drugs? Y N
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake? Y N
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? Y N
25. Have you ever gone to anyone for help for a drug problem? Y N
26. Have you ever been in a hospital for medical problems related to your drug use? Y N
27. Have you ever been involved in a treatment program specifically related to drug use? Y N
28. Have you been treated as an outpatient for problems related to drug abuse? Y N

A SHORT QUESTIONNAIRE ABOUT YOUR ALCOHOL USE

C - Have you ever thought you should CUT DOWN on your drinking? Y N

A - Have you ever felt ANNOYED by others' criticism of your drinking? Y N

G - Have you ever felt GUILTY about your drinking? Y N

E - Do you have a morning EYE OPENER? Y N