Client Information - Adult

Client's name: _____ Today's date: ___/___/_____

Address: _____
(Street) (City) (State) (Zip)

Date of birth: ___/___/_____ Gender: _____ Sexual orientation: _____

Preferred Pronouns: _____ Preferred Name: _____

Occupation: _____ Employer: (if applicable) _____

Phone: _____ (home) _____ (mobile) _____ (work)

Email: _____

CONTACT INFORMATION
OK to send snail mail? ☐Yes ☐No OK to email? ☐Yes ☐No
OK to call? ☐Yes ☐No OK to leave message? ☐Yes ☐No Preferred number?_____

Please provide a name and phone number in case of emergency: _____
_____

PAYMENT INFORMATION

Private (self) Pay: ☐Yes ☐No

If not private pay, Insurance Name: _____

You are responsible for payment of charges incurred, regardless of whether your insurance company decides to honor this claim.

Co-pay or coinsurance: $_____

Do you have a deductible? _____ Amount of deductible: _____

Name of Policy Holder: _____

Birth Date of Policy Holder: _____

Address of Policy Holder: _____

Policy Holder ID Number: _____

Client signature indicating you understand and agree to this payment arrangement:

_____

Please list the concerns that bring you to therapy: _____

_____

_____

FAMILY INFORMATION

Who currently lives with you in your home or is a part of your immediate family?

Name	Age	Relationship (i.e., parent, spouse, partner, child, etc.)

Is there any alcohol or drug use in your current home that concerns you? ☐Yes ☐No ☐Unsure
Is there any violence or other abuse in your current home that concerns you? ☐Yes ☐No ☐Unsure

Was there any alcohol or drug abuse in your home growing up? ☐Yes ☐No ☐Unsure
Was there any violence or physical abuse in your home growing up? ☐Yes ☐No ☐Unsure
Was there any sexual abuse in your home growing up? ☐Yes ☐No ☐Unsure
Was there any verbal abuse in your home growing up? ☐Yes ☐No ☐Unsure
Other childhood circumstances (such as neglect or trauma, frequent moves, parent death, etc.) that you believe have affected your development? _____

_____

HEALTH INFORMATION

Name and location of your medical doctor: _____
Name and location of psychiatrist/prescriber:_____
Have you ever been hospitalized? (if yes, please provide details):_____

_____

Are you currently taking any prescribed medications? (Please list names, dosages, frequency and prescriber):_____

_____

Please list any current health concerns:_____

Have you previously participated in psychotherapy? ☐Yes ☐No

Therapist name	Location (City/State)	Dates

_____

_____

Was therapy helpful ☐Yes ☐No Why or why not?_____

_____

Consent for Psychotherapy and Terms of the Agreement Signature Page

By signing below, the client (or child's parent/guardian) acknowledges that s/he has reviewed and fully understands the terms and conditions of this agreement.

The client has discussed the terms and conditions with the therapist and has had the opportunity to have any questions with regard to its terms and conditions answered to client's satisfaction. Client (or child's parent/guardian) agrees to abide by the terms and conditions of this agreement and consents to participate in psychotherapy with Amy Gray, LICSW.

Moreover, client (or child's parent/guardian) agrees to hold Amy Gray, LICSW free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Name of Client (print):_____

Signature of Client (if over 18 years of age):_____

Signature of Parent/Guardian (if under 18 years of age): _____

Date: _____

HIPAA Notice of Privacy Practices - SIGNATURE PAGE

This form is an agreement between you (the client) _____ and Amy Gray, LICSW. When we use the word "you" below it will mean you, your child, relative, or other person if you have written her/his name here.

When I assess, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions**.**

By signing this form you are agreeing that you have read and understand the **HIPAA Notice of Privacy Practices** and you are agreeing to allow me to use your information and to send it to others in accordance with our written policies. *Please make sure you have read and understand my Privacy Policies above before signing this Consent form.*

If you do not sign this consent form agreeing to what is in my HIPAA Notice of Privacy Practices, I will not be able to work with you.

In the future I may change how I use and share your information and so may change my **HIPAA Notice of Privacy Practices**. If I do change it, you can get a copy from my website: www.amygraytherapy.com or by calling me at 413-522-4903.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on.

Name of Client (print):_____

Signature of Client (if over 18 years of age):_____

Signature of Parent/Guardian (if under 18 years of age): _____

Date: _____