Dawn Wood Counseling New Client Packet

CONTACT INFORMATION

Name: _____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: _____ May we leave a message? □Yes □No

Cell/Other Phone:_____ May we leave a message/text □Yes □No

E-mail: _____May we email you? □Yes □No

What is your preferred way of communication? Email, phone, or text?

Would you like appointment reminders? If so, via Email, phone, or text?

*Please note: Email and text correspondence are not considered to be a confidential medium of communication.

REFERRAL INFORMATION

Referred by (if any): _____

May we thank the person who referred you? □Yes □No

If you were referred by another professional (physician, clergy, therapist, etc.) please fill out then information below:

Name of referring professional:_____

May we contact him/her? _____No _____Yes

If you wish us to continue receiving information from and/or providing information to the referring professional regarding your treatment, please complete an "Authorization to Release Information Form". Available on our website.

Have you previously received any type of mental health services (psychotherapy, Psychiatric services, etc.)?

□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes
□ No
Please list:

_____

_____

Have you ever been prescribed psychiatric medication?

□ Yes
□ No
Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?

□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

□ No
□ Yes
If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

FAMILY INFORMATION

Please list the name of the people you consider to be your close family members and your relationship with them:

Adults:_____

_____

Children (include age):

_____

_____

ADDITIONAL INFORMATION

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

SYMPTOM CHECKLIST:

Please circle any symptom below that you are currently experiencing.

Unhappy most of the time	Memory Problems
Withdrawal From Friends	Body Image Issues
Lack of Interest in Activities	Racing Thoughts
Self-Destructive Behaviors (cutting, self harm)	Frequent Mood Shifts
Alcohol/Drug Abuse	Compulsive Spending
Confused Thinking	Compulsive Lying
Anxiety/Panic Attacks	Stealing
Excessive Worries	Detachment from Reality
Suicidal Thoughts	Problems Coping with Stress
Suicide Attempts	Flashbacks
Changes in Appetite	Intrusive Thoughts
Problems with Sleep	Nightmares
Feelings of Guilt	Disorganization
Excessive Anger	Hoarding
Rage/Yelling	Problems at Work
Feeling Sad/Down	Need to Control Others & Situations
Hallucinations	Financial problems
Delusions	Lack of confidence

Relationship Problems	Too much energy
Sexually Risky Behaviors	Overly sensitive
Change in Sex Drive	Shyness
Significant Tiredness	Easily offended
Unable to relax	Worry about your weight
Disciplining your children	Other:
Low Energy	Other:
Lack of Motivation	Other:
Trouble Focusing	Other:

HEALTH INSURANCE INFORMATION

Client Name:_____ Date of Birth:_____

Person your insurance policy has listed as primary carrier:

Name:_____ Relationship to

client:_____

Phone: (Home)_____(Cell)_____(Work)_____

Address:_____ City:_____

Zip:_____

Date of birth:_____

Employer:_____ Position:_____

Name of Primary Insurance:_____ Contract Number:_____

Do you have secondary Insurance? ____ Yes ____ No

Is Dr. Jerie Oxhandler an in network provider for your policy?_____

If not, what does your insurance policy cover for out of network

providers?_____

Co-Pay amount:_____

Deductible met for the year? ___Yes ___ No If no, deductible remaining? _____

Prior authorization required? ___Yes ___ No If yes, authorization number:_____

Limits of sessions covered? ___Yes ___ No If yes, how many? _____

Dr. Jerie Oxhandler, Ed. D., Licensed Psychologist
Dawn Wood, LLMSW
3503 Greenleaf Blvd, Suite 202
Kalamazoo, MI 49008
Phone: 269- 808-0160 Fax: 269-649-3229

WORKING RELATIONSHIP AGREEMENT & CONSENT TO TREAT

Therapy is a relationship between people that works in part because of clearly defined rights band responsibilities held by each person. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it.

Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

I value our work together. During therapy individuals often have moments were they consider termination for a variety of reasons. I request that you discuss any thoughts about ending therapy during our sessions. If you are considering terminating, please schedule a closure session. Closure is an important part of the therapeutic process.

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FINANCIAL AGREEMENT

Initial Session: $190.00, 60+ minute session. CPT Code: 90791 This session is used for information gathering, discussing counseling arrangements and us getting to know one another. Payment and insurance arrangements are determined. The assessment process is begun.

Psychotherapy Sessions: $187.50 60-minute session. CPT Code 90837 These are the ongoing sessions to help you better understand yourself and/or improve your relationships and are usually scheduled weekly. Your time is reserved exclusively for you. If it becomes necessary to cancel an appointment, 24 hours notice is required. A voicemail message or text is sufficient and is always available. For a broken appointment with no notice, you will be charged the full fee. Insurance companies do not cover cancelation fees.

If we participate with your insurance company, we will provide billing services and you will be asked to pay the co-pay at the time of service. It is important that you understand how your insurance benefits work. **Please contact your insurance carrier (number on back of card) prior to your initial appointment to confirm details of your mental health/behavioral health coverage, including co-pay, deductible amounts as well as any restrictions.**

If we do not participate with your insurance company and this is true for many managed care companies. You are expected to pay the co-pay at the time of service and the remainder fee when received from your insurance company. We will provide the appropriate paperwork for you to submit for reimbursement. Alternately, in some circumstance we may bill your insurance as out of network providers and expect you to pay your co-pay at time of service. Accounts over 60 days in arrears may be referred to a collection agency. You will be liable for all collection costs and attorney fees.

Authorization: I have read the working relationship and financial agreement information on this form and understand the risks involved with treatment. I give my consent to Dr. Jerie Oxhandler/Dawn Wood to provide psychotherapy.

I agree to follow these polices outlined above. Further, I authorize Dr. Jerie Oxhandler and/or Dawn Wood, to release appropriate diagnosis and necessary information to billing personnel and my insurance company. I authorize payment directly to Dr. Jerie Oxhandler/Dawn Wood for counseling services I received.

Signature: _____ Date: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have carefully reviewed and understand the notice of privacy practices have been made available to me and that I may retain a copy for my records, if I so choose.

Signature:_____Date:_____

Client