Rochelle Pruett MA, LPC, NCC

Licensed Professional Counselor

Registration Form, Biological Information & Informed Consent

Patient Information

Date (m/d/yyyy):	Patient Name (First, Full Middle, Last):		
Birth Date (m/d/yyyy):	**Age:**	**Sex:** M ☐ F ☐	**Patient Marital Status:** Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐
Social Security Number (xxxxxxxxxx):	**Home Phone Number** (xxxxxxxxxx):	**Okay to Call?** Yes ☐ No ☐	
Cell Phone:	**Okay to Call?** Yes ☐ No ☐	**Preferred Time to Call:**	
Email:			
Okay to Send Emails Regarding Times, Dates, Basic Information? Yes ☐ No ☐	**Okay to Correspond About Therapy Concerns?** Yes ☐ No ☐		
Street Address with Apartment Number:			
City:	**State:**	**Zip:**	
Occupation:	**Employer:**	**Employer Phone Number:**	
Does This Patient Require a Guardian? Yes ☐ No ☐ If Yes: Sex of Guardian: M ☐ F ☐	**Guardian Name** (First, Middle, Last):	**Guardian Address and Phone Number if different than Patient Information:**	
Name of Emergency Contact:	**Relationship to Patient:**	**Home Phone Number:**	**Work Phone Number:**

Other Patients who will be in treatment:		
Patient Name (First, Full Middle, Last):		
Birth Date (m/d/yyyy):	**Sex:** M ☐ F ☐	**Patient Marital Status:** Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐
Social Security Number (xxxxxxxxxx):	**Phone:**	**Okay to Call?** Yes ☐ No ☐
Patient Name (First, Full Middle, Last):		
Birth Date (m/d/yyyy):	**Sex:** M ☐ F ☐	**Patient Marital Status:** Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐
Social Security Number (xxxxxxxxxx):	**Phone:**	**Okay to Call?** Yes ☐ No ☐
Patient Name (First, Full Middle, Last):		
Birth Date (m/d/yyyy):	**Sex:** M ☐ F ☐	**Patient Marital Status:** Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐
Social Security Number (xxxxxxxxxx):	**Phone:**	**Okay to Call?** Yes ☐ No ☐

PRIMARY REASON(S) FOR SEEKING SERVICES		
☐ Anger Management/ Aggression	☐ School/ Learning/ Developmental Issues	☐ Work/ Employment Issues
☐ Anxiety/ Fears/ Phobias	☐ Grief/ Loss	☐ Weight/ Eating Disorders
☐ Depression/ Mood Problems	☐ Family/ Marriage/ Relationship Issues	☐ Suicidal Thoughts/ Hurting Self
☐ Sleeping Problems	☐ Parenting/ Behavioral Problems	☐ Homicidal Thoughts/ Harming Others
☐ Trauma	☐ Sexual Concerns	☐ Gambling issues
☐ Alcohol/ Drugs/ Addictive Behaviors	☐ Mental Confusion/ Psychosis	☐ Other Concerns

INSURANCE INFORMATION Please give your insurance card to the counselor) - (VERIFY YOUR THERAPIST ACCEPTS YOUR INSURANCE – YOU ARE RESPONSIBLE FOR PAYING FOR THE COUNSELING SESSIONS)

Person responsible for bill:	Date of Birth:	Address (if different):	Home phone Number:	
Occupation:	Employer:	Employer's Phone Number:		
Insurance Carrier:				
Subscriber's Name:	Subscriber's Social Security number:	Birth Date:	Group number:	Policy number:
Patient's Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child	☐ Other (Explain):			

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Personal History Questionnaire All questions answered in this questionnaire are strictly confidential and will not become part of your medical report	
Primary Care Physician:	**Date of last physical exam:**
PCP's Phone Number:	**Release of Information Signed:** ☐ Yes ☐ No
List any medical or physical problems, hospitalizations, and surgeries; include when they were diagnosed	
List all prescription and over-the-counter drugs you are taking with any allergies:	

HEALTH HABITS AND PERSONAL SAFETY					
Exercise	☐ Sedentary (Little to No Exercise)				
	☐ Mild exercise (i.e., climb stairs, walk three blocks, golf				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)				
	☐ Regular vigorous exercise (i.e., work or recreation, 4x/week for 30 minutes)				
Diet	Are you dieting?				☐ Yes ☐ No
	If yes, are you on a physician prescribed diet?				☐ Yes ☐ No
	Number of meals you eat a day?				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	Number of cups/cans per day?				
Alcohol	Do you drink alcohol?				☐ Yes ☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you or others concerned about how much you drink?				☐ Yes ☐ No
	Have you considered stopping?				☐ Yes ☐ No
	Have you ever experienced blackouts?				☐ Yes ☐ No
	Are you prone to "binge" drinking?				☐Yes ☐ No
	Do you drive after drinking?				☐ Yes ☐ No
Tobacco	Do you use tobacco?				☐ Yes ☐ No
	Cigarettes: packs/day	Chew - #/day	Pipe - #/day	Cigars - #/day	
	Years Smoked:	If applicable, the year quit			
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No If yes, please list:				
	Is there a history of problems with drugs or alcohol use in your family? ☐ Yes ☐ No If yes, please describe:				
Gambling	Is there a history of gambling? ☐ Yes ☐ No	If yes what kind?			
Sex	Do you have any concerns about your sexual activity, including sexual dysfunction, sexual orientation, birth control or infertility?				☐ Yes ☐ No
Legal	Do you have any legal concerns?				☐ Yes ☐ No
Personal Safety	Do you have a history of any type of abuse? Physical, sexual, emotional or neglect?				☐ Yes ☐ No
	Is there any type of abuse happening in your life now?				☐ Yes ☐ No

FAMILY HEALTH HISTORY	AGE	Significant health problems including addictive/compulsive behaviors and mental health
Father		
Mother		
Grandmother *Maternal*		
Grandfather *Maternal*		
Grandmother *Paternal*		
Grandfather *Paternal*		
Siblings		

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor? If yes, whom?	☐ Yes	☐ No
If yes, who did you see, and what were the results?		

Questions About Development			
Development	Are there any problems noted in the developmental history	☐ Yes	☐ No
	If yes, please explain:		
Parents	Are parent's divorced or separated?	☐ Yes	☐ No
	If yes, who has legal custody?		
	Does the child/teen's other parent have knowledge of this appointment?	☐ Yes	☐ No
School	Any problems with grades/academic abilities/learning at school?	☐ Yes	☐ No
	Any significant behavioral problems at school?	☐ Yes	☐ No
	Do you have any concerns about social skills?	☐ Yes	☐ No
	Does your child/teen have appropriate friends?	☐ Yes	☐ No

GOALS FOR TREATMENT

What would you like for you/your partner/your family member(s) to accomplish in therapy? Number them in order of importance:

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIION. PLEASE REVIEW IT CAREFULLY.

Effective date: October 20, 2012
Rochelle Pruett MA, LPC, NCC has been and will always be totally committed to maintaining clients' confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes. Identifying Information is used and shared with Rochelle Pruett, MA, LPC, NCC – Licensed Professional Counselor to maintain financial and treatment records.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities. Office staff may use information about you to keep records, file claims, or process information.

Other uses or disclosures of your information which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Missouri State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Client Rights

YOU HAVE THE RIGHT:

1. To be treated with consideration and respect.
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement of purposes, goals, techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to effect the on-going counseling relationship.
4. To obtain information about the case record and to have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the on-going treatment plan.
6. To expect complete confidentiality and that no information will be released without written consent.
7. To see and discuss charges and payment records.
8. To refuse any recommended services and be advised of the consequences of this action

CONFIDENTIALITY OF INFORMATION:

Laws insuring your right to privacy protect matters discussed with your therapist. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Cases where information may be disclosed without your consent include:

1. When child abuse is known or suspected (reporting is required by law).
2. When the abuse of an elderly or depended person is known or suspected (required by law)
3. If you commit a crime against a staff member of another person in the premises,
4. If there is a situation that is potentially life threatening.
5. When the court subpoenas the records.

SECURITY OF RECORDS:

Your treatment of record related and related financial records are kept in a locked file cabinet. Records will not be made available to others without signed authorization to release information and payment for the records prior to releasing them. Special rules relating to the release of treatment records containing information regarding drug and alcohol abuse: CFR 42, PART 2 prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. This information cannot be disclosed to another source without written consent. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is strictly prohibited. Rochelle Pruett, MA, LPC, NCC – Licensed Professional Counselor will utilize records to maintain business and other records as deemed necessary by Rochelle Pruett, MA, LPC, NCC – Licensed Professional Counselor.

RETENTION OF RECORDS:

Treatment records are retained for a period of seven years following the termination of treatment for adults and until ages 28 in the case of minors. At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

INFORMATION REGARDING PSYCHOTHERAPY:

1. Psychotherapy may involve remembering unpleasant events and can arouse intense emotions of fear and anger; feelings of anxiety, depression, frustration, loneliness and helplessness may be experienced. Also feelings of relief, energy, power, self-acceptance, and well-being may also occur
2. Psychotherapy is not always effective and may, in some cases; result in deterioration rather than improvement of a client's psychological functioning. Psychotherapy has been shown effective in about 75% of cases.
3. There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. We will attempt to provide treatment that is realistic in both areas.
4. Current research has failed to demonstrate that any one form of psychotherapy is necessarily more effective than any other.
5. Depending upon a client's condition, there may be available alternatives to psychotherapy, such as medication or behavior modification; we will make these recommendations if they are appropriate, based upon our assessment.

SIGNATURES (PRINT THE ENTRIE INFORMED CONSENT AND HAND-SIGN THIS AREA)

(1) Cancellations/Fees

- **My fee per 50-minute session will be: $90.**
- **Phone calls lasting more than 9 minutes are subject to ¼ of the fee per each 15-minutes of phone conversation.** Insurance companies will not pay this fee; therefore this charge will be the patient or guardians responsibility.
- **If required to testify, appear in court, or complete any paperwork for a court or attorney will be charged a fee of $80 per hour, as well as incidental fees.** Insurance companies may not pay this fee; therefore this charge will be the patient or guardians responsibility.
- **A 24-hour notice is required for all cancellations,** otherwise, ½ of the **normal session fee will be charged** for the missed appointment. Insurance companies do not pay for missed appointments; therefore this charge will be the patient or guardians responsibility.
- Insurance companies do not pay for fees that will be charged for FMLA/Letters to physicians, employers, schools - $20.00.

(2) Authorization to Process Information And Bill Insurance

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance remaining or not covered by insurance. I authorize Rochelle Pruett, MA, LPC, NCC, Licensed Professional Counselor, or representatives to obtain, utilize and release any information required to process my claims or maintain business records.

(3) Authorization to treat & (5) Authorization to treat minor child

I give my consent to my therapist to provide assessment and therapeutic services to me/my child, within the scope of his/her license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I further agree to keep my or my child's scheduled appointments and understand that failure to do so more than two times may result in my care being terminated. I take sole responsibility in arranging for the payment for all counseling services. By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and I give informed consent for myself/my child's treatment. I understand that I will be furnished a copy of the consent whenever I request it.

Name of Child ____ Date of Birth ____

I warrant that I am a custodial parent of the above named minor child. I hereby give permission for him/her to receive counseling. I acknowledge that I am aware of the mandating reporting laws in the state of Missouri. I am also aware that I can withdraw the permission to treat my child at any time. I will assume responsibility to notify my child's other parent that counseling has been initiated and will take sole responsibility in arranging for the payment for all counseling services for my child.

____ ________________________

Client Signature/Responsibility Party Date

____ ________________________

Client Signature/Responsibility Party Date

(4) Professional Disclosure Information (HIPAA)

Your signature below indicates that you have read our HIPAA agreement and agree to its terms and serves as acknowledgement that you have received our HIPAA notification form. Not abiding by these policies may lead to termination of our work together and/or referral to another professional.

____ ________________________

Client Signature/Responsibility Party Date

____ ________________________

Client Signature/Responsibility Party Date

(5) Professional Disclosure Information (Client Rights)

Your signature below indicates that you have read the Client Rights information and agree to its terms and serves as acknowledgement that you have received our Client Rights form. Not abiding by these policies may lead to termination of our work together and/or referral to another professional.

____ ________________________

Client Signature/Responsibility Party Date

____ ________________________

Client Signature/Responsibility Party Date

(6) Consent to Contact Emergency Contact in Case of Emergency

I give permission to staff or therapists at Rochelle Pruett MA, LPC, NCC – Licensed Professional Counselor to contact the emergency contact in case of emergency.

(7) Consent to Communicate By Email – Must Select to Give or Not Give Permission

☐ I give permission to staff or therapists at Rochelle Pruett MA, LPC, NCC – Licensed Professional Counselor to communicate through the exchange of email. I understand that great care should be used when sending personal information by means of email. There is a possibility that personal information may be disclosed when using email. I will not hold Rochelle Pruett MA, LPC, NCC – Licensed Professional Counselor or any therapists counseling through with or on behalf harmless and agree to use care in exchanging personal information through emails.

☐ I DO NOT give permission to communicate through Email

I am signing again to verify that I understand items (1) through (9) listed under SIGNATURES as presented. I also understand that all parties signing must sign a release before any information will be released to any one party.

______________________________	______________________________
Client Signature/Responsibility Party	Date
______________________________	______________________________
Client Signature/Responsibility Party	Date
______________________________	______________________________
Client Signature/Responsibility Party	Date
______________________________	______________________________
Client Signature/Responsibility Party	Date

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Thank You for Choosing Rochelle Pruett MA, LPC, NCC – Licensed Professional Counselor!