## Client Information

Name:_____

Address (with zip code): _____

Date of Birth: _____

Home Phone:_____ May I leave a message?_____

Cell Phone : _____ May I leave a message? _____

E-mail: _____ May I e-mail you? _____

Primary concern or issue for treatment: _____

Prior treatment: _____

Emergency contact: Name and relationship:_____
Phone Number: _____

Who referred you?_____

## Insurance Information

Insurance company name: _____

Policyholder's name: _____ Date of Birth:_____

Policyholder's Employer:_____

Policyholder's Address: _____

Patient name:_____ Date of Birth:_____

Patient Relationship to Policyholder:_____

Policy ID number:_____ Group Number:_____

Authorization number (if needed): _____

Coverage information:

Co-pay amount:_____

Do you have a yearly deductible? _____ Have you met the deductible?_____

# General Health and Mental Health Information

1. Please list any specific health problems you are currently experiencing:

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2. Please list medications that you are taking:_____

3. Please list any specific sleep problems: _____

4. How many times per week do you generally exercise? _____

   What types of exercise do you participate in? _____

5. Please list any difficulties you experience with your appetite or eating patterns.
   _____

6. Are you currently experiencing overwhelming sadness, grief or depression?

   _____ No _____ Yes, for approximately how long?_____

7. Are you currently experiencing anxiety, panic attacks or any other phobias?

   _____No _____Yes, please describe_____

8. Are you currently experiencing any chronic pain?

   _____ No _____ Yes, please describe_____

9. Do you drink alcohol more than once a week? ____No ____Yes, how much_____

10. How often do you engage in recreational drug use?

    _____Never _____Infrequently _____Monthly _____Weekly _____Daily

11. Are you currently in a relationship?
    _____No _____Yes, how long? _____

12. What significant life changes or stressful events have you experienced recently?
_____

13. Are you currently employed? ____Is there anything stressful about your current work?

14. Do you consider yourself to be spiritual or religious (please describe): _____

# Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, sibling, grandparent, uncle, etc.)

| | Please circle | Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | |
| Anxiety | yes/no | |
| Depression | yes/no | |
| Domestic Violence | yes/no | |
| Eating Disorders | yes/no | |
| Obesity | yes/no | |
| Obsessive Compulsive Behaviors | yes/no | |
| Schizophrenia | yes/no | |
| Sexual Abuse | yes/no | |
| Suicide attempts | yes/no | |

# Consent to Treatment Form

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. **If I do not cancel and do not show up, I will be charged for that appointment**.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I understand that communication via e-mail and/or cell phone texting is not a secure or confidential means of communicating.

***Important:** Authorization of treatment from your insurance company does not necessarily mean that they will pay for the treatment that you receive. ***Insurance companies may deny a claim and if this were to occur it is your responsibility to pay "Connie Martin, Ph.D." for all claims that are denied.***

My signature below shows that I understand and agree with all of these statements and will comply with these terms during the course of treatment.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name Relationship to client (if necessary)

___ Copy accepted by client ___ Copy kept by therapist
This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

# Consent For Non-Secure Electronic Communications

## Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Connie Martin, PhD., there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

• People in your home or other environments that can access your phone, computer, or other devices that you use to read and write messages
• Your employer, if you use your work email to communicate with Connie Martin, PhD
• Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with Connie Martin, PhD about ways to keep your communications safe and confidential.

## CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow *Connie Martin, PhD.* to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

• Information related to the scheduling of meetings or other appointments
• Information related to billing and payment.

Other information/communication:

_____

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____

Signature Date

**Outpatient Psychotherapy and Professional Services**
**Policies and Fees Effective January 2021**

**Fees:**

- Individual and Couples Therapy: $180.00 for the initial session. For subsequent sessions of 45-53 minutes the fee is $140.00. For sessions that are 54-60 minutes the fee is $160.00.
- There is a charge for professional services that are rendered over the phone or video. These sessions will be billed in 15 minute increments. Each 15 minute increment will be billed at $30.00

**Payment:** I understand that I am expected to pay for each session at the time it is held and includes self-pay clients and clients who have a co-payment (unless we decide on a different payment plan). Clients who will be using insurance to pay for treatment will need to obtain the following information: deductible amount, co-payment, annual limits, number of approved sessions, approval code (if needed), and information on any other restrictions or limitations.

**Important:**
Authorization of treatment from your insurance company does not necessarily mean that they will pay for the treatment you receive. ***Insurance companies may deny a claim and if this occurs it is your responsibility to pay Connie Martin, PhD for all claims that are denied*.**

**Appointments**

I understand that I am expected to call and cancel an appointment at least 24 hours (1 day) before the time of the appointment. **If I cancel a weekday appointment with less than 24 hours notice I will be charged a cancellation fee of $80.00.**
**If I miss an appointment without notifying Connie Martin, PhD I will be charged $100.00.**
Please note that insurance companies do not reimburse for missed appointments.

**Phone calls, Messages, E-mails and Texts**

- Calls, e-mails, and texts will be returned within 24 to 48 hours. I understand that if Connie Martin, PhD is not able to return my call and I have an emergency I should go the nearest emergency room.
- I understand that I will be given instructions regarding professional resources and/or coverage when Connie Martin, Ph.D. is away from the office. This information will be available by calling 312-458-9086.

My signature below indicated that I have read the information in this document and agree to abide by its terms during the course of outpatient treatment with Connie Martin, PhD.

_____ _____

Signature

**Authorization for Release of Information**

I HEREBY AUTHORIZE: CONNIE MARTIN, Ph.D.

To: X Release Information To and/or X Receive Information From

**Physician's Name:**_____

Phone Number:_____Fax Number:_____

_____

The Following X Verbal Information and/or X Written Information

_____Summary of Psychological Treatment (including history of treatment)

_____Diagnosis (including supporting clinical info.)

_____Most Recent Contact Date

_____Nature of Treatment

_____Treatment Plan

_____Outcome of Treatment

_____Prognosis

_____Other (specify)

**FOR THE PURPOSE OF EVALUATION AND TREATMENT OF CLIENT**:

**Client's Full Name** (please print)_____ Birthdate:_____

**In signing this form, I understand the following provisions:**

a) I am under no obligation to sign
b) I have the right to inspect and copy any information disclosed
c) I have the right to revoke this authorization at any time by WRITTEN REQUEST (except for information already disclosed)
d) Failure to sign will mean that the information WILL NOT be requested or released

**THIS RELEASE WILL REMAIN VALID UNTIL Date:**_____

**The purpose of for this release of information is for:**

_____Continuity of care and treatment planning
_____Third Party Reimbursement
_____Other (specify)_____

Signed:_____Date:_____

Witness:_____ Date:_____

# HIPAA Notice of Privacy Practices Acknowledgment

**Client Name:**_____ **Date of Birth:** _____

The Notice of Privacy Practices tells you how we may use and share your health records. It also describes your rights with respect to your health records. **Please read it.**

- We will use and share your health records to treat you and to bill the services we provide
- We will use and share your health records as required by law.

I understand that the HIPAA Notice of Privacy Practices is available on the Connie Martin, Ph.D. website (www.conniemartinphd.com) and at Connie Martin's office.

**I acknowledge receipt of Connie Martin, Ph.D., Clinical Psychologist Notice of Privacy Practices**

Signature of Client: _____ Date:_____

Signature of Authorized Representative: _____Date:_____

Name of Authorized Representative: _____Date:_____

## INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing /phone services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing/phone sessions (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

Date: _____