Personal Client Information

First Name _____ Last Name _____

Age _____ Date of Birth _____ Sex *(circle)*: Male Female Transgender

Identification #_____ Culture/Ethnicity/Race _____

Street Address _____

City & State _____ Zip Code _____

Cell Phone Number _____ Other Phone Number _____

Background Information - Family

Current Marital Status *(circle)*: Married Single Divorced Widowed Living Together

Number of Children _____ Number of Children Residing in Home _____

Background Information – Education/Employment

Education Level (highest grade) _____ Occupation or Skill _____

Employer _____ How long with this job? _____

Background Information – Medical

Physical ailments or chronic diseases _____

Current medications _____

Name of Primary Care Physician _____

Would you sign a release to allow me to consult with your doctor? Yes No n/a

Any delays in development such as walking, talking, potty training, etc.? Yes No If yes describe:_____

Background Information – Mental Health

Previous experience with therapy _____

Diagnoses (if known) _____

Current or previous psychiatric medications _____

What is your reason for seeking therapy at this time? _____

_____

_____

Have you thought about suicide? Yes No Are you suicidal now? Yes No

Have you attempted suicide? Yes No If so, when _____

Name of previous therapist(s) _____

Are you currently receiving treatment from another therapist? Yes No

Would you sign a release to allow me to consult with your previous therapist(s)? Yes No n/a

Background Information – Legal Concerns

Have you ever been arrested for drugs or any other offense? Yes No

If yes, please list date(s) and offense(s) _____

_____

Pending legal issues? Yes No On parole or probation? Yes No

Would you sign a release to allow me to consult with attorney or PO? Yes No n/a

Background Information – Substance Use

Substance	*Age at first use*	*Date of last use*	*Active use*
Alcohol	_____	_____	Yes No
Amphetamine	_____	_____	Yes No
Barbiturates	_____	_____	Yes No
Caffeine	_____	_____	Yes No
Cocaine	_____	_____	Yes No
Crack	_____	_____	Yes No
Heroin	_____	_____	Yes No
LSD or Hallucinogens	_____	_____	Yes No
Marijuana	_____	_____	Yes No
Methadone	_____	_____	Yes No
Methamphetamine	_____	_____	Yes No
Oxycotin	_____	_____	Yes No
Synthetics	_____	_____	Yes No
Tobacco	_____	_____	Yes No
Other (list) _____	_____	_____	Yes No

Have you ever received treatment for alcohol or drug use? Yes No

If so, please describe the treatment you received. Indicate length of treatment, type of treatment (inpatient or outpatient), and where you were treated. _____

_____

_____

Has anyone said you have an issue with alcohol, drugs, or gambling? Yes No

Has anyone said you have an issue with eating, shopping, or internet? Yes No

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** 30 Days

	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	

Mark Brana, MS, LCPC, LCADC
2520 St. Rose Parkway, Suite 209
Henderson, Nevada 89074
(702) 475-1649

Consent for the Release of Confidential Information

I, _____ authorize _____
(Client name) *(Name of person making disclosure)*

To disclose to _____ the following
(Name of person or agency receiving information)

Information: _____

For the purpose of: _____

I understand that my records are protected by the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken. However, this consent expires automatically as described below:

Specify the event, time, or condition upon which this consent expires:

_____

_____

Executed this _____ day of_____, 201__

_____
Client signature

_____
Witness signature

_____
Signature of parent, guardian, or authorized representative

Disclosure Information For:

Mark Brana
Licensed Clinical Professional Counselor
Licensed Clinical Alcohol and Drug Counselor
2520 St. Rose Parkway, Suite 209
Henderson, NV 89074
(702) 475-1649

Welcome to my practice! This paperwork has been prepared for you to inform you of my qualifications and what you can expect from me as a therapist. This document explains my therapeutic approach, services, fees, policies and your rights as a client. Additionally, this disclosure statement provides you with information about my education, training, and experience. After you have read this statement, you will be asked to sign a statement of acknowledgement stating that you have received it and you will be provided a copy for your records.

Biographical Information:

I graduated from the University of Phoenix with a Master Degree in Mental Health Counseling in 2014. I am dually licensed in the State of Nevada as a Licensed Clinical Professional Counselor (License # CP0197) and a Licensed Clinical Alcohol and Drug Abuse Counselor (License #00408-LC).

I have been Certified in Eye-Movement Desensitization and Reprocessing (EMDR) Therapy by the Humanitarian Assistance Program. My clinical work has focused on individuals struggling with trauma, physical and sexual abuse, addictions, and a variety of interpersonal issues.

Therapeutic Approach:

My formal and informal training has been focused on Cognitive Behavioral Therapy (CBT). The focus is on addressing the cognitions, or beliefs, related to the problems and working to reframe them into more functional cognitions. I also incorporate other treatment modalities into my work, including existential theory and Person-Centered Therapy. I work with my clients to find an internal meaning and motivation to promote change. At times, assignments may be given to accomplish outside of the therapy session.

I am able to work with individuals. I use a blend of humanistic approaches, treatment modalities, and interventions centered on the needs of the client(s). The safe and healthy relationship between the therapist and the client created with open communication sets the stage for productive treatment and ultimate healing. I encourage feedback from clients on their experience throughout the process. I want the working relationship to be a two-way street and my clients to feel involved in decision making.

Treatment typically involves:

1. An assessment, which may include any or all of the following: interviews, observation, review of records, behavior rating scales, biological, psychological and social history, and/or mental health evaluation.
2. Development of a treatment plan, which includes goals and objectives, therapeutic interventions and estimated length of treatment.
3. Implementation of treatment plan during and between sessions.
4. Ongoing assessment, discussion of progress, and revisions to the treatment plan as appropriate.
5. Completion or termination of treatment when satisfactory progress has been made or treatment goals are achieved.
6. Aftercare planning for follow-up care to maintain gains and prevent relapse if needed or desired by the client.

Appointments, Fees, and Payments:

Private practice means small business. My primary goal is to provide a service to clients; however, I am also obligated to pay licensing fees, rent and other bills associated with operating this business. Therefore, listed below is a description of fees, payments and charges associated with this business:

- Individual sessions.
    - Sessions are 50 minutes in length. Full fee is $125 per session. Payments will be collected at the beginning of the session.
    - Running late for your appointment reduces the amount of time we are able to spend together, yet the session fee does not get modified. Please do not ask me to extend your time and inconvenience my next client.
    - Cancellations with 24-hour notice via telephone, text or email message will not be charged. Please use (702) 475-1649 or markbrana.therapist@gmail.com
    - Any late cancellations (less than 24 hours prior to scheduled appointment) or no show for appointment will be charged the full fee. Payment for late cancellations or no-show appointments will be due prior to next session. You will be billed at the address on record after 10 days if payment has not been received. Please acknowledge your understanding of this financial obligation with your initials here _____.
    - Insurance companies do not pay for cancellations or no shows. You will be responsible for any fees for late cancellations (less than 24 hours) and no-show appointments.
    - Insurance billing is done as a courtesy. You, the client remains responsible for the payment of the session. You are not required to use your insurance to pay for services.

- Miscellaneous fees:
    - Preparation for court proceedings includes document review, written summaries, and discussion with legal representative(s) will be calculated and charged at the full fee rate.
    - Appearance for court hearing includes time to travel to and from court room, time spent waiting to be called to the stand, and time spent testifying will be calculated and charged at full fee rate.

- **Other Fees/Charges:** You are responsible for all fees/charges incurred and will be billed for all charges not previously paid by you.

- **Refunds:** No refunds are provided for services already rendered.

Emergencies:

I am not available after hours. In case of medical or psychiatric emergency, please contact 911. I will notify you and discuss your concerns when I will be unavailable for longer than one week (vacation, training, etc.). In my absence, I may leave contact information for another therapist in my voice message.

Confidentiality:

I follow the American Counseling Association code of ethics and the Nevada statutes concerning confidentiality. I am required to obtain your written consent to disclose any information about you or disclosed during sessions to another person or entity. This includes family members for whom a specific consent has not been signed. If for some reason, you believe a spouse or significant other may need access to the information, I would encourage you to sign the form, as if a problem arising prior to any consent being signed I am unable to release information. The only exceptions to confidentiality are stated in the individual therapy section of this disclosure statement (below).

Your rights as an individual therapy consumer:

1. To receive information concerning the methods of therapy employed, the techniques used, the duration of therapy (if known), and the fee structure provided.
2. To seek a second opinion. I can provide you with names of other qualified professionals.
3. To terminate therapy at any time without moral, legal, or financial obligations other than those already accrued.
4. To know that in a professional psychotherapeutic relationship sexual intimacy between the therapist and client is never appropriate.
5. To know that our therapeutic relationship is confidential except under the following conditions:
    a. If you threaten bodily harm or death to yourself or another person
    b. If you reveal information about physical abuse, sexual abuse or neglect in regard to a child or elderly person.
    c. If you are in court-ordered therapy.
    d. If a court of law issues a legitimate subpoena or a judge breaks your confidentiality.
    e. If you are under the age of 18, in the State of Nevada, parents have access to information in regard to their child's medical records.
6. If you request, any part of your records can be released to any person or agency if you have signed an authorization for me to do so.

All marriage and family therapy and professional counselor services in Nevada are regulated by the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors. Questions or complaints may be addressed to P.O. Box 370130, Las Vegas, NV 89134. The phone number is (702) 486-7388.

Preferred Method of Contact:

Please identify your preferences (1st, 2nd, 3rd or no) for communicating with this therapist on issues associated with scheduling or cancelling appointments ONLY.

_____ Voice Message Yes / No _____

_____ Text message Yes / No _____

_____ Email Yes / No _____

I understand and acknowledge the importance and limitations of confidentiality when communicating via electronic media, and I accept the following: Calls, texts or emails are for the purpose of scheduling or canceling appointments and should not contain any clinical information. Any messages or voicemails left after hours will be reviewed the following business day. Business hours are from 9:00 am to 6:00 pm, Monday through Friday. Limiting the information provided electronically means what is necessary to schedule or cancel appointments. Messages are not appropriate substitution for therapy sessions. In the case of an emergency, call 911.

Consent to Treatment

As a client of Mark Brana, MS, LCPC, LCADC, I understand that:

1. I have the right to refuse any or all parts of the treatment plan, with the exception of emergency treatment.
2. Consent to any or all parts of the treatment plan may be withdrawn at any time.

3. I will be informed of the nature, consequences and purposes of the treatment plan, and any alternative plans and resources available.
4. All counseling/therapy sessions are confidential other than the situations outlined in the disclosure statement.
5. As a client of Mark Brana, MS LCPC LCADC, I have read my rights and acknowledge receipt of a copy of her disclosure statement.
6. I have been fully informed of the above, understood the process, and agree to accept such treatment and to cooperate in its implementation.

Acknowledgement

By signing below, I acknowledge that I have received a copy, I have a copy of Mark Brana's Disclosure Statement. In addition, I acknowledge:

1. I have read and understood the above policies.
2. I have read and understand the financial obligations and cancellation policies.
3. I have been informed of my therapist's credentials and my rights as a client.
4. I have read and understand the Privacy Policies and been provided a copy of policies.

Print _____ _____
Name of client name or parent/guardian Date of Birth

Sign _____ _____
Signature of client or parent/guardian Date

Witness _____ _____
Mark Brana, MS, LCPC, LCADC Date

Brana Mental Health LLC,
DBA Mark Brana MS, LCPC LCADC
NOTICE OF PRIVACY PRACTICES

How I protect the confidentiality of your health care records
Keep This for your reference

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

What this notice does for you: This notice tells you the ways Brana Mental Health LLC, DBA Mark Brana MS, LCPC LCADC may use and disclose medical/treatment information about you. It also describes your rights in regard to this information, and it details certain obligations I have regarding the use and disclosure of this information.

I am committed to protecting your confidential treatment information. Furthermore, I am required by law to make every effort to ensure that any health information that identifies you in any way is kept private. I am also required to give you this Notice of Privacy Practices, and to make certain that the terms of the notice currently in effect are followed.

My Responsibilities: The following categories describe the different ways I use and disclose health information. For each category of use or disclosure I will explain what is meant and try to give some examples. Not every use or disclosure in a category will be listed, but most instances of how I am permitted to use and disclose information will fall into one of the categories.

Regardless of the category, I must obtain an authorization for any use or disclosure of psychotherapy notes except to carry out certain treatment, payment, or healthcare operations as noted below. Psychotherapy notes means notes recorded in any medium by a health care provider who is a mental health professional that document or analyze the contents of the conversation held during a private, group, joint, or family counseling session that are separated from the rest of the medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

For Treatment: I may use medical information about you to provide you with medical treatment, care, or services. The originator of psychotherapy notes may use those notes for your treatment. For example, if you are treated for depression, it may be necessary to know that you have been diagnosed with substance abuse because untreated substance abuse may impede the recovery from depression. I may also disclose medical information about you to other people who may be involved in your medical care, either while you are a client or after your course of treatment is completed. Examples of this may be physicians, other mental health and/or substance abuse professionals, or personnel from other agencies when you provide written authorization to do so. If you would like us to share information regarding your health/treatment status with your family members, you will be given the opportunity to sign an authorization permitting us to do so. If you choose not to sign this, information will not be given without a legal consent for the requesting party to obtain it, unless the appropriate authorization is received from you prior to the request.

For Payment: I may use and disclose health information about you so that the treatment and services you receive may be billed to and payment collected from you, a government payor, or third party. For example, I may need to give your health plan, Medicaid, or Medicare information about services you received to be paid for these services. It may also be necessary to inform your health plan about a treatment modality you are going to receive to obtain prior authorization for that treatment.

For Service Alternatives: I may use and disclose medical/treatment information to tell you about or recommend possible service options or alternatives that may be of interest to you.

Health Related Benefits and Services: I may use and disclose medical/treatment information to tell you about health-related benefits or services that may of interest to you.

Individuals Involved in Your Care or Payment for Your Care: I may release treatment information about you to a friend or family member who is involved in you care, but only with your authorization. Nevada State law (NRS 49.209 and NRS 49.247) establishes the "general rule of privilege" by which I am bound.

As Required by Law: I will disclose medical/treatment information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: I may use or disclose medical/treatment information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military Command Authorities: I may use or disclose medical/treatment information about you as required by military command authorities. I may also release medical/treatment information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: I may release medical/treatment information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks: I may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability;
- To report deaths;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;

The effective date of this notice is June 1, 2016.

Brana Mental Health LLC,
DBA Mark Brana MS, LCPC LCADC
NOTICE OF PRIVACY PRACTICES

- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if I believe a client has been the victim of abuse, neglect, or domestic violence in any form. I will only make this disclosure if you agree, or when required or authorized by law.

Coroner, Medical Examiners, and Funeral Directors: I may disclose health information to such entities consistent with applicable law to carry out their duties.

Research: I may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your treatment information.

Your Health Information Rights

You have the following rights regarding medical/treatment information I maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your treatment. Usually this includes medical and billing records, but may not include psychotherapy notes, as per 45 CFR 164.524

Right to Amend: If you feel that health information I have about you is incorrect or incomplete, you may ask to amend that information, as per 45 CFR 164.528.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information, as per 45 CFR 164.528.

Right to Request Restrictions: You have the right request a restriction or limitation on certain uses and disclosures of your information as provided by 45 CFR 164.522.

Right to Request Confidential Communications: You have the right to request that I communicate with you about medical/treatment matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. I will not ask you the reason for your request. I will accommodate all reasonable requests. You must specify how or where you wish to be contacted in writing.

Right to Paper Copy of this Notice: You have the rights to a paper copy of this notice, even if you have agreed to receive this notice electronically. You may ask me to give you a printed copy of this notice at any time.

Other Uses of Your Health Information: Not covered by this notice or the laws that apply to me will be made only with your written permission. If you provide permission to use or disclose information about you, you may revoke that permission in writing at any time. If you revoke your permission, I will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that I am unable to take back any disclosures already made with your permission, and that I am required to retain the records of the care that I provided to you.

Changes to this Notice: I reserve the right to change the contents of this notice. I reserve the right to make the revised or changed notice effective for medical/treatment information I already have about you as well as any information I receive in the future.

Complaints: If you believe your privacy rights have been violated, you may file complaint directly with me and/or with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

The effective date of this notice is June 1, 2016.

Payment & Credit Card Authorization Form

Brana Mental Health LLC

All payments are due at time of service.

Client Name: _____

Sometimes scheduled appointments need to be cancelled and rescheduled. Please call and leave a message 24 hour prior to avoid charges for your scheduled session. Cancelled or missed appointments will be billed as follows:

24-hour notice (telephone, text or email message) – no charge.
No notification or less than 24-hour notice – $125 cancellation fee (or the agreed upon rate for a session if at reduced rate).

Note: Insurance companies do not pay for missed appointments. The late cancellation fee will be the client's responsibility.

How do you plan to pay for your sessions/copays? Cash or Check* Credit Card Debit Card Insurance

Insurance Company _____ Insurance Copay $ _____

*In the event of a returned check, the fees for the returned check will be added to the client's balance and are the client's responsibility.

INSURANCE AUTHORIZATION

In order for me to receive payment from your insurance company, it is necessary for me to have your authorization on file.

1. I authorize the release of any medical or other information necessary to process my insurance claim. I also request payment of government benefits either to myself or the party who accepts assignment of the claim.
2. I authorize payment of medical benefits to the clinician or mental health professional for services described in the claim.

_____ _____

Signature Date
Insured's or authorized person's signature

CREDIT CARD HOLDER INFORMATION

Please circle credit card type:
Visa MasterCard Discover American Express

Credit Card Number: _____ Expiration Date: _____/_____ (mm/yy)

Name as it appears on the credit card: _____

Billing Zip Code: _____ CVV #: _____

Client agrees to allow card on file to be charged for re-occurring scheduled appointments: YES / NO

Cardholder Signature: _____ Date: _____