

Heritage Behavioral Health Consultants

Julie Summers, M.A., LPC-S
Julie Ottosen, M.A., LPC
Jennifer Hofman, M.A., LPC
Selenia Pellerin, M.A., LPC
Danielle Mitchell, M.Ed., R.D., L.D, LPC
Sarah Jane Paton M.A., LPC
Jill Early, M.Ed., LPC
Allie Sauls, M.A., LPC
Ekpedeme Wade, M.D., LPC-Intern
(Under supervision of Julie Summers, M.A., LPC-S)

Jerry Duncan, M.Div., LMFT
Elizabeth Warren, MBA, M.A., LPC-Intern
(Under supervision of Julie Summers, M.A., LPC-S)
Ana Ince M.Ed. LPC Intern
(Under supervision of Julie Summers, M.A., LPC-S)
Alicia Gilpin, M.A., LPC-Intern
(Under supervision of Julie Summers, M.A., LPC-S)
Taylor Garcia, M.A., LPC-Intern
(Under 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

In the event of a medical emergency please call 911, the Crisis Hotline (713-HOTLINE), or go to the nearest emergency room. Your clinician usually will be available to assist you personally should an emergency consultation be necessary; however, at times, a colleague may cover calls. You may reach us at (713) 365-9015, leave a message and a call back number on your therapist's private voicemail and your therapist will be paged. 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: _____

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

Credit Card Billing Address: _____

Signature: _____

Indicate which of the following symptoms you have experienced

- Fatigue/lack of energy
- Weakness
- Lack of sleep
- Sleeping too much
- Increase/decrease of appetite
- Increase/decrease in weight
- Repetitive/senseless thoughts
- Repetitive/senseless behavior
- Sad/down in the dumps
- Depressed
- Irritability/anger
- Nervousness
- Fearful feelings
- Frequent crying
- Frequent negative thinking
- Frequent thoughts of death
- Suicidal thoughts
- Homicidal thoughts
- Fainting/feeling faint
- Tremors
- Trembling/shakiness
- Seizure/convulsions
- Skin rash
- Aggressive/violent behavior
- Seeing things that are not real
- Hearing things that are not real
- Difficulty making decisions
- Difficulty concentrating
- Memory problems
- Worthless feelings
- Excessive guilt feelings
- Helplessness
- Hopeless feelings
- Sweating
- Dizziness/light headedness
- Unsteady feelings
- Jumpiness
- Keyed up/on edge
- Restlessness
- Constant worry
- Panic
- Feeling life not worth living
- Increase/decrease in sex drive
- Fear of going crazy
- Fear of dying
- Feeling of unreality
- Feeling in dream-like state
- Isolation/withdrawal
- Double vision
- Difficulty in focusing vision
- Eye pain
- Eye discomfort in bright light
- Sinus pain or congestion
- Increase/decrease in tearing
- Increase in sensitivity to sounds
- Ear infections
- Joint pains or stiffness
- Backache
- Muscle tension
- Muscle pain/soreness
- Swelling of hands/feet/ankles
- Leg cramps
- Numbness/tingling in limbs
- Foot problems
- Trouble walking
- Balance problems
- Cold/clammy hands
- Unable to sit still
- Chest pain/discomfort
- Palpitations
- Difficulty swallowing
- Nausea
- Diarrhea
- Constipation
- Vomiting
- Food intolerance
- Fear of losing bowel control
- Inability to control bowels
- Shortness of breath
- Dry mouth
- Unusual taste sensation
- Inability to control urine
- Penile/vaginal sores
- Penile/vaginal discharge
- Difficulty in sexual frustration
- Breast discharge
- Other: _____

Chief Concern: Please describe the main reason that you here today:

Diet and Exercise:

Weight: Current _____ 1 year ago _____ Desired _____

Are you on a special diet? _____

Please complete if patient is female:

Menstrual History:

Age at onset: _____ Date of last period: _____ Cycle: _____ days Duration: _____ days

Regular: Yes / No Pains/Cramps: Yes / No PMS: Yes / No

Pregnancies: Total # of pregnancies: _____ Miscarriages: _____ Terminations: _____

Age of youngest living child: _____ yrs

Educational History:

High School(s): _____

College(s): _____

Treatment History:

Have you ever received psychological, psychiatric or counseling services before?

Yes No

When	From whom	For what problem	With what results
------	-----------	------------------	-------------------

Have you ever taken medications for psychiatric or emotional problems?

Yes No

When	From whom	For what problem	With what results
------	-----------	------------------	-------------------

Personal History:

What is your marital status?

Married Divorced Separated Widow/Widower Single Dating

Do you have children, and if so, how many? _____

How many times have you been married? _____ # of Years Married _____

Please describe the following relationships in your family of origin:

Your parents' relationship with each other:

Your relationship with each parent and with other adults present:

Your relationship to your brothers and sisters, in the past and present:

Family History:

In either side of biological parents, is there any history of the following:

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Suicide/ Attempts |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Psychiatric Hospitalization |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Rage |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tremors or tics |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hormone Disorders | |

Present Relationships:

How do you get along with your present spouse or partner if you have one?

Please list your spouse/partner's physical health problems, chemical use, and mental or emotional difficulties if any:

How do you get along with your children if you have any?

Please list your children's physical health problems, chemical use, and mental or emotional difficulties if any:

Your most important friends, past and present:

Name	Good Parts of Relationship	Bad Parts of Relationship
------	----------------------------	---------------------------

Personal Abuse History:

I was not abused in any way I was abused I am not sure if I was abused

If you know you were abused, please list all incidents below using the following letters:

P = Physical, such as being shoved, hit, or beaten.

S = Sexual, such as touching/molesting, fondling, or intercourse.

N = Neglect, such as failure to feed, shelter, or protect you.

E = Emotional, such as humiliation, verbal attacks.

Your age	Kind of abuse	Effects on you	Did you tell anyone?	Consequences of telling
----------	---------------	----------------	----------------------	-------------------------

Substance Use:

Have you ever felt the need to cut down on your drinking? Yes No

Have you ever felt annoyed by criticism of your drinking? Yes No

Have you ever felt guilty about your criticism of your drinking? Yes No

Have you ever taken a morning "eye-opener"? Yes No

How many drinks (beer, wine, or hard liquor) do you consume each week, on average?

How much tobacco do you smoke or chew each week?

Which drugs (not including prescription medications) have you used in the last 10 years?

Please provide details about your use of these drugs or other chemicals, such as amounts, how often do you use them, their effects, and so forth:

Legal History:

Are you presently suing anyone or thinking of suing anyone? Yes No

Is your reason for coming to see us related to an accident or injury? Yes No

Is your appointment required by a court/police/probation/office/parole? Yes No

If you answered yes to any of the above questions, please explain:

Your current attorney's name: _____ Phone: _____

Please list all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones using the following letters:

Jurisdiction: (F=Federal, S = State, Co = County, Ci = City)

Sentence: Time served and type of sentence (AR = accelerated or alternate resolution, CS = community service, F = fine, I = incarceration, Pr = probation, Po = parole, O = other, R = restitution)

Date	Charge	Jurisdiction	Sentence	Probation/Parole Officer	Your Atty's Name
------	--------	--------------	----------	--------------------------	------------------

Are there any other legal involvements that we should know about?

Current medications:

Name	Dosage	Reason for taking
------	--------	-------------------
