New Patient Demographics

Today's Date: _____

Last:_____ **First:**_____ **M:**_____

Preferred Name: _____

SS#:_____ **Date of Birth**:_____ **Birth Sex**: ☐ M ☐ F

Gender Identity: _____ **Sexual Orientation:** _____

Marital Status: ☐ Single ☐ Married ☐ Remarried ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity / Race: ☐ White ☐ Hispanic ☐ African American ☐ American Indian ☐ Asian/Pacific Island ☐ Other

Address: _____ **City:**_____

County: _____ **State:**_____ **Zip:** _____

Phone: (H) _____ **(M)** _____ **(W)** _____

Email Address: _____

Guardian / Responsible Party / Parent ☐ Same As Above

Name: _____ **Relationship:** _____

SS#:_____ **Date of Birth**:_____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (H) _____ **(M)** _____ **(W)** _____

Email Address: _____

Guardian / Responsible Party / Parent ☐ N/A

Name: _____ **Relationship:** _____

SS#:_____ **Date of Birth**:_____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (H) _____ **(M)** _____ **(W)** _____

Email Address: _____

Who is the custodial parent/guardian of the client? _____

Emergency Contact

Name: _____ **Relationship:** _____

Phone #: (Home) _____ **(Mobile):** _____

Referral Information
Reason for Referral: _____

Referred from: _____

☐ Clergy ☐ Court ☐ Mobile Crisis ☐ Family / Friend ☐ Public Health / Welfare Agency
☐ MD/NP Office ☐ Self ☐ Police ☐ School ☐ Community Mental Health Center
☐ Psychiatric Hospital ☐ General Hospital

Health Insurance Portability and Accountability Act (HIPAA)

Patient Notification of Privacy Rights

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Preamble

The Licensing Laws of the State of Tennessee provide privileged communication protections for conversations between your therapist and you in the context of your established professional relationship with your therapist. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers, and in some cases, not to the patient himself/herself.

HIPAA provides privacy protections regarding your personal health information, which is called "protected health information," which could personally identify you. PHI consists of three (3) components: *treatment, payment, and health care operations.*

Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided to you.

Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "medically necessary."

The *use* of your protected health information refers to activities our office conducts in filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care. *Disclosures* refer to activities you authorize which occur *outside* our office, such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

1. **Uses and Disclosures of Protected Health Information (PHI) Requiring Authorization**

The State of Tennessee requires authorization and consent for treatment, payment and health care operations. HIPAA does nothing to change this requirement by law in Tennessee. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you).

Additionally, if you ever want our office to send any of your protected health information to anyone outside our office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon request. The requirement that you sign an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I speak with your physician about your treatment and/or medications. Before I talk to that physician, you will first have signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: psychotherapy notes. In recognition of the importance of the confidentiality of conversations between therapist-patient in treatment settings, HIPAA permits keeping 'psychotherapy notes' separate from the overall 'designated medical record." 'Psychotherapy notes' cannot be secured by insurance companies, nor can they insist upon their release for payment of services. "Psychotherapy notes' are the notes of the clinician and are defined as follows: " notes recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that are separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you; hence, the need for increased security of the notes. "Psychotherapy notes' are not the same as your "progress notes' which provide the following information about your care each time you have an appointment at my office: assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your PHI to only your "designated record set" which includes the following: all identifying paperwork you completed at your initial visit, all billing and reimbursement information, a summary of our first appointment, your mental status and progress notes for each session, your treatment plan, discharge summary, reviews by managed care companies, results of psychological testing, and any authorizations you have signed. Please note that the actual test questions or raw data of psychological tests are *not* part of your 'designated mental health record set.

You may, in writing, revoke all authorizations to disclose PHI at any time. You cannot revoke an authorization to disclose PHI that has already been disclosed, or an authorization that was obtained as a condition for obtaining insurance in cases where Tennessee law provides the insurer the right to contest the claim under the policy.

Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative services for my practice and refers to these people as "Business Associates." These include our secretaries, telephone answering service, health insurance billing service and collection agency. These business associates need to receive some of your PHI in order to do their jobs properly. To protect your privacy they have agreed in their contract with us to safeguard your information in accordance with state and federal standards.

Uses and Disclosures Not Requiring Consent nor Authorizations

By law, PHI may be released without your consent or authorization in the following instances:

1. Child abuse
2. Suspected sexual abuse of a child
3. Adult and domestic Abuse
4. Health oversight activities (i.e. licensing boards investigations)
5. Judicial or administrative proceedings (i.e., court ordered treatment and/or evaluations)
6. Serious threat to health or safety (i.e., Duty to Warn law, national security threats)
7. Workers Compensation claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

No information will ever be released for any sort of marketing purposes.

Patient's Rights and Agency Duties

You have a right to the following:

The right to request restrictions on certain uses and disclosures of your PHI. The agency may or may not agree to these restrictions, but if so, they shall apply unless the agreement is changed in writing.

The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so the agency will send them to another location of your choosing.

The right to inspect and receive a copy of your PHI in the designated mental health record set for as long as PHI is maintained in the record.

The right to amend material in your PHI, although the agency may deny an improper request and/or respond to any amendment(s) you make to your record of care.

The right to an accounting of non-authorized disclosures of your PHI.

The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of same.

The right to revoke any authorization of your PHI except to the extent that action has already been taken.

For more information on how to exercise each of the rights, please do not hesitate to ask for further assistance. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed. Current practices are applicable unless you receive a revision of my policies at a future time. Our duties as an agency include maintaining the privacy of your PHI, providing you with this notice of your rights and my privacy practices with respect to your PHI, and abiding by the terms of this notice unless it is changed and you are so notified.

Complaints

The appointed "Privacy Officer" for Revelation of Hope Counseling Services, LLC is Alvin G. Bonds, II. If you have any concerns that your privacy rights have been compromised, please let us know immediately. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Effective Date

The notice shall be effective June 17, 2014.

Informed Consent

Patient Name: _____ Date of Birth: _____

I agree and consent to participate in behavioral health care services offered and provided by the following behavioral health care provider:

Alvin Bonds II
NCC, ACS, RPT-S, LMFT, LPC/MHSP/AS

National Certified Counselor (NCC)
Approved Clinical Supervisor (ACS)
Registered Play Therapist – Supervisor (RPT-S)
Licensed Marital and Family Therapy (LMFT)
Licensed Professional Counselor/Mental Health Service Provider/Approved Supervisor (LPC/MHSP/AS)

I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within the scope of the provider's license, certification and training.

If the client is under the age of sixteen or unable to consent to treatment:

I, _____attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent for treatment on behalf of this individual.

I understand that treatment may involve the risk of remembering painful events and can arouse intense emotions of fear or anger. Other feelings of anxiety, depression, frustration, loneliness or helplessness may also be aroused. I understand that my condition may worsen as a result of the process of counseling and drastic lifestyle changes might occur that could negatively affect my relationships and/or ability to cope. I understand the benefits of treatment may be that I will be better able to handle or cope with my family, my work or school, my social relationships or that I may have a better understanding of myself or my goals and values which could lead to growth as a person. I realize, however, there is no guarantee of positive results.

I understand I can discontinue counseling sessions at any time and I have had a chance to ask questions and have my questions satisfactorily answered. All communications become a part of my clinical record.

I UNDERSTAND THE INFORMATION LISTED ABOVE AND AM AWARE OF THE RISKS AND LIMITATIONS OF TREATMENT.

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Authorized Representative Date

_____ _____
Signature of Staff Reviewing Date

Payment Responsibility

Patient Name: _____ Date of Birth: _____

Intake Appointments	$100 / session
Individual Therapy	$75 / session
Group Therapy	$75 / session
Family/Couples Therapy	$125 / session
Subpoena to Court for Expert Testimony Non-Refundable Up-Front Retainer	$500 / one-time fee
Court Appearance and Preparation	$200 / hour
Additional Expenses for Court	TBD
Additional Practice Fees	TBD on a case-by-case basis

I understand that I am responsible for charges incurred for services rendered as part of my (or my child's) treatment. I shall pay these charges at the time services are provided unless alternative arrangements are made. I authorize payment of medical benefits directly to Revelation of Hope Counseling Services, LLC or my assigned provider for any third-party benefits (insurance, etc.) to which I am entitled. I understand that insurance benefits paid to Revelation of Hope Counseling Services, LLC will NOT reduce my payment responsibility unless the insurance benefits and my payment responsibility combined should exceed the standard fee charged by the agency. In such event, the excess will be used to reduce my responsibility or if my account has been paid in full, will be refunded to me.

I further authorize the release of information needed to process third party claims. If I choose to be the payee of the insurance benefits or refuse to allow my insurance to be filed, I will be responsible for payment of the standard charge for services.

I also understand that 1.5% interest per month will be charged on all unpaid accounts. I understand that Revelation of Hope Counseling Services, LLC reserves the right to use established collection procedures if I do not meet my payment responsibilities and that any collection fees will be added to my account.

Employer (or student):_____ ☐ Unemployed

Household Size: _____ Annual Gross Household Income (All Sources): _____

	First Funding Source	Second Funding Source
Insurance Co. Name		
Insurance Co. Address		
Insurance Co. Phone #		
Subscriber ID #		
Group #		
Cardholder's Name		
Address		
Phone #		
SSN		
DOB		
Relation to Client		
Employer		

Any deviations from the above fee schedule are indicated here: _____

Patient Initial: _____ Staff Initial: _____

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Authorized Representative Date

_____ _____
Signature of Staff Reviewing Date

Treatment Consent

Patient Name: _____ Date of Birth: _____

Please initial beside the following statement(s) and sign where indicated.

_____ I have received a copy of the patient client/counselor contract which outlines in detail the mental health services provided at this office, session/meeting requirements, cancellation policies, professional fees, billing and payment options, insurance reimbursement, contacting the counselor, and child therapy policies.

I understand that my confidentiality will be waived in the event of any suspected child/adult/elder abuse or when there is a potential for harm to myself or others.

Your full participation in treatment will include keeping all scheduled appointments including medication clinics and therapy appointments. If you have an appointment which you cannot keep, please call the office and let us know so adequate response can be made on your behalf.

Due to confidentiality, we ask for the following information that indicates persons, in addition to yourself, to whom we may provide reminders of appointments, as well as how you would like to be notified of reminders of appointments.

Please initial any of the following:	***YES***	***NO***
Voice Mail Reminder	_____	_____
SMS/Text Message	_____	_____
Email	_____	_____
Leave a message with a family member	_____	
Leave a message only with	_____	

☐ Do **not** make a reminder of scheduled appointments

We expect our clients to show up promptly for all scheduled appointments or cancel any appointments at least 24 hours prior to scheduled time.

For children & adolescents only

☐ I have been given a copy of information regarding the State of Tennessee EPSDT Program.

By signing this document, I am consenting to the evaluation and mental health services provided by:
Alvin Bonds II, NCC, ACS, RPT-S, LMFT, LPC/MHSP/AS

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Authorized Representative Date

_____ _____
Signature of Staff Reviewing Date

Medical History

Patient Name**:** _____ Date of Birth: _____

I have recently traveled outside the United States ☐ NO ☐ YES If YES, Where & When_____

We would like for you to answer these questions so we can provide the best care possible. Sometimes emotional symptoms have influence on your body and physical illness can affect your emotions. This form is part of your case history and is confidential.

	YES	NO		YES	NO
I have poor appetite or unusual eating habits	☐	☐	I sleep badly	☐	☐
I have fits or convulsions or epilepsy	☐	☐*	I am under medical care	☐	☐
I have or have had anemia or thin blood	☐	☐	I am allergic to certain things	☐	☐
I drink 5-10 cups of coffee per day	☐	☐	I have high blood pressure	☐	☐
I have fainted or passed out frequently	☐	☐	I have/had cancer	☐	☐
I have trouble breathing or shortness of breath	☐	☐*	I drink 3 or more colas per day	☐	☐
My heart beats too fast or irregularly	☐	☐*	I have headaches often	☐	☐
I smoke ____ packs of cigarettes per day	☐	☐	I have trouble with my eyes	☐	☐
I have constipation or diarrhea frequently	☐	☐	I have trouble with my ears	☐	☐
I often have blood in my bowel movements	☐	☐*	I have thyroid trouble	☐	☐
I have had liver trouble or hepatitis	☐	☐	I have asthma or emphysema	☐	☐
I drink ____ mixed drinks per day/week	☐	☐	I have pains in my chest	☐	☐*
I drink ____ beers per day/week	☐	☐	I have heart trouble	☐	☐*
I have trouble with my kidneys or bladder	☐	☐	I cough up blood	☐	☐*
I am in pain when I urinate or pass water	☐	☐*	I have had tuberculosis	☐	☐*
I have had a sexually transmitted disease	☐	☐	I have diabetes	☐	☐
I have used narcotics or other habit forming drugs	☐	☐	I have or have had an ulcer	☐	☐
I have arthritis or stiff and painful joints	☐	☐	I often feel sick to my stomach	☐	☐
I have had a recent unusual change in weight	☐	☐	I have trouble with my balance	☐	☐*

***If any of these are answered Yes, confirm they are being addressed by PCP or refer to PCP**

TUBERCULOSIS SCREEN: ☐ Unexplained weight loss ☐ Productive cough (> 3 weeks) ☐ Night sweats

- ***If all 3 present, immediately refer to PCP***

WOMEN ONLY

# of Pregnancies: ☐ # of Live Births: ☐ # of Abortions: ☐ # of Miscarriages: ☐

	YES	NO		YES	NO
I am pregnant	☐	☐	I am using birth control	☐	☐
I am now going through the change of life	☐	☐	I have hot flashes and sweats	☐	☐
I have severe pains during menstrual periods	☐	☐	I receive hormone treatments	☐	☐
I am very nervous during menstrual periods	☐	☐	I have had a hysterectomy	☐	☐

Primary Care Provider (Doctor/NP) _____ Phone #: _____

Date last Physical Exam:_____ Current on all Immunizations? ☐ Yes ☐ No

Brief summary of any current medical conditions / diagnoses: _____

_____

_____

_____

ALLERGIES: (Include medications, foods, seasonal, dye, latex, etc.) ☐ None

Allergen: _____ Reaction: _____

Allergen: _____ Reaction: _____

Brief summary of any past medical history (treatment procedures, diagnoses or problem, etc.): _____

_____

_____

History of: ☐ HIV/Aids ☐ Hepatitis; Type:____ STDs:_____

Relevant Family History: _____

_____

_____

VISION SCREENING:

Last eye exam? _____ Any problems? ☐ No ☐ Yes if yes, explain: _____

DENTAL SCREENING:

Provider: _____ Date of Last Exam: _____

Describe any current problems: _____

CHILD / ADOLESCENT ONLY

Is your child current on all immunizations? ☐Yes ☐No ***PLEASE PROVIDE COPY FOR RECORDS***

Do you have any concerns regarding your child's use of drugs or alcohol? ☐ No ☐ Yes If Yes, explain: _____

_____

Do you have any concerns about your child being sexually active? ☐ No ☐ Yes If Yes, explain: _____

_____

Has your child been sexually abused? ☐Yes ☐No physically abused? ☐ Yes ☐ No

CLINICIAN SUMMARY

_____

_____

_____ _____

Patient Signature Date

_____ _____

Signature of Patient's Authorized Representative Date

_____ _____

Signature of Clinical Staff Reviewing Date

Comprehensive Medication List

Patient Name: _____ Date of Birth: _____

Medication	Dosage	Frequency	Indication	DC Date/Reason	Medical Provider

_____ _____

Patient Signature Date

_____ _____

Signature of Patient's Authorized Representative Date

_____ _____

Signature of Staff Reviewing Date

Photography/Video Recording Consent Form

Patient Name**:** _____ Date of Birth: _____

Based on professional experience, it can be very useful to have a photograph or make video recordings of clients seen in therapy sessions. These photographs and video recordings are made for several different purposes:

Identification: Photographs are taken with the intention of including them in the client file for purposes of identification. These photographs are kept in the chart and are not released with other records.

Classroom or Workshop Training: Therapists sometimes participate in workshops or in-services for instruction of other therapists. It is often very helpful in teaching to have a photo or video clip of a client demonstrating a particular therapy technique. All effort is taken to not reveal the client's identity in these cases.

Marketing: Photographs and video recordings taken for this purpose illustrate what is done in therapy or to provide awareness about mental health. No identities are revealed and specifics of diagnoses are not included with the marketing material.

Please initial beside the following statement(s) and sign where indicated.

☐ I do **NOT** give my permission for photography or video recordings to be taken of myself/my child in the course of treatment at *Revelation of Hope Counseling Services, LLC*. _____

☐ I give my permission for myself/my child (please circle) to be photographed and/or video recorded by the staff of *Revelation of Hope Counseling Services, LLC* for the following purposes indicated by my initials:

_____ Identification

_____ Classroom Training

_____ Marketing

**This consent shall remain effective indefinitely until patient or parent/legal guardian completes written notice of revocation.*

☐ I give my permission for these photographs and/or video recordings to be sent to me via:

_____ Mail

_____ Email

_____ Text Message

_____ _____

Patient Signature Date

_____ _____

Signature of Patient's Authorized Representative Date

_____ _____

Signature of Staff Reviewing Date

Informed Consent and Release of Liability for Animal Assisted Activities and Therapy

Patient Name: _____ Date of Birth: _____

Therapy animals can be a vital part of the treatment team; I hope that you are comfortable with Beacon's presence in your sessions. However, because he is an animal and not a human, we are responsible for his welfare. Because Beacon's behavior cannot always be predictable it is important to discuss in advance the risks and rules needed to insure Beacon and your safety and health, and try to create as safe a working situation as possible. It is important to provide you with diligent warning about the potential harm that could be present when working with animals. While I have listed some of these risks below, we cannot foresee all potential problems that may occur. Therefore, by signing this form you are releasing Alvin Bonds, II and any of the staff of Revelation of Hope Counseling Services, LLC from any liability should any injury occur as part of your treatment here.

Beacon is a pure breed Portuguese Water Dog who was born on December 27, 2016 to a "Breeder of Merit" of the American Kennel Club. Beacon receives regular grooming at a local Groomer and regularly sees the local Veterinarian and he is current on all required shots and has been neutered as recommended by the Veterinarian.

RISKS

1. Beacon is currently in training, which means he has not been certified to do Animal Assisted Therapy. He is in the beginning stages of this process and still needs to learn several skills to pass his certification test. During his training process, and even once he is certified, you may opt to not have him a part of your session. Should you choose, he will stay in his designated area for the duration of your session. Please do not feel obligated to have him participate.
2. Animals have their own natural defenses. While I will do everything possible to prevent any injury, it is possible that someone will get scratched or bitten.
3. Animals often use their mouths in play. Therefore, even when playing, it is possible for light biting to occur. When playing with a toy with Beacon, he may miss the toy and get your finger. When he realizes this, he releases and does not bite down, but you may still feel his teeth.
4. While Beacon has been screened by a veterinarian before commencing to work as a therapy animal, animals do sometimes carry disease. Because your contact is minimal, this risk is very small. Beacon is up to date on all of his vaccinations.
5. While Beacon is a "hypoallergenic" dog (as he has hair and not fur) there may still be risk for allergic reaction. Please let me know if you typically have allergies to animals.

RULES

1. Animals have individual rights, just as each client has rights. Therefore, Beacon is allowed to determine if and when he participates with others. While it may be planned to have him in session, he will never be forced to do so.
2. Beacon has his own quiet space in the office where he can rest, sleep, or just take a quiet break. He should not be disturbed when he is in this area, unless permission is given by the staff.
3. Beacon should always be treated gently. He should never be hit, have his tail or any other parts pulled, be carried or treated in any other way that is uncomfortable to him.
4. Beacon will always need Alvin present in any therapeutic situation.
5. If Beacon becomes irritated, scared, or in any way acts in a negative manner, Alvin or staff will put him in a safe place. No other person should touch him at these times.
6. Beacon can only be carried by Alvin or designated staff.
7. Because of the unpredictability of animals in unfamiliar situations, clients may not bring their own animal to be involved in their therapy session.

By signing below you are stating your acceptance of these rules and risks and agree to accept full liability in the event that Beacon harms you or your child in any way in the course of treatment or you or your child is harmed in any way as a result of being on the property owned or leased by Alvin Bonds II or Revelation of Hope Counseling Services, LLC or at any other place while in the presence of Alvin Bonds II and Beacon.

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Authorized Representative Date

_____ _____
Signature of Staff Reviewing Date

Children & Youth Assessment

Child/Youth's Name: _____ DOB: _____

Father's Name: _____ Occupation: _____

Employer: _____ Highest Level of Education: _____

Mother's Name: _____ Occupation: _____

Employer: _____ Highest Level of Education: _____

Current Living Situation (With whom does the child/youth live): _____

Describe any custody/visitation arrangements: _____

List other members of the household and their relationship to the child:

Name	Relationship	Age	School & Grade	Learning or Behavioral Issues

Are there any other family members living out of the child's home?

_____

Has the child experienced any of the following?

□ Moving? How many times?_____ When? _____

□ Long visits with relatives? If so, whom? _____ When? _____

□ Living with someone other than a parent If so, whom? _____ When? _____

□ Death in the family If so, whom? _____ When? _____

□ Terminal or chronic illness If so, whom? _____ What type of illness? _____

□ Parental separation and/or divorce When? _____

□ New step-parent Which parent re-married? _____ When? _____

□ Other traumatic or upsetting experience Explain: _____

DEVELOPMENTAL HISTORY

PREGNANCY & DELIVERY:

Prenatal Care: ☐ Adequate ☐ Inadequate ☐ Unknown

Significant illnesses (mother): _____

Perinatal Events: Was child premature? ☐ Yes ☐ No ☐ Unknown

Birth Weight: _____ Birth Height: _____

Birth Complications? ☐ Yes ☐ No ☐ Unknown If Yes, explain: _____

FIRST YEAR:

Breast Fed? ☐ Yes ☐ No ☐ Unknown If Yes, how long? _____

Allergies? ☐ Yes ☐ No ☐ Unknown If Yes, explain: _____

Problematic Sleep Patterns? ☐ Yes ☐ No ☐ Unknown If Yes, explain: _____

MILESTONES: (Give approximate age if known)

_____ Sat without Support _____ Crawled _____Walked with Assistance

_____ Ate with a Fork _____ Toilet Trained _____ Able to Dress Self

_____ Said first Word _____ Used Sentences

If unable to remember specific dates, were milestones reached Within Normal Limits? ☐ Yes ☐ No ☐ Unknown

<u>Prenatal History</u>

Did the mother receive regular prenatal care? □ Yes □ No

Were there any illnesses or problems during pregnancy for the child or the mother? □ Yes □ No

Explain: _____

Were any medications or drugs taken during pregnancy? □ Yes □ No

Explain: _____

Does the child have difficulty with any of the following:

□ Balance □ Throwing a ball □ Skipping □ Writing/coloring □ Buttoning □ Memory

□ Following instructions □ Understanding what others are saying □ Paying attention/staying focused

Explain: _____

DEVELOPMENTAL FUNCTIONING

Physical (including hearing and speech): _____

_____

Emotional/Psychological: _____

_____

Cognitive: _____

_____

Nutritional: _____

_____

Social: _____

_____

MEDICATION

Has the child ever been prescribed any additional medication for conditions other than common childhood illnesses?

_____

Has anyone in the child's family been diagnosed as having any chronic medical or emotional disorders?

Explain:

_____

_____

Did either of the child's parents have a learning disability or behavior concerns during childhood?

Explain:

_____

_____

SOCIAL-EMOTIONAL HISTORY

Did the child attend pre-school? □ Yes □ No If so, where and when? _____

Where does the child attend school? _____ Grade? _____

Does the child have an IEP? □ Yes □ No Reason: _____

Who handles the discipline in the home? _____

What methods of discipline are most effective with the child? _____

_____

Does the child exhibit any of these behaviors frequently at home or within the community?

□ Shyness □ Unable to make/keep friends □ Prefers to play alone □ Cries easily □ Irritable

□ Very independent □ Fearful □ Harms pets/animals □ Plays with sex organs or other body parts

□ Insists on his/her own way □ Physical ailments/complaints □ Unable to show feelings □ Indecisive

□ Threatens to harm self □ Threatens to harm others □ Shows preoccupation with fire □ Nightmares

□ Hand waving or flapping □ Runaway □ Rocking □ Head banging □ Quick temper □ Bites

□ Lies, steals, and/or cheats □ Difficult to discipline □ Nail biting □ Thumb sucking □ Talks baby talk

□ Overactive □ Always worried □ Daydreams □ Easily distracted □ Destructive □ Accident prone

□ Other unusual behavior_____

If so, explain: _____

Has this child ever seen a counselor/therapist (including a school counselor)? □ Yes □ No

If so, list the names and contact numbers for any providers or professionals who have pertinent information about your child (i.e.- pediatrician prescribing psychotropic medications, community mental health agencies, school counselor, etc.).

_____

_____

CLINICIAN SUMMARY

_____

_____

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_____ _____

Patient Signature Date

_____ _____

Signature of Patient's Authorized Representative Date

_____ _____

Signature of Staff Reviewing Date

Authorization for Requesting/Releasing Protected Health Information

Patient Name: _____ Date of Birth: _____

☒ **Information Released By: Revelation of Hope Counseling Services, LLC**

Release Records to: _____

Address: _____ City/State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____ Email: _____

PRIMARY CARE PHYSICIAN (PCP)

☒ **Information Requested From:** _____

Address: _____ City/State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____ Email: _____

Release Records To: **Revelation of Hope Counseling Services, LLC, 384 C Carriage House Drive, Jackson, TN 38305**
731.868.7297 (Phone) | 877.273.4824 (Fax) | alvin@rohcs.org

Purpose of Disclosure: ☒ Continuing Care ☐ Insurance ☐ Family Involvement ☐ At the Request of the Individual

Dates of Treatment: ALL Place of Treatment: ☒ Inpatient ☒ Outpatient Other: _____

Choose from the following (please initial beside documents):

____Entire Chart
____Audio/Visual Recordings
____Completion of Submitted Form
____Discharge Summary
____Educational Records
____Lab (may include AIDS/HIV information)
____Letter
____Medical Assessment
____Multidisciplinary/Psychosocial Assessment
____Progress Notes – Clinical
____Progress Notes – Nursing
____Progress Notes/Orders – Medical Provider
____Treatment Plan
____Verbal Communication
____Other (specify): _____

I understand that:

1. I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information (releasing facility). However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.
2. This authorization allows the facility to which records are being released (hereafter referred to as the receiving facility) to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The receiving facility is hereby released from any liability and the undersigned will hold the receiving facility harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.
6. The authorization will expire in 12 months unless I provide an alternate date or event.
7. An electronic copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I hereby authorize the release, use, and disclosure of the above-requested protected health information.

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Authorized Representative Date

_____ _____
Witness Signature Date

Authorization for Requesting/Releasing Protected Health Information

Patient Name: _____ Date of Birth: _____

☒ **Information Released By: Revelation of Hope Counseling Services, LLC**

Release Records to: _____

Address: _____ City/State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____ Email: _____

SCHOOL/DISTRICT

☒ **Information Requested From:** _____

Address: _____ City/State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____ Email: _____

Release Records To: **Revelation of Hope Counseling Services, LLC, 384 C Carriage House Drive, Jackson, TN 38305**
731.868.7297 (Phone) | 877.273.4824 (Fax) | alvin@rohcs.org

Purpose of Disclosure: ☒ Continuing Care ☐ Insurance ☐ Family Involvement ☐ At the Request of the Individual

Dates of Treatment: ALL Place of Treatment: ☒ Inpatient ☒ Outpatient Other: Educational Setting

Choose from the following (please initial beside documents):

____Entire Chart
____Audio/Visual Recordings
____Completion of Submitted Form
____Discharge Summary
____Educational Records
____Lab (may include AIDS/HIV information)
____Letter
____Medical Assessment
____Multidisciplinary/Psychosocial Assessment
____Progress Notes – Clinical
____Progress Notes – Nursing
____Progress Notes/Orders – Medical Provider
____Treatment Plan
____Verbal Communication
____Other (specify): _____

I understand that:

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_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Authorized Representative Date

_____ _____
Witness Signature Date

Authorization for Requesting/Releasing Protected Health Information

Patient Name: _____ Date of Birth: _____

☐ **Information Released By: Revelation of Hope Counseling Services, LLC**

Release Records to: _____

Address: _____ City/State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____ Email: _____

SPECIALISTS

☒ **Information Requested From:** _____

Address: _____ City/State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____ Email: _____

Release Records To: **Revelation of Hope Counseling Services, LLC, 384 C Carriage House Drive, Jackson, TN 38305**
731.868.7297 (Phone) | 877.273.4824 (Fax) | alvin@rohcs.org

Purpose of Disclosure: ☒ Continuing Care ☐ Insurance ☐ Family Involvement ☐ At the Request of the Individual

Dates of Treatment: ALL Place of Treatment: ☒ Inpatient ☒ Outpatient Other: _____

Choose from the following (please initial beside documents):

____Entire Chart
____Audio/Visual Recordings
____Completion of Submitted Form
____Discharge Summary
____Educational Records
____Lab (may include AIDS/HIV information)
____Letter
____Medical Assessment
____Multidisciplinary/Psychosocial Assessment
____Progress Notes – Clinical
____Progress Notes – Nursing
____Progress Notes/Orders – Medical Provider
____Treatment Plan
____Verbal Communication
____Other (specify): _____

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Patient Signature Date

_____ _____
Signature of Patient's Authorized Representative Date

_____ _____
Witness Signature Date