



**Medical Information:**

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Changes within last year \_\_\_\_\_

Are you currently being treated for any medical conditions or taking any medication(s) \_\_\_\_\_

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Prior Hospitalizations \_\_\_\_\_

Any known allergies: \_\_\_\_\_

**Clinical Information:**

1. Please describe your reason for seeking treatment at this time?

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2. Please list three people in your life that you interact with regularly?

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3. What results do you expect from treatment?

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4. Have you ever received mental health treatment before? If so, please list dates, provider name and the issue for which treatment was sought.

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Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety Levels/ Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A
Sleeping Habits	1	2	3	4	5	N/A
Sexual Functioning	1	2	3	4	5	N/A
Alcohol/Drug Usage	1	2	3	4	5	N/A
Ability to Concentrate	1	2	3	4	5	N/A
Ability to control temper	1	2	3	4	5	N/A

### Cancelled/Missed Appointments

A scheduled appointment means that time is reserved for only you. If an appointment is missed or cancelled with less than 24 hours notice, you will be billed a \$45.00 Missed Appointment Fee.

### Emergency Contact Information

In case of emergency, please provide following:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Alt. Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Alt. Phone \_\_\_\_\_

## Client's Rights and Responsibilities:

By signing below you are consenting to receive services from The Stone Foundation with an understanding of the following rights, responsibilities and office policies:

### Rights:

- ✦ I have a right to receive quality, respectful and non-judgmental services in a warm and professional environment.
- ✦ I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.
- ✦ I will have information about fees methods of payment, insurance coverage and cancellation policies, and the opportunity to ask questions as necessary before entering therapy.
- ✦ I have a right to privacy in my conversations with my therapist. Generally, any information I supply cannot be shared with others without my written permission. There are four situations in which my therapist is required by law to reveal information, even without my permission:
  1. If I seriously threaten to harm myself or another person, my therapist must warn that person and the authorities. Likewise, my therapist must take steps to protect me from hurting myself.
  2. If a court orders my therapist to testify about me, he/she must do so.
  3. If my therapist is treating me under a court order, he/she must report his/her findings to the court.
  4. If I report child abuse or elder abuse, my therapist must intervene.

### Responsibilities:

- ✦ I understand that I am responsible for understanding my insurance policy and to comply with all requirements to ensure that The Stone Foundation can be reimbursed for all services.
- ✦ I understand that all **co-pays, deductibles and services not covered by an insurance company** will be paid at the time of service. Furthermore, I will be billed and responsible for the costs of collection agency services for unpaid balance.

**\* I understand that there is a \$35 fee for all cancelled/returned checks.**  
**\* I understand that no client balance will be allowed to exceed \$75.**  
**\* If I do not show for a scheduled appointment or cancel an appointment with less than 24 hours notice I will be charged a \$45 fee. Three missed appointments may result in my being asked to leave the practice.**

\_\_\_\_\_ (initial and date)  
*I understand and agree to these financial policies and fees.*

I FURTHER AUTHORIZE THE RELEASE OF INFORMATION, INCLUDING MEDICAL DOCUMENTATION, FOR THIS OR ANY OTHER RELATED CLAIM TO MY INSURANCE COMPANY. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to client