CEDAR CREEK ASSOCIATES LLC

ADULT PATIENT INFORMATION

Date: _____ Clinician/Provider: _____

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Local Address: _____

Permanent Address: _____

Is it Ok to contact you via (circle answer): Email: Yes No Email: _____ Text: Yes No

Phone: Yes No Cell: Yes No Work: Yes No

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: _____ Marital Status: _____ Social Security Number: _____

Employer: _____ Address: _____

Student: _____ Full Time: _____ Part Time: _____ Not in School: _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Family Physician: _____ Phone: _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Name of Patient Date

_____ _____

Signature of Responsible Party Name of Responsible Party

The Complete Notice of Privacy Practices is located in our waiting room. It is also on our website Cedarcreekassociates.com under Privacy Act.

CONSENT TO TREATMENT

By signing the document below, you assert that you have read and understand this page, and that you consent to treatment for yourself, your minor child, or your family. I will be happy to discuss any questions or concerns you may have.

CONFIDENTIALITY

What we talk about, and even the fact that you are coming here for treatment, is private information and cannot be disclosed except under the following circumstances:

- If you give me a signed authorization to release the information;
- If I have reason to think you may be an immediate danger to yourself or to others;
- If a court orders me to release the information;
- In order to collect fees, information can be released to the third party payor;
- To other professionals for consultation (in which case your identity will not be disclosed);
- To qualified personnel for management or financial audits (an insurance company audit, for example).

THE NATURE OF PSYCHOTHERAPY

I will use traditional verbal techniques in providing therapy to you, or traditional play therapy techniques with your child. Treatment planning requires an assessment and diagnosis. If you have questions about the diagnosis or the diagnosis process, please ask me.

Some questions that I will ask will be very personal and may cause you more anxiety. Please feel free not to answer, or to talk to me about your feelings about the issue. I may ask you to carry out an assignment outside of the therapy hour. If so, the assignment is intended to help you, but if you feel uncomfortable with it or think it may be harmful in any way, please do not carry it out and do talk with me about your concerns.

I will see you by appointment in my office. If I see you outside the office, I will be friendly, but will not discuss your issues nor indicate the nature of our relationship unless you make it clear that you want the relationship known.

Psychotherapy is not an exact science. It involves a cooperative effort between us. I encourage your questions and open participation. Please discuss with me any questions or concerns about our work, the staff, or the facility. Psychotherapy is intended to address the problems you present and that we agree to work on together. There is a possibility that therapy can make problems worse or even create new problems. Usually, this is a stage toward getting better, but if you do not understand how what we are doing can help, please talk to me about it.

TERMINATION

It is usually most beneficial for therapist and client to discuss the termination process and I encourage you to do so. However, if I have had no contact with you for two months, your case will be automatically terminated. It is always easy to re-open a case, so we can do so if you contact me again.

_____	_____
Name of Patient	Date
_____	_____
Signature of Responsible Party	Name of Responsible Party

FINANCIAL POLICIES

Thank you for choosing me as your therapist. Your treatment involves payment for services. Please read this statement of my financial policies carefully, and sign it to show that you have read and understand it.

Fees are charged for the following:

- Therapy sessions (individual, family, couples, or group)
- Non-cancelled appointments or those missed without 24 hour prior notice
- Preparing/copying records, reports, and letters
- Telephone consultations
- Returned checks
- Interest may be added to accounts due for 90 days
- Court appearances, depositions, travel and preparation time (ask for my legal policy)
- If an account is sent to collection, the fee will be what the collection agency charges plus any legal fees necessary to collect.

Please note:

- Payment is expected at the time of service
- Payment plans are available with prior notice

About Cedar Creek Associates: Cedar Creek Associates is an office-sharing LLC only. It is not a group clinical practice. Each associate maintains his or her own independent practice. No other professional relationship exists among the clinicians.

Regarding Insurance: I may accept assignment of benefits once you provide needed information. This means that you would pay co-pays and deductibles at the time of service and the staff will bill the insurance company for the balance. When we tell you what the benefits and authorizations for sessions are, we cannot guarantee that the information is correct. I am providing you with an estimate of your share of the cost treatment as provided to me by your managed care company, insurance company, or employee assistance program. Sometimes this information is not consistent with later information we receive from the insurance company. Your actual share may be more than this estimate. You are ultimately responsible for the charges. Remember to please let me know if you change insurance or managed care companies.

Managed care companies: Many insurance companies contract with a managed care company to manage the benefits and care. The managed care company may require that I obtain prior authorization for sessions and I usually am required to submit clinical information about you to do so.

By signing below, you authorize me to bill your EAP or Managed Care Company, and you authorize the payer to pay me directly.

Thank you. If you have any questions or concerns about these policies, please speak with me or with one of the office staff.

_____	_____
Name of Patient	Date
_____	_____
Signature of Responsible Party	Name of Responsible Party

THE PURPOSE OF THIS RELEASE IS TO ALLOW YOUR THERAPIST TO BILL YOUR INSURANCE COMPANY AND OBTAIN AUTHORIZATION FOR TREATMENT.

Patient's Name (print): _____ Date of Birth: _____

1. I authorize the following person: _____ (Name of therapist)

2. To use or disclose the information below from the initial date of service until financial liabilities are satisfied.
   ____ Inpatient or outpatient treatment records for physical or psychological, psychiatric, or emotional illness.
   ____ Admission and discharge summaries.
   ____ Psychological, psychiatric, and or medical evaluations, reports, histories, assessments, treatment notes, treatment plans, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or documents received from other medical and mental health providers.
   ____ Billing records.

3. Name of your insurance company and/or Employee Assistance Program: _____

4. I understand and agree that this authorization will be valid and in effect until service with this provider is completed and payment of benefits have been collected. I understand that after this date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization.

5. I understand that I can revoke or cancel this authorization at any time by sending a letter to my provider. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that time.

6. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the Provider named above, nor will it affect my eligibility for benefits. **However, I may not be able to have further sessions authorized other than those contained in the initial authorization of services and I will assume financial responsibility for all subsequent services.**

7. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

9. I have discussed the issues above with the Provider and I understand the terms of this authorization.

_____ _____
Signature of client or his/her personal representative Date

_____ _____
Print name above Relationship to client

_____
Description of the personal representative's authority

Cedar Creek Associates LLC

Adult Questionnaire

Personal and Family Information

Name _____ Date _____

Date of Birth _____

Present Job _____

Length of time at job _____ Education Level _____

Religion _____ Military service history _____

Approximate family income _____

Marital History

Number of marriages _____ Number of divorces _____

Spouse's Name Marriage Dates From/To Names/ages of children

_____

_____

Occupation of spouse _____

Please list everyone else (other than your children) who lives in your home and state the relationship to you:

_____

_____

Your parent's names Married or Divorced Deceased?

_____

_____

Please list your brothers and sisters by first name and give their age. Place yourself in the list.

_____

_____

Physical and Health Information

Physician: Date of last physical exam:

List significant illnesses, chronic medical conditions, or injuries with approximate dates:

_____

_____

Have you ever been unconscious from a head injury?
If so, when? _____

Please check any item below that you have experienced:

Childhood		Adulthood
_____	Neglect	_____
_____	Physical Abuse	_____
_____	Verbal Abuse	_____
_____	Sexual Abuse	_____
_____	Injury due to Violence	_____
_____	Other Trauma	_____

Have you gained or lost any weight in the last year? Y: _____ N: _____

Do you have any concerns about your weight? _____

Has anyone in your biological family ever had a nervous breakdown, a mental illness, been depressed, had anxiety problems, attempted or committed suicide? If so, please state the relationship of the person to you and describe the problem he/she had:

_____
_____

Have you ever had previous counseling? If so, with whom (please give approximate dates of service):_____
_____
_____

Social and Recreational Information

How do you spend your leisure time? _____
Please list other hobbies or interest _____
Do you have a close friend or friends _____
Do you exercise? _____
Is there any reason you cannot exercise? _____

Legal Information

Have you ever been the victim of a crime? Circumstances: _____
_____
Have you ever been arrested? Circumstances _____
_____
Are you currently involved in any litigation? _____

Presenting Problem

Please state the reason you are seeking services: _____
How long has this been a problem? _____
What have you done to try and deal with this situation?_____
_____

How would you rate the severity of the problem?
_____ Mildly upsetting _____ Moderately Severe _____ Severe _____ Very Severe

What else would you like your therapist to know? _____

Medication Lists & Medical Allergies

Patient Name: _____ Date: _____

No Medications: _____

List Allergies to Medications: _____

_____

Medications currently taking:

Medication/Start Date	M.D. Name	Dosage/Frequency

Substance	Amount	How Often Used	Began Using	Last Used
Alcohol				
Cocaine				
Heroin				
Inhalants				
LSD				
Marijuana				
Methamphetamine				
Nicotine				
Opiates				
Tranquilizers				
Other				

Has anyone in your family had a drug or alcohol problem? Please check all that apply:

Mother _____ Father _____ Grandfather _____ Grandmother _____ Sister _____
Brother _____ Uncle _____ Aunt _____ Child _____ Spouse _____

_____ _____
(Signature) (Date)

Thank you for providing this information.
Your therapist will be happy to answer questions and address your concerns.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	