URBAN COUNSELING

CLIENT INFORMATION SHEET

(Parent Information if Client is a Minor)

Name____DOB____________________

Address____

Phone Number_________________Work________________________Sex M_______F_____

Single_______ Married______ Separated______ Divorced_______ Widowed______

Have you had counseling before? Yes___ No___ When?________ Therapist_____________

Number of people in household_____________
Total Income Before Taxes From All Sources (include all income of all persons in the home)

___Less than $5,000
___$5,000 – 9,999
___$10,000 – 14,999
___$15,000 – 19,999
___$20,000 – 24,000
___$25,000 – 29,000
___More

Source of Income:
____Employment
____Social Security
____SSI
___Pension
___Disability
___Spouse
___Other

Are you handicapped? Yes___ No___ If so, please explain:____

___Black
___Hispanic
___White
___Other

Emergency Contact:______________________________
Phone:_________________**Relationship**:____________

Place of Employment:____
Address:__________________________________ Phone Number_____________________
Method of payment: Cash____ Check____ Credit Card____ Insurance____
Name of Insurance Company____

Policy Number_____________________________Group Number_______________________

Please read, sign and date: I understand that this is not an application. I authorize use of this information or any subsequence information derived from this form with the understanding that data will be used for general reporting purposes only. I consent for therapy.

____ ________________________________
Client Signature Date of Signing

____ ________________________________
Therapist Signature Date of Signing

URBAN COUNSELING, L.L.C.
1130 SE 18TH PLACE
OCALA, FL 34471

PSYCHO-SOCIAL HISTORY

IDENTIFYING INFORMATION

Today's Date________________

First Name________________________________ M.I._____ Last Name________________________________

Date of Birth________________________ Age ______ Marital Status____________________________

Address____

Social Security #____ Phone________________________________

PRESENTING PROBLEM/COMPLAINT

What is the nature of the problem?____

____

When did the problem begin (date of onset)?____

How often does it occur?____

How does it affect your daily functioning?____

____

Are there events, situations, or persons that make it worse?______________________________________

____

Circle any of the following that apply to you:

Nightmares	Take sedatives	Irritable	Unable to have a good time
Feel tense	Feel Panicky	Sexual Abuse	Concentration problems
Feel Depressed	Suicidal ideas	No Appetite	See or hear things that are not there
Unable to relax	Sexual problems	Alcoholism	Can't make decisions
Don't like weekends	Over ambitious	Take drugs	Home conditions bad
Can't make friends	Inferiority feelings	Shy with people	Feel people are against me
Can't keep a job	Memory problems	Blackouts	Sleep disruptions/disturbances
Physically abused	Financial problems	Cry easily	
Fatigue	Hungry often	Verbally abused	

Previous treatment (If yes, by whom? Outcome and reason of terminating)________________________________

____

Have you ever attempted suicide? Yes ____ No ____

When________________________________ Method used________________________________

Medical:
Physician's Name____

Address:____Phone Number:__________________

Medications____

Describe reason for treatment____

____

Allergies:____

Psychiatric:
Therapist/Hospital Name____

Treatment Dates: From____________________ To________________________

Describe reason for treatment____

____

Prescription Drugs____

Substance Usage____
(Tobacco, alcohol, illicit drugs)

____

____
(Description, frequency, amount)

____

DEVELOPMENT HISTORY

Describe:

Childhood____

Significant events_______________________________________

Teen years____

Significant events_______________________________________

(Female only) Number of pregnancies _______ Number of deliveries__________

Menopausal: Yes____ No ____ PMS: Yes____ No ____

Number of Children___________ Are they living with you? Yes ____ No ____

FAMILY HISTORY

Parents (names, ages, occupations) ______________________________

____

Living ________ Deceased ___________ Married ______ Divorced _____

Describe relationship with parents__________________________________

____

Brothers and/or Sisters (names & ages) ____________________________

____

Describe relationship with siblings __________________________________

____

Significant extended family _______________________________________

____

EDUCATIONAL/OCCUPATIONAL HISTORY

Education (highest grade achieved) ____

____

Learning Disability? Yes ____ No ____

Occupation (kind of jobs, length of employment, vocational interest) ____________________

____

____

____

HEALTH HISTORY

Childhood diseases, prior illnesses, surgeries, etc. ________________________________

____

____

Current Health____

____

Circle any of the following that apply to you:

Palpitations	Seizures	Fainting spells
Headaches	Dizziness	Tremors
Bowel Disturbances	Stomach trouble	

Family Health (grandparents, parents, children)_____________________________________

____

Current medications (Prescribed and over the counter)________________________________

____

MARTIAL HISTORY – Current Status

Number of years married ____________________ Currently living together? Yes ____ No ____

Children and ages ____

____

Description of current relationship with spouse/partner ___________________________________

____

Your perception of your sexual relationship (attitudes/behavior) ____________________________

____

____

____

LEGAL HISTORY

Have you ever been arrested? Yes ____ No ____

If so, describe the circumstances ____

____

MISCELLANEOUS

Social network/friends ____

____

Leisure activities ____

____

URBAN COUNSELING
1130 SE 18TH PLACE
OCALA, FL 34471
PHONE (352) 390-6656
FAX (352) 390-8756

Notice of Privacy Practices Acknowledgement Form

I, ____ have read and

understand the **Urban Counseling, L.L.C.,** notice of Privacy practices.

Information can be shared with:

Name ______________________ Relationship ____________ Phone #__________

Name ______________________ Relationship ____________ Phone #__________

Name ______________________ Relationship ____________ Phone #__________

____

Signature of Patient or Legal Guardian

____

Date

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CONFIRMATION FOR COUNSELING AND FEE AGREEMENT

This Agreement confirms my decision to participate in counseling at Urban Counseling.
I realize that Urban Counseling is not a crisis center and the counselors are not available 24 hours a day. The therapeutic services provided by Urban Counseling include individuals,families, children, adolescents, relationships and martial counseling. Each session should be 45-50minutes in length. This will be discussed with the counselor at the time of my first visit.

Self-Paying Clients: Services are provided on a sliding fee schedule for clients not covered by other payers. Proof of annual income and number of people living in a household determine fee arrangements. I certify that my annual family income before taxes is $_________________
And that there are _____ people living in my household. Accordingly, I agree to pay a fee of $_______ for the first session and $______ per session thereafter. I realize that Urban Counseling is charging me a low and reasonable fee. **If this payment cannot be paid at the time of session, future sessions will be postponed until payment is made.** I realize that if my income level changes, the fee can change. I agree to notify Urban Counseling if and when my income level or the number of people in my household change.

Basic Fee: Sliding scale fees are contingent upon **proof of income.** Failure to provide proof of income at the time of service will result in our maximum fee of $125.00.

I recognized that if I fail to show up for my appointment, I will be charged for a full session. Therefore, I agree that if I DO NOT notify Urban Counseling 24 hours in advance that I am going to miss that scheduled appointment, I will pay the fee for that appointment. Consecutively missed appointments and non-payment of fees will result in termination of my counseling; and fee collection by other means.

____________ Initials
I have read the above information, have had the opportunity to have any questions about the above answered, and I understand the requirements. Urban Counseling will give me a signed copy of this Agreement upon request.

____ _________________________
Client's Signature Date Signed

____ _________________________
Witness's Signature Date Signed

Urban Counseling, L.L.C.
1130 SE 18TH PLACE
OCALA, FL 34471
PHONE: (352)390-6656

Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a Federal Program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties covered entities that misuse personal health information.

We may use and disclose your medical records only for each of the following purposes:
Treatment, payment and health care operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost –management analysis and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions or certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- Right to Inspect and Copy: You have the right to inspect and copy mental health information that may be used to make decisions about your care. This includes your own billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed

- Right to Amend: If you feel that the mental health information we have about you (not including psychotherapy notes), in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your record.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information by asking to speak to our Privacy Officer or for written inquires, note “Attention Privacy Officer”.