Heritage Behavioral Health Consultants

Julie Summers, M.A., LPC-S
Julie Ottosen, M.A., LPC
Jennifer Hofman, M.A., LPC
Ekpedeme Wade, M.D., LPC Intern
(Under supervision of Julie Summers, M.A., LPC-S)
Elizabeth Warren MBA, M.A.
(Under supervision of Julie Summers, M.A., LPC-S)
Dr. Angela Mosley, M.D.
Allie Sauls, M.A., LPC
Nadia Knutzen, M.A., LPC Intern
(Under the supervision of Julie Summers, M.A., LPC-S)
Guy Bender, M.A., LPC-Intern
(Under the supervision of Dr. Crystal Collier, PhD. LPC-S)
Jerry Duncan, M. Div., LMFT
Danielle Mitchell, Med., R.D., L.D. LPC
Jill Early, M. Ed., LPC
Sarah Jane Paton, M.A., LPC
Selenia Pellerin, M.A., LPC
Ana Ince, M.Ed., LPC-Intern
(Under the supervision of Julie Summers, M.A., LPC-S)
Alicia Gilpin, M.A., LPC-Intern
(Under the supervision of Julie Summers, M.A., LPC-S)

Welcome to the practice of Heritage Behavioral Health Consultants. We are pleased you have chosen our office and will assure you that we are working with you in a caring and professional manner. Please take a few moments to read our office policies and do not hesitate to ask any questions you may have. These policies are further detailed in the Notice of Privacy Practices following this form.

OFFICE HOURS

Regular support staff hours are from 8:00am to 5:00pm Monday through Friday. Each clinician sets his or her own schedule and will work with you to schedule a mutually agreeable time.

SESSIONS

Full sessions are 45 minutes and half sessions are 25 minutes long. In order to ensure that your time is respected and waiting time does not interrupt your schedule or ours, every effort is made to start and stop on time. Extended sessions can be arranged when necessary, that will include an additional fee.

CANCELLATIONS

There is no charge for missed appointments **IF APPOINTMENT IS CANCELLED AT LEAST 24 HOURS IN ADVANCE**. If the appointment is for Monday, the cancellation may be made-by leaving a message with the answering service. **WE DO CHARGE FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE.**

EMERGENCY SERVICES

As a general practice, emergency consultation is provided 24 hours each day, seven days a week. In the event you are unable to reach your therapist please call 911, the Crisis Hotline (713-HOTLINE), or go to the nearest emergency room. Your clinician will discuss specific emergency procedures with you in detail. You may reach us at (713)365-9015. If we do not answer in 30 minutes, please call a second time and let the service know this is an emergency. If the consultation requires more than 15 minutes, you may be billed for time.

NOTICE OF PRIVACY PROCEDURES

In accordance with the Health Insurance Portability and Accountability Act (HIPPA), Heritage Behavioral Health Consultants is required to: 1) maintain the privacy of your health information, 2) provide you with a

Notice to our legal duties and privacy practices with respect to the information that we collect and maintain on you, 3) abide by the terms of the Notice, 4) notify you if we are unable to agree to a requested restriction, 5) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. Please refer to our **Notice of Privacy Practices** for detailed information.

FEES

Payment is due at the time of service rendered in the form of cash, check or credit card. We do not file insurance in this office; however for those clients that belong to an insurance company that wish to file, we will give you an itemized statement so that you can file it with your insurance company in order to have them reimburse you directly.

It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 10% charge to the outstanding balance.

TYPES OF THERAPY AND ASSESMENTS

A variety of therapies are available depending on your needs and wishes. During your first visit, you and one of our clinicians will evaluate together what issues you wish to address and the type of therapy that would be most appropriate for you.

Please check each type of therapy or assessment you feel may be appropriate.

___ Marriage or Relationships Counseling
___ Individual Counseling
___ Parent Consultation
___ Family Therapy
___ Attention Deficit Disorder Assessment
___ Psychological Testing

PERSONAL RELATIONSHIPS

Our goal is that we will develop a positive, rewarding relationship. At this time, please take a few minutes to fill out the enclosed information so that we may better help you achieve your goals.

I HAVE READ AND FULLY UNDERSTAND THE **PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT** AND AGREE TO ITS TERMS.

Patient's Full Name (please print): _____

Signature: _____ Date: _____

I HAVE RECEIVED A **NOTICE OF PRIVACY PRACTICES** AND AGREE TO ITS TERMS.

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

Heritage Behavioral Health Consultants

Client Information

Date: _____ Clinician Name: _____

Patient's Name: _____

D.O.B.: _____ Sex: M_____ F_____

Patient's Address: _____

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Business Address: _____

Wk Phone: _____ Email: _____

Emergency contact: _____ Phone: _____

Referred by: _____

Would you like an invoice after every visit? : ☐ Yes ☐ No

Is it OK to leave a voicemail on your answering device? : ☐ Yes ☐ No

At which phone number? ☐ Home ☐ Cell ☐ Work

Would you like to keep your credit card info on file for ease of payment: Yes No

Card Holder Name: _____

Credit Card

No.: _____ Exp.Date: _____

Credit Card Billing Address: _____

CVV Code: _____ (3 digit code on back of card)

Signature: _____

Health Assessment Patient Questionnaire

Name: _____ Date: _____

Background Information

Age: _____ Birth date: _____ Preferred phone number: _____

E-mail: _____ Occupation: _____

Work hours: _____ Marital status: _____

Highest level of education: _____

Please list the people in your household and their relationships to you: _____

_____

General Health Information

Physician's name: _____ Physician's phone: _____

Physician's address: _____

Date of most recent physical exam: _____ Date of most recent blood tests: _____

How do you rate your health? _____ Poor _____ Fair _____ Good _____ Excellent

Height: _____ Weight: _____

Review of Systems (circle all that you currently have or are concerned about)

Respiratory

Shortness of breath	Emphysema	Disturbed sleep
Coughing	Snoring	Sleep apnea
Asthma or wheezing	Daytime sleepiness	History of pneumonia, chronic bronchitis, or COPD

Cardiovascular

High blood pressure	Heart murmur	Ankle or feet swelling
Heart disease/heart attack	Irregular heartbeat or palpitations	Varicose veins
Congestive heart failure	Chest pain or discomfort	Blood clots or clotting disorders

Gastrointestinal

Nausea/vomiting	Ulcer disease	Diarrhea
Abdominal/stomach pain	Rectal bleeding or blood in stools	Gallbladder disease/gallstones
Heartburn/acid reflux	Hemorrhoids	Celiac disease
Belching/burping	Constipation	Hernia

Genitourinary

Difficulty urinating	Inability to empty bladder fully	Sexual problems
Urinary incontinence (leaking urine)	Recurrent urinary tract infections (UTIs)	Abnormal menstrual periods
	Infertility	Enlarged prostate

Musculoskeletal

Aching muscles or joints	Lower back pain/disc problems	Arthritis

Endocrine

Diabetes mellitus	Thyroid disease	High triglycerides
High cholesterol	Gout	

Skin and Hair

Skin sores or infections (boils, ulcers, skin fold irritations)	Chronic rashes or dermatitis or eczema	Excessive facial/ body hair (women only)
Bruises easily		

Other

Low energy level	Obsessive-compulsive disorder (OCD)	Binge eating
Depression		Bulimia
Bipolar disorder	Psychological or psychiatric care	Anorexia
Attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD)	History of child abuse, rape, or molestation	Anemia
		Headaches or migraines
Anxiety disorder or panic attacks	History of being subjected to any physical or verbal abuse	

Cancer (list type): _____

Other serious medical conditions (list types): _____

Do you have a family history of any of the following? (Circle all that apply)

High blood pressure, high blood cholesterol, diabetes, thyroid disease, obesity, heart disease, cancer, other (list):

_____

List the types of surgeries you have had: _____

_____

How often do you use tobacco? _____ How often do you drink alcohol? _____

How many hours of sleep do you average per night? _____ Is your sleep restful? Yes No

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life? _____

_____

Please list any religious practices that affect your heath care or diet:

_____

List all prescription and over-the-counter medications that you currently take (include the dosages):

_____

_____

_____

List all vitamins, minerals, supplements, and herbs that you take:

_____

_____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes?

1 2 3 4 5

What makes it hard for you to lose weight and keep it off? _____

_____

_____

Nutrition Information

What one or two things would you like to change about your diet? _____

_____

In the following chart, describe when and what you usually eat in a typical day. (Write "None" if you do not eat that meal or snack.)

Meal	Time	Foods Eaten/Amount
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Physical Activity Information

What is the most physically active thing you do in an average day? _____

_____

What, if any, regular exercises do you do? How often and for how long do you participate? _____

_____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain the reasons.

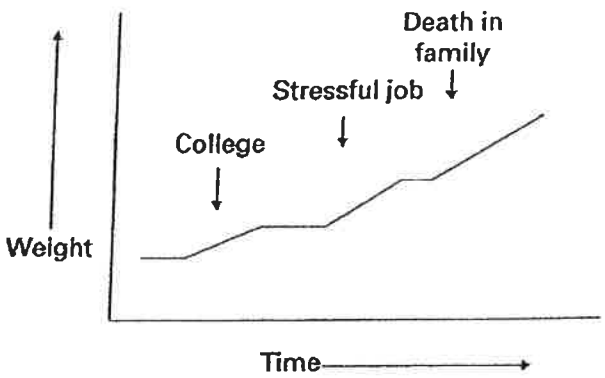
_____

_____

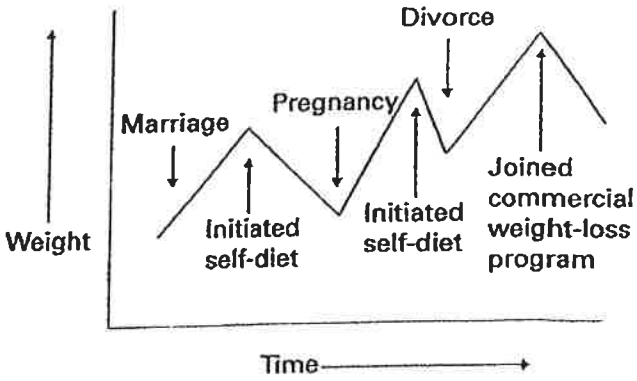
Weight History Graph

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.

Progressive (or Ratcheting) Weight Gain



Weight Cycling or "Yo-Yo" Weight Gain



Please draw a graph of your weight gain. Mark *life events* and *diet attempts* that have contributed to your current weight.