ASSOCIATES IN BRIEF THERAPY, INC
4346 Starkey Road, Suite 1
Roanoke, VA 24018
(540) 772-8043

New Patient Information Sheet

(PLEASE PRINT)

Main Office: Roanoke
Satellite Offices: Blacksburg
Daleville
Salem
Floyd

PATIENT INFORMATION:

Patient's Name_____
Last Name **First Name** **Middle Initial**

Responsible Party (if a minor) _____

Mailing Address (Street and/or PO Box) _____ **Apt #**_____

City_____ **State**_____ **Zip Code**_____

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

Email Address: _____ ❒ Yes, I would like to receive periodic informative emails from ABT, Inc.

Sex: _____Male ____Female Date of Birth_____ **Age**_____ **Social Security Number**_____

_____Single _____Married (How long? _____) _____Divorced _____Widowed _____Separated

Please list children and their ages: (if applicable)

_____

_____

Patient Employer_____

Address_____ **City**_____ **State**_____ **Zip**_____

Occupation_____

How or from whom did you hear of ABT? (Name:_____**)**

❒ Doctor ❒ Church/Pastor ❒ Yellow Pages ❒ Current/Former Patient ❒ Internet ❒ Other _____

In Case of Emergency, Please Contact: _____ **Phone** _____

PARENT/SPOUSE INFORMATION:

Spouse/Parent _____ **Date of Birth**_____

Employer_____ **Work Phone**_____

Occupation_____ **Social Security Number**_____

INSURANCE INFORMATION:

Primary Insurance Company_____ **Phone Number**_____

Subscriber's Identification Number_____ **Group Number**_____

Subscriber's Name_____ **Relationship to Patient**_____

Subscriber's Social Security Number _____ **Date of Birth**_____

RELEASE OF INFORMATION:

I authorize ABT, Inc. to obtain/release/exchange information with my Primary Care Physician (PCP), other healthcare practitioners, or as requested by my insurance company for the purpose of service coordination and continuity of care.

Primary Care Physician's/Other practitioner's name _____

Address _____

_____

Phone _____ **Fax** _____

❒ Check here if you do not authorize this release of information.

_____
(Signature of Patient or Responsible Party) **(Date)**

For Office Use Only:

Chart# _____

❒ ABT ❒ Medisoft
Initials _____

Communication Between You and ABT, Inc.

Occasionally it will be necessary for our office to contact you regarding matters about counseling. This permission form will help us know when and how to contact you in ways which are comfortable for you.

By giving permission for us to contact you in one or more of the ways listed below, you are agreeing for us to leave messages and information. We will always try to be discreet in any messages we leave, but we cannot guarantee confidentiality once the message is left.

Which is your **preferred contact phone number**? (circle one) Home Work Cell

Home

Yes No May we contact you at your home telephone number? # _____

Work

Yes No May we contact you at your work telephone number? # _____

Cell Phone

Yes No May we contact you at your cell telephone number? # _____

Courtesy Appointment Reminders **IMPORTANT:** (*We are no longer making phone call reminders*)

Would you like us to remind you of your appointment via e-mail, text messaging or both? *Yes*____ *No*____

E-Mail Yes No *If you choose this option, E-mail reminders are sent (2) two business days before your scheduled appointment.*

E-Mail Address:_____

Text Messaging Yes No Cell Phone Carrier_____ Cell Phone ( )_____

Choose how often you would like a text message: **(You cannot respond back to a text message)**

- ○ 48 hours
- ○ 24 hours
- ○ 2 hours
- ○ 48 & 24 hours
- ○ 48 & 2 hours
- ○ 48, 24 & 2 hours

NOTE: If you need to make/change/cancel an appointment, have patient account or insurance questions, please CALL our office at 540-772-8043.

Client Name: _____ Date: _____

Client or Guardian Signature: _____

Patient Health Questionnaire (PHQ)

ASSOCIATES IN BRIEF THERAPY, INC.

All information is kept confidential in adherence with current HIPAA regulations.

Name: _____ **Date:** _____

People commonly have some problems in the following categories. Please indicate how you are affected by each by circling the appropriate number beside the item. *Please circle only ONE number for EVERY item.*

Not a Problem 0	A Slight Problem 1	A Moderate Problem 2	A Serious Problem 3	A Severe Problem 4

1. Feeling sad, depressed or unhappy	0 1 2 3 4
2. Feeling discouraged or hopeless	0 1 2 3 4
3. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0 1 2 3 4
4. Little interest or pleasure from things I usually enjoy	0 1 2 3 4
5. Feeling guilty, worthless, helpless	0 1 2 3 4
6. Crying spells	0 1 2 3 4
7. Restless, irritable or agitated	0 1 2 3 4
8. Feeling tired or having little energy	0 1 2 3 4
9. Trouble falling or staying asleep, or sleeping too much	0 1 2 3 4
10. Poor appetite or overeating	0 1 2 3 4
11. Trouble making decisions	0 1 2 3 4
12. Difficulty with concentration	0 1 2 3 4
13. Less interest in sex	0 1 2 3 4
14. Thoughts that you would be better off dead, or of hurting yourself in some way	0 1 2 3 4

1. Anxious/nervous/worried	0 1 2 3 4
2. Stressed/overwhelmed	0 1 2 3 4
3. Intense fear, panic/discomfort	0 1 2 3 4
4. Panic or fear with physical symptoms (such as pounding heart, sweating, shaking, nausea, dizzy, fear of losing control, etc.)	0 1 2 3 4
5. Anxiety about being in certain situations (such as being in a crowd, traveling, standing in line, etc.)	0 1 2 3 4
6. Anxiety or fear related to being in social situations or having to perform (such as public speaking, test taking, etc.)	0 1 2 3 4
7. Fear, anxiety, or avoiding specific situations (such as flying, heights, animals, etc.	0 1 2 3 4
8. Worrying about health problems	0 1 2 3 4

1. Having unwanted thoughts over and over again	0 1 2 3 4
2. Repeating specific acts over and over (such as hand washing, checking, etc.) or mental acts (such as counting, repeating words)	0 1 2 3 4

1. Euphoria (feeling high)	0 1 2 3 4
2. Sudden changes in mood for no apparent reason	0 1 2 3 4
3. Decreased need for sleep (such as feeling rested after only 3 hours of sleep)	0 1 2 3 4
4. More talkative than usual	0 1 2 3 4
5. Racing thoughts	0 1 2 3 4
6. Acting impulsive (such as buying sprees, drinking more, sexual activity, etc.)	0 1 2 3 4
7. Excessive irritability or agitation	0 1 2 3 4
8. Angry outbursts	0 1 2 3 4
9. Property destruction	0 1 2 3 4

1. Making careless mistakes at school, work or other activities	0 1 2 3 4
2. Difficulty sustaining attention during tasks	0 1 2 3 4
3. Difficulty following through or finishing things	0 1 2 3 4
4. Difficulty in organizing tasks or activities	0 1 2 3 4
5. Easily distracted	0 1 2 3 4
6. Losing things or forgetful	0 1 2 3 4
7. Hyperactivity (can't sit still)	0 1 2 3 4
8. Poor impulse control	0 1 2 3 4

1. Hearing things	0 1 2 3 4
2. Seeing things	0 1 2 3 4
3. Experiencing confusion	0 1 2 3 4
4. Memory lapses/forgetting	0 1 2 3 4
5. Feeling of unreality or being outside of self	0 1 2 3 4
6. "Missing time"	0 1 2 3 4
7. Suspiciousness (questioning other people's motives)	0 1 2 3 4

I have been experiencing these problems for:

❑ < 1 Mo ❑ 1-6 Mos ❑ 7-12 Mos ❑ > 1 Yr

Check any of the following that have caused concern or difficulties during the last 6 months:

❑ Taking care of personal grooming needs
❑ Taking care of children or others
❑ Enjoyment of hobbies
❑ Enjoyment of work
❑ Preparing meals for family/self
❑ Meeting financial obligations
❑ Meeting "home" responsibilities
❑ Meeting "work" responsibilities
❑ Getting along with spouse/partner
❑ Getting along with children
❑ Getting along with co-workers & others

Current Life Stressors

❑ Relationship issues (arguments, separation, divorce)
❑ Financial (owe money, loss of job, unemployment)
❑ Legal difficulties (law suit, traffic, criminal charges)
❑ Health issues (illness or injury)
❑ Abuse (physical, mental, emotional, sexual)
❑ Substance abuse (alcohol/drugs/food)

If you checked off *any* of the above problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Briefly describe why you are seeking help at this time: _____

_____

Please check below if you have had any of the following medical conditions:

- ❑ Arthritis
- ❑ Stomach ulcers
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Kidney problems
- ❑ Colitis/Crohn's
- ❑ Chronic pain
- ❑ Lupus
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Head injury/concussion
- ❑ Seizures
- ❑ Heart attack
- ❑ Angina
- ❑ High blood pressure
- ❑ Urinary retention
- ❑ Migraines
- ❑ Chronic headaches
- ❑ PMS
- ❑ Asthma
- ❑ Other Respiratory Problems
- ❑ Cancer
- ❑ Menstrual Problems: _____
- ❑ Pregnancy: _____ times
- ❑ Miscarriage: _____ times
- ❑ Hysterectomy
- ❑ Surgery: _____
- ❑ Other: _____

Please list all current medications: (Use the back of this form if necessary)

Medication	Strength	Frequency	Date started	Prescribed by

Please list all PREVIOUS psychotropic medications you have EVER taken.

Medication	Strength	Frequency	Date started	Prescribed by

Medication Allergies: ❑ No ❑ Yes (Describe: _____)

Please list all previous counseling/psychiatric treatment including any psychiatric hospitalizations.

Dates	Reason	Counselor's/Doctor's Name

❑ Yes ❑ No Has any family member ever had a problem with drugs and/or alcohol? If so, who and what?_____

❑ Yes ❑ No Has any member of your family ever had any history of depression, anxiety, or other mental problems? Any history of suicide?

❑ Yes ❑ No ❑ Never 1. Do you have thoughts about suicide now?
❑ Yes ❑ No ❑ Never 2. Have you ever thought about suicide?
❑ Yes ❑ No ❑ Never 3. Have you ever attempted suicide?
❑ Yes ❑ No ❑ Never 4. Do you have access to guns/weapons?

❑ Yes ❑ No ❑ Never 1. Are you thinking about hurting someone now?
❑ Yes ❑ No ❑ Never 2. Have you ever thought about hurting someone else?
❑ Yes ❑ No ❑ Never 3. Have you ever hurt someone else?

Please answer the following questions:

Do you drink alcoholic beverages? ❑ Yes ❑ No ❑ Never (Skip to next section)

If yes, how many alcoholic drinks do you have in the average: day _____, week _____, month _____, year _____

If yes to the above, please answer the following:

❑ Yes ❑ No Have you ever sought help for alcohol or drug use (including AA or NA meetings)?

❑ Yes ❑ No In the past year, have you ever drunk alcohol or used drugs more than you meant to? Or have you spent more time drinking or using than you intended to?

❑ Yes ❑ No Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?

❑ Yes ❑ No Have you felt you wanted or needed to ***cut down*** on your drinking or drug use in the last year?

❑ Yes ❑ No Has anyone ever objected to your drinking or drug use?

❑ Yes ❑ No Have you ever found yourself preoccupied with wanting to use alcohol or drugs?

❑ Yes ❑ No Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?

❑ Yes ❑ No Has your drinking or drug use ever caused legal problems (DUI's, traffic accidents, violence, etc.)?

Check if you have taken any of the following drugs: ❑ Yes ❑ No ❑ Never (Skip to next section)

❑ Marijuana/Pot	❑ Cocaine/crack	❑ Inhalants
❑ Amphetamines/speed	❑ Barbiturates/sedatives/downers	❑ Designer drugs, Ecstasy
❑ Heroin/opiates	❑ Intravenous drug use	❑ Tranquilizers (Xanax, Valium, etc.)
❑ PCP/Angel Dust	❑ Pain medicine	❑ LSD/hallucinogens

❑ Yes ❑ No Have you ever taken prescribed medication inappropriately?

Sleep Difficulties (Check all that apply):

❑ None	❑ Nightmares
❑ Falling asleep	❑ Wets bed
❑ Falling back to sleep	❑ Walks in sleep
❑ Tired upon waking	❑ Snores
❑ Early morning awakening	❑ Stops breathing during sleep
❑ Bad dreams	❑ Falls asleep when emotional

Usually, the time that I …

Go to bed: _____ A.M. _____ P.M.

Wake up: _____ A.M. _____ P.M.

Smoking:

❑ None

Packs per day: 1 ❑ 2 ❑ 3 ❑ Other ❑

Age began: _____

Caffeine (cups per day):

Coffee: 1 ❑ 2 ❑ 3 ❑ 4 ❑ More ❑

Tea: 1 ❑ 2 ❑ 3 ❑ 4 ❑ More ❑

Soda/other: 1 ❑ 2 ❑ 3 ❑ 4 ❑ More ❑

Are you sensitive to caffeine? ❑ Yes ❑ No

Please answer the following questions:

❑ Yes ❑ No Is there any history of violence, verbal or sexual abuse in your family?

❑ Yes ❑ No Have you ever been physically abused?

❑ Yes ❑ No Have you ever been sexually abused?

❑ Yes ❑ No Have you ever experienced or witnessed a traumatic event (accidents, crime, major medical illness)?

If yes to any of the questions above, please elaborate with your counselor.

I certify that all information above is true and accurate.

_____ _____

Signature of Client, Parent or Guardian **Date**

Associates In Brief Therapy, Inc.
4346 Starkey Road, Suite 1
Roanoke, VA 24018
(540) 772-8043 (877) 895-8674 Toll-Free

Locations: Roanoke
Salem
Blacksburg
Daleville

HIPAA NOTICE OF PRIVACY PRACTICES

(Effective Date: April 14, 2003)

This privacy notice is provided on behalf of: Associates In Brief Therapy, Inc.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties and your rights concerning your Protected Information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect April 14, 2003. It will remain in effect unless and until we publish and issued a new notice.

OUR PLEDGE TO YOUR PRIVACY

We are responsible for the information that we collect about you and your privacy is important to us. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. These are designed to protect your information. We understand how important it is to protect your privacy. We will continue to make this a priority.

OUR LEGAL DUTIES

We are required by law to make sure that your Protected Information that identifies you is kept private. We are to give you this notice of your legal duties and privacy practices with respect to medical information about you and follow the terms of this notice that is currently in effect.

The HIPAA Privacy Regulations generally do not preempt state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a state, or other federal laws, rather than the HIPAA Privacy Regulation, might impose a privacy standard that we are required to follow. Where such laws are in place, we will follow more stringent state privacy laws that relate to use and disclosure of Protected Information about mental health, substance abuse, chemical dependency, etc.

DISCLOSURE AND USES OF PROTECTED INFORMATION

The following categories describe different ways that we use and disclose your Protected Information for purposes of treatment, payment and health care operations:

***For Treatment.** We may disclose your Protected Information to people outside this facility who may be involved in your treatment such as doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you. We may also disclose your Protected Information to people who may be involved in your medical care such as family members, clergy or others we use to provide services that are part of your care.

***For Payment.** We may use and disclosed your Protected Information so that the treatment and services you receive at this facility may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

***For Health Care Operations.** We may use and disclose your Protected Information for health care operations. These uses and disclosures are necessary to run this facility and make sure that all of our patients receive quality care. For example, we may use your Protected Information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of the facility's patients to decide what additional services the facility should offer, what services are not needed and whether certain treatments are effective. We may also disclose information to other health care personnel for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care without learning who the specific patients are.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED INFORMATION

We must disclose your Protected Information to you with some exceptions. This will be described in the Individual Rights sections of this notice. You may give us written authorization or release of information to use or disclose your Protected Information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosure permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your Protected Information for any reason except as described in this notice.

The following is a description of other possible ways we may (and are permitted by law) to use and/or discuss your Protected Information without your specific authorization:

***Family and Friends.** If you are unavailable to agree, we may disclose your Protected Information to a family member, friend or other person when the situation indicates that disclosure would be in your best interest. This includes a medical emergency or disaster relief. If you are available and agree, we may disclose your Protected Information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

***Research, Death or Organ Donation.** We may use or disclose your Protected Information for research purposes in limited circumstances specified in the HIPAA privacy regulation. We may disclose the Protected Information of a deceased person to a coroner, medical examiner, funeral director or organ procurement organization for certain purposes.

***Public Health and Safety.** We may disclose some of your Protected Information permitted by state law to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your Protected Information to a government agency that oversees the health care system or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

***Required by Law.** We may use or disclose your Protected Information when we are required to do so by law. For example, we must disclose your Protected Information to the U.S. Department of Health and Human Services upon request in order to determine if we are in compliance with federal privacy laws. We may disclose your protected information to comply with worker's compensation or similar laws.

***Legal Process and Proceedings.** We may disclose your Protected Information in response to a court or administrative order, subpoena, discovery request, or other lawful process. These disclosures are subject to certain administrative requirements imposed by the HIPAA privacy regulation and permitted by state law.

***Law Enforcement.** We may disclose limited information to a law enforcement official concerning the Protected Information of a suspect, fugitive, material witness, crime victim or missing person subject to certain administrative requirements approved by the HIPAA privacy regulation and permitted by state law. We may disclose the Protected Information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances specified by the HIPAA privacy regulation. We may also disclose Protected Information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

INDIVIDUAL RIGHTS

Right to Inspect and Copy.** You have the right to inspect and copy your Protected Information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, submit your request in writing to: ***Associates In Brief Therapy, Inc., 4346 Starkey Road, Suite 1, Roanoke, VA 24018. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy. If you are denied access to medical information, you may request that the denial be reviewed.

***Right to Amend.** If you feel that your Protected Information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our office. We are required by law to keep records for six (6) years. We may deny your request for an amendment if it is not made in writing or does not include a reason to support the request. In addition, we may deny the request to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Associates In Brief Therapy, Inc.;
- Is not part of the information which you would be permitted to inspect or copy;
- Is accurate and complete

***Accounting of Disclosures.** You have the right to request and receive an accounting of disclosures of your Protected Information made by us. We are not required under the HIPAA regulation to provide you with an accounting of certain types of disclosures. The most significant types include:

- Any disclosures made prior to April 12, 2003
- Disclosures for treatment, payment of health care operations activities
- Disclosures to you or pursuant to your release of authorization
- Disclosures to persons involved in your care
- Disclosures for disaster relief, national security or intelligence purposes

To request an accounting of disclosures, you must send a written request to our office. The first list your request within a 12 month period will be free. For additional lists, we may charge you for the costs involved and you may choose to withdraw or modify your request at that time.

Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or a friend. ***We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

***Confidential Communications.** You may believe that you will be in danger if we communicate Protected Information to you or to your address of record. If so, you have the right to request that we communicate with you about your Protected Information at an alternative location or by alternative means. We will make reasonable efforts to accommodate your request if you specify an alternate address.

CONTACTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

You may also submit a written complaint to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

Signature below is acknowledgement that you have received our Notice of Privacy Practices:

Print Name:_____ Signature:_____

Date:_____ Witness:_____

The client wanted a copy of this privacy practice (Circle one) YES NO
This signed HIPAA will remain in the patient's file; a copy may be given upon request.