JUDITH RANDALL COMPANY
8471 Turnpike Dr. #205 Westminster CO 80031

INTAKE

Client Name: ______________________________ D.O.B. __________

Address ____
____

Telephone: __________________________ Emergency Contact # __________________________

Insurance: __________________________ I.D. # __________ Group __________________________

Sex: M F   Marital Status: Occupation: Education:

Others living in the home:

PRESENTING PROBLEMS:
Please describe the reasons for seeking counseling (include date/month the problem started):

HISTORY OF PRESENT ILLNESS
Completed by Patient/Client
Please indicate how the following symptoms/problems/complaints are affecting you:(Leave blank if no affect)
1)Little 2)Some
3)Much 4)Significant

___Eating habits/Appetite: eating more; eating less; weight change______; binge; purge.
___Sleep: Trouble falling asleep;
Trouble staying asleep;
Trouble waking up;
Average # hours sleep_____
#Naps_____
___Decreased energy/Fatigue
___Sexual functioning
___Loss of interest in activities
___Tearfulness
___Hopelessness/Helplessness
___Decreased attention span
___Inattentive/Distractible
___Memory: Long term; short term

___Difficulty planning ahead
___Opposition
___Anger outbursts
___Impulse control; difficulty controlling physical behavior/hyperactive
___Mood changes
___Anxious/Nervous
___Worry/Fear
___Stealing
___Lying
___Truancy
___Fire setting

Comments

Describe: History of present illness. Onset/intensity/frequency.

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Goals and Interventions

Define in concrete measurable terms where appropriate. ______________________

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: ______________________

Past treatment for substance use:

____

____

Family history of substance use:

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Psychosocial History/Functioning

Completed by Patient/Client

Rate how the problems/symptoms/ complaints are impacting areas of **FUNCTIONING:**

1) Mild 2) Moderate 3) Severe

__ Marriage/Relationship
__ Work/School
__ Family
__ Friendships
__ Financial situation
__ Physical health
__ Social interests
__ Leisure activities
__ Clubs/Group memberships
__ Legal
__ Housing
__ Attending to daily living activities (i.e. shower, grooming, self care, etc.)
__ Spirituality
__ Current stressors
Other ____________________________

WHAT DO YOU SEE AS STRENGTHS:______________________________

WHAT DO YOU SEE AS WEAKNESSES:______________________________

GOALS FOR TREATMENT:______________________________

GOALS AND EXPECTATIONS OF SIGNIFICANT OTHERS:______________________________

____

MOTIVATION FOR TREATMENT:______________________________

WHAT CULTURAL EXPERIENCES DO YOU FEEL WOULD BE HELPFUL IN YOUR TREATMENT:

Past Treatment History

Completed by Patient/Client

Comments

Psychiatric or psychological treatment of any kind before? YES___ NO___

HISTORY OF PRESENT ILLNESS continued
Completed by Patient/Client
__ Police/Probation involvement
Comments

__ Spending sprees
__ Rapid Heartbeat
__ Phobia
__ Sweating
__ Trouble Breathing
__ Flashbacks of traumatic event
__ Nightmares
__ Racing thoughts
__ Hearing Voices
__ Seeing things that are not there

Substance Use

Completed by Patient/Client
Completed by Provider
Comments
Completed by Provider
Goals and Interventions
Coffee (#____cups/daily)
Cigarettes (#____ per day)
Alcohol (#____ drinks/weekly)
Date last drank: ____________
Street drugs:
Type:_________________________
Describe onset and duration; blackouts; withdrawal; attempts to stop; legal problems; DUI; work problems; relationship problems; hospitalizations, treatment.
Recommendations: Does the patient/client need further evaluation? YES NO
Referral for CD Tx needed?:
YES NO
Relapse prevention; education.
Amount:______________________
Frequency:____________________
Date last used:_________________
Prescription Drugs:
Type:_________________________
Amount:______________________
Frequency:____________________
Date last used:_________________
Describe impact of substance
Abuse use on your life:
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____
____

If **Yes**, What type of care was received?
Inpatient___ Outpatient___ Both___
When was the treatment?________________
Where was the treatment?________________
____
How long was the treatment?________________
Name(s) of therapist or doctor:____________
____
Were medications prescribed at that time?
YES___ NO___ Not applicable___
If **Yes**, what was prescribed (include dosages if known)?________________________
Family history of psychiatric treatment:
____
________________________________Family members currently in psychiatric treatment:
____

Patient/Legal Representative Must Complete the following Medical History

MEDICAL HISTORY:
ALLERGIES:
Current Medications: (Dosage, frequency, and prescribing M.D.)

HISTORY OF INFECTIOUS DISEASES: (PANDAS, encephalitis, Lyme Disease, meningitis, GABHS)
DATE OF LAST PHYSICAL:
Are you currently taking any medication for PAIN MANAGEMENT? YES NO
If **YES**, what medication?
Prescribing Pain Medication M.D.
Over the Counter Medications, Herbal Medicines, Supplements:
FEMALE LIFE CYCLE HISTORY: Current # pregnancy?
Are you planning for pregnancy?
If **YES**, when?
When was your last menstrual period?
Are you currently using any form of birth control?
If **YES**, what?
Other information the provider should know (i.e. family medical history):

INFORMED CONSENT FOR TREATMENT

WELCOME TO JUDITH RANDALLCOMPANY

Client Name ____

Welcome! I am happy to have you or your family member as a client, and will do everything within my professional capacity to make the treatment as productive as possible.
The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals are essential for the best benefit of therapy. If you ever have any questions about the nature of the treatment or anything else about the care, please do not hesitate to ask.

CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION

It is understood that all information between patient and psychiatrist/therapist is held strictly confidential, and the psychiatrist/therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with Colorado State Laws,
2. The patient presents an imminent danger to self,
3. The patient presents an imminent danger to others,
4. Child/elder abuse/neglect is suspected,
5. As necessary for continuity of care,
6. If a judge determines that our discussions are not confidential, a judge may request specific information,
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3 and #4, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions. Judith Randall follows the 'minimum necessary" rule for release.

CLIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child's case) with the referral source and other co-treating health care providers and facilities for the purposes of treatment, payment and Health Care Operations. I further consent to the release of information to my health plan for claims, certification/case management/quality improvement and other health plan purposes.

GENERAL CONSENT FOR TREATMENT

I further authorize and request that my therapist carry out psychological examinations, treatment, and/or diagnostic procedures that now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. (If patient is a child or dependent of beneficiary) On the patient's behalf, I (the legal Guardian or Legal Representative) authorize Judith Randall to deliver mental health services to the patient. I understand that all policies stated on this page apply to the patient. I accept that the child's records are confidential and that by law, I cannot have access to the child's records if such access would be detrimental to the child

____

Client/Legal Representative Signature Date

____

Provider Signature and License Date

I know I have the right to revoke this Authorization which must be in writing and given to my provider. I understand that if I revoke this authorization, my providers may determine that treatment cannot be effective without Continuity of Care, and may elect to transfer my care outside of the JUDITH RANDALL COMPANY. This Authorization is valid as long as I am treated at JUDITH RANDALL COMPANY, or by my revoking this Authorization in writing.

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Parent/Legal Representative Signature Date

FINANCIAL TERMS:

INDIVIDUAL SESSIONS: $85 COUPLES/FAMILY SESSIONS: **$110**
I understand that I can submit Out of Network Provider Forms to my insurance company and it is ultimately my responsibility to know my insurance benefits and coverage. Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will reimburse me according to my contract with them for Out of Network Providers. I will be responsible for payments at the time of service at JUDITH RANDALL COMPANY. I agree to make these payments at each appointment. I understand the charge for a bounced check is $20.

EMERGENCY PROCEDURES
If you need to contact your provider, leave a message at (720) 530-6031 and your call will be returned by the next business day. If an emergency situation arises, call 911 or go to the nearest emergency room.. Please do this for true emergencies only. There may be a charge for telephone consultations that require 10 minutes or longer.

CANCELLED/MISSED APPOINTMENTS & REQUEST FOR RELEASE OF RECORDS
In the event of a "No Show" or failure to give a full 24-hour notice of a cancellation, a $50 charge will be assessed to all late cancellations and missed appointments. If I sign to request my records to be released, there will be a $20 fee for release of records (government agency request are excluded).
Patient's Initials

Client Notice of Privacy Practices

To My Valued Clients:

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their clients' consent for uses and disclosures of health information about the client to carry out treatment, payment, or healthcare operations.

As my client, I want you to know that I respect the privacy of your personal medical records and will do all I can to secure and protect that privacy. I strive to always take reasonable precautions to protect your privacy. When appropriate I provide the minimum necessary information to only those I feel are in need of your health care information. This includes information about treatment, payment and/or health care operations in order to provide health care that is in your best interest.

I also want you to know that I support appropriate access to your medical records. With your consent, I may disclose personal health information for purposes of treatment, payment, or health care operations such as communication to hospitals, co-treaters, pharmacies, health plans, and laboratories.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your Personal Health Information (PHI), I have the right to refuse to treat you. If you choose to give consent in this document, at some future time you may request to refuse to disclose all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You may request a restriction on any authorization to disclose PHI. I am not required to agree with this restriction request. You have the right to have your physician amend you Protected Health Information. If I deny your request, you may file a disagreement and prepare a rebuttal, which will be added to your PHI. You have the right to receive accounting of any disclosures I have made.

I want you to know that all I continually undergo training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." I strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

As part of this plan, I have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. More so, I welcome your input regarding any service problem, so that I may remedy the situation promptly.

Thank you for being one of my highly valued clients.

Judith A. Randall, LMFT