DEMOGRAPHICS / INSURANCE Today's Date: ___________________

CLIENT NAME: ______________________________________ Age: ______ DOB: ___________________

Address: ____

Social Security # ____________________________ Home # ____

Cell# _____________________________________ Work# ____

REFERRED BY: ________________________________ Phone# ______________________________________

EMERGENCY CONTACT: ____ Relationship: ___________________

Work# ______________________________ Home# __________________________Cell# ____________________

PRIMARY INSURANCE COMPANY: ____

Member ID# _________________________________ Group# _______________________________________

Phone# and Department: ____

Subscriber's Name: ____________________________ Employer: ____

Relationship to client, if not self: ___________________ DOB: ___________ SS# _____________________________

SECONDARY INSURANCE COMPANY: ____

Member ID# _________________________________ Group# _______________________________________

Phone# and Department: ____

Subscriber's Name: ____________________________ Employer: ____

Relationship to client, if not self: ___________________ DOB: ___________ SS# _____________________________

Authorization number(s) & quantity: ____

Limited Visits: __________________________ or Unlimited

Authorization given by: ____

Phone# _____________________________________ Date & Time: ____

Co-pay Amount: ____

The above information is accurate. If there are any disputes with my insurance company, I understand that I am fully responsible for payment of services, rendered to John Geremia, LCSW-C. I authorize the release of any necessary information for any related claims to my insurance company. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time, in writing.

_____________________________________ _______________________

(ADULT Signature is requested) ***(Date is requested)***

<u>INFORMED CONSENT for TREATMENT</u>: I ________________________________ (name of client), agree and consent to participate in behavioral health care services offered and provided by John Geremia, LCSW-C. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification, and training. If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

<u>Consent for Release of Confidential Information to Primary Care Physician</u>:

IF YOU <u>DO NOT</u> WISH TO AUTHORIZE RELEASE OF INFORMATION TO YOUR PRIMARY CARE PHYSICIAN, PLEASE INITIAL HERE: __________ (or complete the next paragraph)

I ___________________________ hereby authorize John Geremia, LCSW-C to disclose to my primary

care physician: ____________________________ with office location and/or phone number:

____ , all clinical information about me, as to permit my primary care physician to monitor the continuity of care and to inform my primary care physician of my health status. This authorization becomes effective ________________________ and may be revoked by me in writing at any time. Unless earlier revoked be me, this authorization automatically terminates at the time treatment terminates. **I understand that this authorization does not extend to the release of any AIDS/HIV information unless I have also placed my initials here ______**. I further understand that the information authorized by this release will be released to the authorized recipient only, for purpose noted above. I understand that I (or my legal representative) is entitled to a copy of this authorization form for my records. *<u>It is my responsibility to inform John Geremia, LCSW-C of any change in my primary care physician's information</u>*.

<u>Notice to Recipient</u>: This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2) and/or state law. In accordance with federal and state law requirements, the information received pursuant to this document is **<u>confidential</u>** and recipient is prohibited from making further disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise indicated by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

____ ____________________________________

Legal Signature of Client or Legal Guardian Date

____ ____________________________________

Name of Client (Please PRINT) Witness

FINANCIAL POLICY for JOHN GEREMIA, LCSW-C, LLC

All co-pays are due at the beginning of your therapy session. If you are a self-pay client, the amount of your visit will be collected at the beginning of your session.

It is NOT my responsibility to know your insurance carrier. It is your responsibility to know the co-pays and benefits of your plan. If the insurance information is incorrect, due to your failure to submit current information, it is the client's responsibility to pay for the full payment amount, of the services rendered. **It is your responsibility to notify me of any change in address, phone numbers or any change of insurance with appropriate authorization and/or referral.**

Account balances will be expected in full, unless arrangements have been made. You will be charged an additional $30.00 fee for each returned check. You will be responsible for all unpaid balances, fees, attorney and court costs resulting in debt collection procedures.

APPOINTMENTS: It is your responsibility to know when your appointment is scheduled. You will not receive a reminder phone call for any appointments. **You will be charged $50.00 for any appointment that is not cancelled at least one week prior to your scheduled appointment**. This charge is your responsibility. Insurance companies do not pay for missed appointments. If we are able to reschedule your appointment within the same week, you will not be charged the missed appointment fee.

Notice of Private Practices: My practice is committed to securing the privacy of your Health Information (HIPAA). Accordingly, I have posted this "Notice of Health Information Practices" in the waiting area. I would like your acknowledgement that you have been notified that this practice has such a notice as required with HIPPA regulations. I would also like your acknowledgement of receiving a copy.

Patients Assignment of Benefits: I hereby authorize John Geremia, LCSW-C, LLC to apply for benefits on my behalf for covered services rendered. I request payments are made directly to John Geremia, LCSW-C, LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at anytime in writing. **If you are a self-paying client, no information will be given to your insurance company, without a separate written consent of authorization by you.**

____________________________________ ______________________________

Client or Authorized Person's Signature   Date

____________________________________ ______________________________

Relationship to the Client   Witness

ALCOHOL & DRUG USE, CURRENT and HISTORY

Please remember this is confidential, so please be honest

Y N Have you ever felt you ought to cut down your drinking or drug use?

Y N Have people annoyed you by criticizing your drinking or drug use?

Y N Have you ever felt bad or guilty about your drinking or drug use?

Y N Have you ever had a drink or used drugs first thing in the morning?

Y N Do you drink or use drugs alone?

If applicable, what does drinking and/or the use of drugs do for you?

Y N Do you smoke cigarettes? If yes, how many and how often? And, what does smoking do for you?

Y N Do you drink caffeine-containing beverages? If yes, what type and amount? And, what does the caffeine do for you?

Y N Have you ever been in treatment for drug and/or alcohol use? If so, please list period of time(s) and the name of the program.

Y N Have you ever recognized any consequences (negative ways it has effected your life) to your drug and/or alcohol use? If so, please explain.

Y N Is there any family history of alcohol and/or drug use? If so, please explain.

Y N Have you ever experimented with drugs? If so, please list the names/type and the period(s) of time (your age and/or year) when you used.

Y N Have you ever abused the use of prescription drugs? If so, please explain.

Please remember this is confidential and I'm not here to judge you.

Y N Are you currently using illegal drugs? If so, please list the names, frequency and the amount of use.

Y N Do you currently drink alcohol? If so, please list the type, frequency and the amount of use.

OBJECT RELATIONS:

Relationship: ○ Married ○ 1st Marriage ○ 2nd Marriage ○ 3rd Marriage

○ Single ○ Divorced ○ Separated ○ Widowed

○ Significant Other / Partner ○ Girl Friend ○ Boy Friend

Children (include age & please list if deceased)

Siblings (include age & please list if deceased)

Parents (please list as living or deceased)

Supportive People in your life

Please describe your **Social Life**

Employment History (During the past 5 years)

Employer / Company	Years of Employment	Job Title

Are you seeing a **psychiatrist**? ○ yes ○ no

If yes, please give name & phone: ____

Are you currently taking **psychiatric medication**? ○ yes ○ no If yes, please list:

Name	*Dosage (in mg)*	*Frequency*	*Start Date*

Have you taken **psychiatric medication in the past**? ○ yes ○ no If yes:

Name	*Reason for discontinuation*

Please list, *chronologically*, your experiences in **therapy and/or psychiatric treatment:**

Dates	*Reason*	*Therapist /Psychiatrist/ Hospital*	*Frequency of visits / Helpful?*

Please list anyone in your **family** (including extended family members), present or with history of psychiatric and/or therapy treatment:

Relationship to You	*Diagnosis/Issue*	*Type of Treatment, including medication, if known*

Do you **currently** have any **medical** issues / diagnosis? ○ yes ○ no If yes:

Problem *Onset Date* *In Treatment?* *Medication (dosage & frequency)*

How do your **medical issues interfere with your life**? List anything that comes to mind.

Please list **past medical issues**, including hospital admissions and/or surgeries (and Dates):

Please list all medications, foods or other agents that cause an **allergic reaction** & specify the reaction(s):

Please check the appropriate circles, if it applies. We will go over this during your assessment.

Symptoms / Interference in life / Significant changes

SLEEP
○ initial insomnia

○ mid insomnia

○ terminal insomnia

normal hrs. of sleep:_

current hrs. of sleep:_

SEX
○ ↓ libido (sex drive)

○ ↑ libido

○ sexual dysfunction

○ pornography

○ ↓masturbation

○ ↑ masturbation

FOOD
○ ↓ eating / appetite

○ ↑ eating / appetite

○ binge eating

○ self-induced vomit

○ ↓weight

○ ↑ weight

BEHAVIOR
○ ↑ alcohol / drug
○ ↓ chores, house
○ ↑ cleaning
○ ↓ dress / presentation
○ gambling
○ ↓ hygiene
○ ↓ multitasking
○ ↓ organization
○ ↑ smoking cigarettes
○ ↑ clutter
○ ↑ spending money
○ ↓ normal level of functioning

MOOD
○ agitation
○ anger
○ anxious
○ ↑ arguments
○ ↓ motivation
○ crying spells
○ irritation
○ ↓ relaxation
○ sad
○ stressed
○ yelling
○ ↓ interest
○ feeling lost, just kind of existing
○ not feeling good about yourself

THOUGHT PROCESS
○ ↓ attention
○ ↓ concentration
○ racing thoughts
○ ↓ focus
○ flashbacks
○ mind only shuts down during sleep

SOCIAL
○ isolation
○ ↓communication
○ avoidance
○ loneliness
○ boredom
○ friendship conflict
○ relationship conflict

EMPLOYMENT
○ ↑ absence
○ ↓ production
○ co-worker/boss conflict

PHYSICAL SYMPTOMS
○ digestive system
○ headaches
○ ↓ energy level
○ aches & pains
○ other