**PERSONAL INFORMATION FORM**

 Today's Date:

**Patient's Name**:       SS #       -       -

Address:       Apt #

City:       State:       Zip:       E-mail:

Home Phone: (      )       Date of Birth      Age:       [ ]  M [ ]  F

Employer:       Work Phone:       Ex

 May we contact at work: [ ]  Yes [ ]  No

**Spouse's / SO’s / Parent’s Name**:       SS #       -       -

Address:       Apt #

City:       State:       Zip:       E-mail:

Home Phone: (      )       Date of Birth      Age:       [ ]  M [ ]  F

Employer:       Work Phone:       Ex

 May we contact at work: [ ]  Yes [ ]  No

**Insurance Information**

**Name of Responsible Party** **/ Policy Holder**: (Patient, Spouse or Parent)

Relationship to Patient [ ]  self [ ]  parent [ ]  spouse [ ]  other

Address:       Apt #

City:       State:       Zip:       E-mail:

Home Phone: (      )       Date of Birth      Age:       [ ]  M [ ]  F

**Employer:**       Work Phone:       Ex

 May we contact at work: [ ]  Yes [ ]  No

Primary Insurance:

ID Number:       Group Name (Number):       SS #       -       -

**Referred by**:

Family Physician:       Phone:

Emergency Contact (Other than Spouse):

Relation:       Phone:

***AUTHORIZATION FOR DIRECT PAYMENT - RELEASE OF RECORDS***

I hereby authorize insurance payments directly to George J. Joumas, M.A. I hereby authorize the release and exchange of pertinent psychological, psychiatric, educational, and/or medical records for insurance purposes / case management purposes only.

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**INFORMED CONSENT FOR TREATMENT**

1. I have chosen to receive psychotherapy / counseling services. I understand that my choice has been voluntary and that I may terminate therapy at any time. I understand that there is no assurance that I will feel better, and that material may be discussed that may be upsetting in nature. I understand that psychotherapy / counseling is a collaborative effort between my therapist and myself. I understand that I have the right to be informed of the various steps and activities involved in receiving services. I will attempt to work with my therapist to develop and follow a plan of treatment. I also understand that I have the right to humane care and protection from harm, abuse, or neglect. I understand that I have the right to make an informed decision whether to accept or refuse treatment.
2. I understand that confidentiality of all records or information collected about me, and all information discussed in consultation and / or therapy sessions will be held in accordance with state and federal laws (42 CFT Prt 2) and cannot be released or disclosed without my written consent unless otherwise provided for in state and federal regulations. I understand that state and local laws require that my therapist report all cases of physical or sexual abuse of minors or the elderly. I understand that state and local laws require that my therapist report all cases in which there exists a clear danger to self or others.
3. I understand that George J. Joumas, M.A. will respond to written and phone request for medical records in a timely fashion. Request for release of records should include a signed written authorization of release identifying the individual and/or organization to which the records are released, and that confidential medical records are stored, accessed and released in accordance with Arizona state regulations (32-3211).
4. I understand that insurance companies require that my name and an identification number be place on every page of my medical record, and that a chart number (i.e..., JG1999125, initials date of intake) will be used rather than my insurance ID (social security number).

 (Initial) I understand that my portion of therapeutic expenses (insurance co-pay or deductible) is due at the conclusion of each session, and that I am responsible for payments not made by my insurance (within the limits of my insurance contract). I understand that I will be charged a fee of $35.00 for any check returned for [NSF] non-sufficient funds. I also understand that I will be responsible for my portion of balances and fees (collection fee of 50% of balance) for balances that have not been paid in 90 days and turned over to a collection agency, and subject to reporting to credit bureau. I also agree to give accurate and current billing information (i.e..., insurance and billing address) and understand that incorrect information may result in my account being turned over immediately to a collection agency.

 (Initial) I understand that George J. Joumas, M.A. requires the minimum of a 24 hour notice if I will be unable to attend my appointment. I understand that if I no show for a scheduled appointment or fail to give minimum of a 24 hour notice, **I will be charged full fee for that session** (unless limited by my insurance). If I need to cancel with less than 24 hours, I will leave a message with the answering service and not on Mr. Joumas’s voice mail. I also understand that George Joumas holds himself responsible and abides by this same no show / late cancellation policy. Mr. Joumas will reimburse you should he no show or late cancel an appointment, or offer you a free makeup session. I also understand that a pattern on my part, of no show or failure to give notice of cancellation, will be discussed with my therapist with regards to current motivation or appropriateness for treatment and may result in a therapeutic discharge and/or referral back to my insurance company. I also understand that there will be additional fees for reports (e.g. for purpose of disability, legal, court, etc.).

1. I understand that in the case of a “*If this is a life threatening or other emergency”* (as instructed on Mr. Joumas’s voice mail) “*I will call* ***602-494-7110 and ask that I be contacted immediately. After normal office hours please call my service at 480-308-1513 and ask that I be contacted immediately. If they are not able to reach me immediately, please call your referring insurance or managed care company and ask for a Crisis Case Manager and / or call 911.****”* I understand that many insurance companies require me to call their Crisis Manager if I am unable to reach George Joumas immediately.
2. I have read and understand the above.

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Patient's Signature Date

1. I have also received and read **HIPAA Notice of Information Practices and Privacy Statement**.

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Patient's Signature Date

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Witness Signature Date

**PERSONAL INTAKE / HISTORY**

**Patient Name**:       Education       Current School:

Current Relationship Status: [ ]  Single [ ]  Living with Partner [ ]  Married [ ]  Divorced [ ]  Separated [ ]  Widowed

Number of Marriages / Significant Partner Relationships       Religious / Spiritual Tradition:

**PRESENTING PROBLEMS**

**Brief explanation of why you are currently seeking psychological support**.

**What is the duration of this problem (s)**

**CURRENT SYMPTOMS CHECKLIST**

Do you have any of the current or past psychological problems?  *Please check appropriate boxes that apply* ****

**SYMPTOM OR PROBLEM** **** **NO** **** **current problem** ******past problem Age when first a problem**

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Depression **** **[ ] **no ******[ ]**  current ******[ ]**  past

Bipolar disorder **[ ] **no **[ ]**  current **[ ]**  past

Anxiety / Panic disorder **[ ] **no **[ ]**  current **[ ]**  past

Obsessive - Compulsive Disorder [OCD] **[ ] **no **[ ]**  current **[ ]**  past

Post Traumatic Stress Disorder [PTSD] **[ ] **no **[ ]**  current **[ ]**  past

Psychosis, delusions, hallucinations **[ ] **no **[ ]**  current **[ ]**  past

Paranoia **[ ] **no **[ ]**  current **[ ]**  past

Attention Deficit / Hyperactivity Disorder [ADHD] **[ ] **no **[ ]**  current **[ ]**  past

Other learning / educational disorder **[ ] **no **[ ]**  current **[ ]**  past

Suicidal thoughts / feelings / ideation **[ ] **no **[ ]**  current **[ ]**  past

Homicidal thoughts / feelings / ideation **[ ] **no **[ ]**  current **[ ]**  past

Self-mutilation **[ ] **no **[ ]**  current **[ ]**  past

Anger, agitation or aggression **[ ] **no **[ ]**  current **[ ]**  past

Victim of emotional, physical or sexual abuse **[ ] **no **[ ]**  current **[ ]**  past

Perpetrator of emotional, physical or sexual abuse **[ ] **no **[ ]**  current **[ ]**  past

Gambling or other addictive behavioral problems **[ ] **no **[ ]**  current **[ ]**  past

Eating disorder, bingeing and / or purging **[ ] **no **[ ]**  current **[ ]**  past

Other       **[ ] **no **[ ]**  current **[ ]**  past

**SUBSTANCE USE HISTORY**

**SUBSTANCE AGE 1ST USE LAST USE**

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Nicotine, cigarettes, smokeless tobacco 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Alcohol 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Amphetamines , speed or other stimulants 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Barbiturates, downers 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Caffeine 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Cannabis (marijuana) or hashish 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Cocaine, crack 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Ecstasy 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Hallucinogen (LSD, Angel Dust, Mescaline) 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Inhalants (glue, gas) “huff” 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Opiates (Heroin, Methadone, Codeine, etc.) 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

Prescription or other abuse 1st use     last use       **[ ] **no use [ ]  current use [ ] current abuse [ ]  past problem

**TREATMENT HISTORY**

Have you had any previous psychological consultations? [ ]  No [ ]  Yes When:

Where:       Dr. / Therapist:

Have you ever been hospitalized for psychiatric reasons? [ ]  No [ ]  Yes When:

**Current or prior psychiatric medications** **[ ]  No** **[ ]  Yes**

Where:       Dr. / Therapist:

Medication dosage frequency start date end date side effects helpful

Name of current psychiatrist:       Phone :

Any other current psychiatric / psychological supports? [ ]  No [ ]  Yes Where:

**Other current or prior non psychiatric medications** **[ ]  No** **[ ]  Yes**

Medication dosage frequency start date end date side effects helpful

Name of current primary care physician:       Phone :

Do you have any current or past medical problems ? Please list and include treatments, including physicians and medications.

**MEDICAL HISTORY**

**FAMILY MEMBERS AND OTHERS NOW IN HOUSEHOLD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Relationship | Age | Occupation | MaritalStatus |
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**PATIENT’S FAMILY OF ORIGIN (Mother, Father, Siblings, if different from above)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Relationship | Age | Occupation | MaritalStatus |
|  |  |  |  |  |
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**OTHER HISTORY**

**Military history:** [ ]  No [ ]  Yes [ ]  No Problems [ ]  Problems When:

**Financial**: [ ] No Problems [ ]  Problems Explain:

**Living situation / housing**: [ ] No Problems [ ]  Problems Explain:

**Employment**: [ ] No Problems [ ]  Problems Explain:

**Legal History**: [ ] No Problems [ ]  Problems Explain:

**Social support system**: [ ] No Problems [ ]  Problems Explain:

**Family**: [ ] No Problems [ ]  Problems Explain:

**Cultural / spiritual**: [ ] No Problems [ ]  Problems Explain:

**AUTHORIZATION FOR RELEASE AND / OR EXCHANGE OF INFORMATION**

I understand that my records and information obtained during consultation / therapy are confidential and protected under the federal regulations governing *Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFT Prt 2*, and cannot be disclosed, exchanged or obtained without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this authorization at any time, except to the extent that information based on this authorization has already been released, exchanged or obtained. This consent will automatically expire:

[ ]  60 Days post completion of treatment [ ]  Other

**Information to be Released, Exchanged, and/or Obtained:**

**** Psychological **** Psychiatric **** Educational **** Testing **** Medical **** Alcohol **** Drug

[ ]  Other

**Specific Information to be Released, Exchanged, and/or Obtained:**

**** Diagnosis **** Dates of Treatment **** Treatment Plan **** Treatment Progress **** Discharge Summary

**** Test results / data **** History and Physical **** Lab results **** Summary of Treatment

[ ]  Complete records [ ]  Other

**Purpose**

**** Facilitate treatment, coordinate services and assure continuity of care **** To assist in making referral

**** Communication with insurance or managed care case management [ ]  To arrange leave of absence from work or return to work [ ]  To comply with court order, subpoena, employer request, or other appropriate requests for information.

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When completed and signed, this document authorizes the release and/or exchange of confidential information regarding the following patient:

Name:       Date of Birth

Between: **George J. Joumas, MA, Shea Mental Health, 4545 E. Shea Blvd., Suite 112,**

 **Phoenix, Arizona 85028 (602) 494-7110 , (602) 494-1724 Fax (602) 392-2012 voice mail**

 And [ ] **RELEASE Insurance Company / Managed Care Case Manager**

**Primary Care Physician [PCP]**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient / Parent / Legal Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Date**

And **[ ]  OBTAIN** **Insurance Company / Managed Care Case Manager**

**Primary Care Physician [PCP]**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient / Parent / Legal Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Date**

**INFORMED CONSENT FOR TREATMENT [Patient Copy]**

1. I have chosen to receive psychotherapy / counseling services. I understand that my choice has been voluntary and that I may terminate therapy at any time. I understand that there is no assurance that I will feel better, and that material may be discussed that may be upsetting in nature. I understand that psychotherapy / counseling is a collaborative effort between my therapist and myself. I understand that I have the right to be informed of the various steps and activities involved in receiving services. I will attempt to work with my therapist to develop and follow a plan of treatment. I also understand that I have the right to humane care and protection from harm, abuse, or neglect. I understand that I have the right to make an informed decision whether to accept or refuse treatment.
2. I understand that confidentiality of all records or information collected about me, and all information discussed in consultation and / or therapy sessions will be held in accordance with state and federal laws (42 CFT Prt 2) and cannot be released or disclosed without my written consent unless otherwise provided for in state and federal regulations. I understand that state and local laws require that my therapist report all cases of physical or sexual abuse of minors or the elderly. I understand that state and local laws require that my therapist report all cases in which there exists a clear danger to self or others.
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 (Initial) I understand that my portion of therapeutic expenses (insurance co-pay or deductible) is due at the conclusion of each session, and that I am responsible for payments not made by my insurance (within the limits of my insurance contract). I understand that I will be charged a fee of $35.00 for any check returned for [NSF] non-sufficient funds. I also understand that I will be responsible for my portion of balances and fees (collection fee of 50% of balance) for balances that have not been paid in 90 days and turned over to a collection agency, and subject to reporting to credit bureau. I also agree to give accurate and current billing information (i.e..., insurance and billing address) and understand that incorrect information may result in my account being turned over immediately to a collection agency.

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2. I have read and understand the above.

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Patient's Signature Date

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Witness Signature Date

1. I have also received and read **HIPAA Notice of Information Practices and Privacy Statement**.

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Patient's Signature Date

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