Debi J Pruitt LCMHC PLLC
[C] 336.542.3349
www.debijpruittlcmhcpllc.com

Client Information: ADULT Therapist: _____

Please print clearly Record # _____

Who referred you to us? _____

Admission (initial appointment) Date: _____ Discharge Date: _____

Name: _____ Age: _____ Sex: M F Race: _____

Address : _____ _____ _____ _____

Street or Box Number City State Zip Code

Home Phone: _____ Mobile Phone: _____ Email: _____

Social Security Number: _____ Date of Birth: _____

Occupation: _____ Employed By: _____

Work Phone: _____

Status: Single_____ Married_____ Partnered _____ Separated_____ Divorced_____ Widowed_____

Significant Other's Name: _____ Age: _____

Significant Other's Occupation: _____ Employed By: _____ Work Phone: _____

In Case of Emergency Contact: _____ Phone:_____

Address: _____

Family or Personal Physician (PCP): _____ Psychiatrist: _____

Please present your insurance card (and the card for secondary insurance if you have it) to your therapist so a copy may be placed in your record.

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CLIENT NAME: _____ MC ID #: _____ Record # _____

CONSENT FOR TREATMENT

I freely give my consent for psychological/counseling services to be provided by Debi J Pruitt LCHMC PLLC. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the therapist. I am aware that I may stop treatment at any time, though understand that doing so may be therapeutically premature or that I may have to deal with other problems (legal, for example, if treatment is court ordered).

FINANCIAL RESPONSIBILITY

I accept responsibility for payment of services rendered by Debi J Pruitt LCHMC PLLC. I agree to make a full payment or a co-payment, if insurance coverage is available, at the time services are provided.

Debi J Pruitt LCHMC PLLC is not responsible for determining or verifying insurance coverage. I understand and accept that it is my responsibility to determine my insurance coverage and to get any pre-authorizations required. Because Debi may not be aware of other professionals involved in my care, it is also my responsibility to keep track of the total number of mental health sessions used here and elsewhere, and to tell my therapist of insurance limitations.

I further understand that my insurance may not cover all sessions and activities that I may be billed for, and accept responsibility for payment for services that are not covered and/or not reimbursed (for example, exceeding the number of authorized sessions, denied sessions, psychological evaluations, couples counseling, telephone consultations, letters and reports).

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. I accept that if I do not cancel and do not show up I will be charged for that appointment at up to the therapist's full fee and understand that it cannot be billed to insurance. If seen through an Employee Assistance Program, I know a late cancellation or missed appointment may count as one of my sessions.

I authorize release of information acquired in the course of examination and treatment to my insurance company and assign payment of fees directly to Debi J Pruitt LCHMC PLLC.

If I don't pay as agreed in accordance to the above conditions, I accept that my name and account may be turned over to a collection agency and that all collection costs associated with the debt will be my responsibility.

ELECTRONIC LIMITATIONS

There may be at times a need to communicate via electronic means (e.g., cell phone, email, text, fax, client portal, video-chat). Debi uses a password protected and encrypted web based calendar for scheduling. Debi J Pruitt LCHMC PLLC exercises all reasonable precautions to protect confidentiality but cannot guarantee confidentiality of such electronic and web-based systems as some difficulties are beyond our control.

My signature below indicates that I have received or downloaded the Emergency Procedures form.

My signature below shows that I have carefully read, understand and agree with all of these statements.

_____ _____

Client Signature Date

Debi J Pruitt LCMHC PLLC

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NAME: _____ MC#: _____ Record #: _____

Debi J Pruitt LCHMC PLLC is sensitive to your privacy and the confidentiality of services. However, for rescheduling or appointment confirmation purposes, it may occasionally be necessary for our office to contact you.

Please let us know the best way to reach you:

Cell: _____ May we leave a message? Yes No

Home: _____ May we leave a message? Yes No

Work: _____ May we leave a message? Yes No

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CONSENT FOR RELEASE OF INFORMATION TO YOUR PRIMARY CARE PHYSICIAN AND PSYCHIATRIST

CLIENT: _____ Record #_____

DOB: _____

Your (or your child's) primary care doctor and your psychiatrist (if you are seeing one) are interested in knowing if you are being seen for counseling. Having this information helps them to better serve your health care needs and is consistent with best practices.

_____ I authorize Debi J Pruitt LCHMC PLLC to release relevant treatment information, such as history, symptoms and diagnostic impression, and alcohol and/or drug use if relevant, to my/my child's primary care doctor and psychiatrist for coordination of treatment and continuity of care. I also authorize my/my child's primary care doctor and psychiatrist to release relevant information to Debi J Pruitt LCHMC PLLC. I understand that these records are confidential and cannot be released without written authorization except as provided by law. This consent may be revoked at any time and expires one year from the date signed.

Primary Care Physician: _____

Psychiatrist: _____

_____ I decline the release of treatment information to my/my child's primary care physician and psychiatrist.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid for a period not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that action on this consent has been taken. In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

CLIENT: _____ OR _____

Parent, Guardian or Legal Representative

Debi J Pruitt LCHMC PLLC

Patient Consent Form and Confidentiality

Client Name: _____ MC#: _____ Record #_____

By signing this form, you grant consent to Debi J Pruitt LCHMC PLLC the right to use and disclose your protected health information for the purposes of treatment, payment and health care operations (TPO) subject to our Privacy Policy and as they may change from time to time. The following is a summary of our Privacy Policy. A complete copy is available as outlined below.

Debi J Pruitt LCHMC PLLC has developed a Privacy Policy to address the following:

- We will use and disclose your health care information for the purposes of treatment, payment, and to support other related, defined health care operations.
- We will keep your health care information confidential, releasing it only according to our policies. In general, we will release your information to others only if we are referring you for care, or if you direct us to do so. However, there are exceptions to that general limitation. (An example would be a release of information that is required by State or Federal law.)
- You have the right to request to inspect and copy the health care information we keep regarding you, or regarding someone for whom you are the guardian. In some cases, we may refuse to permit you to do so. For example, if we determined that doing so might cause you or another person harm.
- You have the right to request that we amend the health care information we keep regarding you, or regarding someone for whom you are the guardian.
- You have the right to request a list of non-routine disclosures to other parties we have made of your health care information, or that of someone for whom you are a guardian.
- You have the right to request a limit to the type and amount of health care information that we disclose. We are not required to accept that limit, if it affects our ability to engage in TPO, for example. If we do honor the limit request we will be bound by that agreement.
- You have the right to request specific confidential communications that further restrict the parties who will have access to your information, though in general, we will not disclose personal health care information except as described above. Again, we are not required to agree to that limitation but, if we do so, we will be bound by that agreement.
- When a child is in treatment and the parents are divorced, and the parents have joint custody, the N.C. Attorney General's Office has advised us that as psychotherapists, we are obligated to inform both parents that the child is in treatment and the nature and course of treatment.
- If a therapist suspects that child abuse or neglect has occurred, the law requires that it be reported to the proper authorities.
- If a therapist believes you to be a clear and imminent danger to yourself or another person, she or he must take steps to prevent that occurrence. These steps may require breaking confidentiality.
- In a legal proceeding, client-therapist communications are privileged. A judge can, however, order the therapist to divulge confidential information if this information is deemed necessary for the proper administration of justice. There is one exclusion; N.C. law provides that a marriage counselor is incompetent to testify in any subsequent legal action regarding divorce.
- Your records can be released without your consent to prove to the appropriate agencies that Debi J Pruitt LCHMC PLLC. is in compliance with federally mandated HIPAA privacy laws.
- Your records can be released without your consent upon request from the military for purposes of national security.

Our Privacy Policy is subject to change from time to time. If we change our policy, you may obtain a copy of the revised notice by contacting us at debipruittcps@gmail.com or 336.542.3349

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent previously granted.

Signature:_____Date: _____

Debi J Pruitt LCMHC PLLC

CLIENT NAME: _____ MC ID #: _____ Record # _____

Credit Card Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.

I, _____, hereby authorize Debi J Pruitt LCMHC PLLC to use my credit card information to charge my credit card under the following conditions:

- Missed appointments ($50 then $75 thereafter)
- Cancellations with less than 24 hours notice ($50 then $75 thereafter)
- If a check is returned for any reason (plus bank charges)
- Balances of charges not paid by me or my insurance
- Fees not covered by insurance
- Miscellaneous other fees (e.g., court preparation/testimony, disability preparation, letters/reports, etc.)

Type of Card: VISA MasterCard Discover

Card Number: _____-_____-_____-_____

Exp. Date: _____/_____

Verification/Security Code: _____

Billing Address Zip Code: _____

Billing Address Street Number: _____

I may revoke this agreement at any time by providing a written request.

_____ _____

Client (or parent/guardian) Signature Date

Client Information: ADULT Chart#_____

Client Name_____ Age_____ Date_____

Who Referred You Here? _____ Your Marital Status_____

Please describe what your concerns are today: _____

_____

FAMILY (spouse/partner, children, parents, include those living with you if others)

Name	Relationship	Age	Lives where

HISTORY OF PSYCHIATRIC ILLNESS WITHIN FAMILY/RELATIVES

Substance Abuse/Dependence - yes no How Related/Explain Problem_____

_____

Depression/Anxiety/Schizophrenia/Etc - yes no How Related/Explain Problem _____

_____

Suicide or Attempts - yes no How Related/Explain Problem _____

MEDICAL HISTORY

Allergies (including to medication): _____

Have you ever had a serious head injury?_____

List any medical problems:_____

_____

Past Surgeries:_____

PAST PSYCHIATRIC HISTORY

Are you currently being treated by a psychiatrist? If so, please list the name, date of first session and date of most recent appointment:_____

_____

Have you ever been hospitalized for treatment of an emotional/psychiatric problem? If so, what for (e.g., anxiety, depression), when & where:_____

_____

Have you worked with a therapist/counselor in the past? If so, please list names, dates and reason (e.g., anxiety, depression, marital):_____

_____

Do you have a history of any of the symptoms listed earlier for which you did not receive treatment? yes no Briefly describe:_____

_____

What psychiatric medications have you tried?_____

Client Name_____ Date_____ Chart#: _____

SUBSTANCE USE

Caffeine - yes no How much per day?_____
Tobacco - yes no How much per day?_____
Drugs - yes no Describe specific drugs:_____
How often? _____ How much? _____
How old were you when you first began using?_____
History of (circle): tolerance withdrawal arrest conviction NA meetings treatment
Alcohol - yes no How much?_____ How often?_____
How old were you when you first began drinking?_____
History of (circle): blackouts tolerance withdrawal arrests convictions AA attendance
treatment attempts to cut back/control

ANY HISTORY OF CURRENT OR PAST

Sexual abuse - yes no Explain_____
Physical abuse - yes no Explain_____
Emotional abuse - yes no Explain_____
Legal problems - yes no Explain_____

CURRENT SYMPTOMS (Circle appropriate descriptions) Please rate for the past two weeks:

Mood - normal sad anxious angry irritable elated variable other: _____
Anxiety - yes no panic attacks physical symptoms: _____
Sleep - increased decreased variable nightmares hours of sleep/night: _____
Appetite - increased decreased variable compulsive overeating/binging purging
weight loss or gain: _____ over what period of time?_____
Energy level - very low low average high very high variable
Motivation - below average average above average
Memory - decreased normal describe:_____
Concentration - decreased normal describe: _____
Crying spells - yes no frequency: _____
Self-Esteem - poor self-concept neutral positive self-concept extremely positive self-concept
Hopefulness - absent partially present definitely present describe: _____
_____
Danger to self - none thoughts of suicide suicide plan intent to follow through actions
describe:_____
Danger to others - none thoughts of hurting others plan intent to follow through actions
describe: _____
Other Symptoms - delusions flashbacks paranoia hallucinations (see, hear things others don't)
racing thoughts incoherent speech pressured speech compulsions
Behavioral Concerns – none frequent lying stealing excessive fighting/arguing work absenteeism
running away from home arrests other:_____
Additional Symptoms not Listed_____
_____

Client/Guardian Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

Medication Record

Name: _____ **Date of Birth:** _____ **Chart #:** _____

Medication History: Please list active and discontinued medication during the past 6 months, both prescription and over the counter. Record additional pertinent information such as the reason for the medication or any notable side effects. (Please advise your therapist of any changes during the course of therapy so this record can be kept current.)

Date Began	Date Ended	Medication Name	Dosage	Administration Directions	Comments	Physician

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EMERGENCY PROCEDURES

Some helpful emergency resources in the community to which you have 24/7 access include:

Sandhills Center 201 N Eugene Street, Greensboro, NC	1800-256-2452
Moses Cone Behavioral Health Systems 700 Walter Reed Drive, Greensboro, N.C.	1800-711-2635 or (336) 832-9700
ADULTS CAN GO TO: Wesley Long Hospital 501 N. Elam Avenue, Greensboro, N.C. (Go to the Emergency Room Entrance)	(336) 832-1000
CHILDREN AND ADOLESCENTS GO TO: Moses H. Cone Memorial Hospital 1200 North Elm Street, Greensboro, N.C. (Go to the Emergency Room Entrance)	(336) 832-9000
National /suicide Prevention Lifeline	1800-273-8255

Your local Mental Health Center, if you live outside of Guilford County

Your psychiatrist, if you have one, may have an emergency services pager.

******* In the event of an immediate life-threatening emergency, call 911, and the police or an emergency response team will be called if the emergency room cannot be reached in time.**

If you receive emergency services from providers outside of this group, always contact your primary therapist as soon as possible after the emergency.