Denise E. Turner, LICSW, LCSW
2215 Broadway
Vancouver, WA 98663
(360) 906-7156

CLIENT INFORMATION FORM

Name:_____ DOB:_____ Age: _____Today's Date: _____

Address_____ City_____ State_____ Zip_____
Home Phone (_____)_____ ☐ OK to leave message.

Work Phone (_____)_____ ☐ OK to leave message.

Gender: Male ☐ Female ☐ By whom were you referred? _____

Guardian's Name (If you are a minor): _____

Marital Status: Single ☐ Married ☐ Committed Partner ☐ Separated ☐ Divorced ☐

Partner's Name: _____
DOB:_____

EDUCATION

Currently enrolled in school? Yes ☐ No ☐ Total number of years completed/degree:_____
If you are a minor: Current school_____ Teacher_____ Phone_____

EMPLOYMENT

Are you currently employed? Yes ☐ No ☐
Employer:_____

Occupation:_____ Job responsibilities and stress level of job:_____

_____

LEGAL

Are you involved in any legal activities (civil, criminal, custody, probation, etc.)? Yes ☐ No ☐

If yes, please describe:_____
Past History: Traffic Violations? Yes ☐ No ☐ DUII/DWI? Yes ☐ No ☐
Felony/misdemeanor charges/convictions? Yes ☐ No ☐ Civil/custody lawsuits? Yes ☐ No ☐

MENTAL HEALTH TREATMENT

Have you participated in counseling before? Yes ☐ No ☐ If so, with whom?_____

Reason for treatment?_____

PRESENTING PROBLEMS

Please describe what brought you here today? _____

_____

_____

What do you hope to gain from therapy? _____

_____

_____

What do you do to help cope or feel better? _____

_____

_____

CONCERNS

Please check the behaviors and symptoms that occur more often than you would like:

- ☐ Aggression
- ☐ Alcohol use
- ☐ Angry outbursts
- ☐ Argue/conflicts
- ☐ Anxiety
- ☐ Computer use
- ☐ Confused thoughts
- ☐ Depression
- ☐ Delusions
- ☐ Disorientation
- ☐ Disorganized thoughts
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug use
- ☐ Eating
- ☐ Elevated mood
- ☐ Fatigue
- ☐ Gambling
- ☐ Hallucinations
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Memory Impairment
- ☐ Mood swings
- ☐ Panic attacks
- ☐ Phobias/fears
- ☐ Racing thoughts
- ☐ Reoccurring thoughts
- ☐ Self-harm
- ☐ Sexual addition
- ☐ Sexual difficulties
- ☐ Smoking
- ☐ Spending money
- ☐ Sleeping problems
- ☐ Social isolation
- ☐ Suicidal thoughts
- ☐ Worrying

Briefly describe how the above checked symptoms impair your ability to function effectively:_____

_____

_____

Have you ever had thoughts about hurting yourself or seriously harming someone else?
Yes ☐ No ☐

If yes, please describe: _____

_____

Have you ever purposely hurt yourself or another? Yes ☐ No ☐ If yes, please describe:_____

_____

FAMILY HISTORY

Relationship	Name	Age	Deceased	Quality of relationship
Mother				
Father				
Step-Mother				
Step-Father				
Significant Other				
Children				

MEDICAL INFORMATION

Current Physician:_____
Phone:_____

Physician's address: _____

Date of most recent complete physical examination:_____

Do you have a history of any of the following medical conditions?

- ☐ Serious accident
- ☐ Head injury
- ☐ High fevers
- ☐ Vision problems
- ☐ Digestion problems
- ☐ Abortion
- ☐ Cancer
- ☐ Seizures
- ☐ Surgery
- ☐ Meningitis
- ☐ Hearing problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Chronic pain
- ☐ Heart problems
- ☐ Allergies
- ☐ Hospitalization
- ☐ Headaches
- ☐ Loss of consciousness
- ☐ Pregnancy/Miscarriage
- ☐ Speech/language problems
- ☐ Sexually transmitted disease
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Hepatitis A,B,C,D,E,G
- ☐ Fibromyalgia
- ☐ Anemia/Blood problems
- ☐ Immune deficiencies
- ☐ Significant weight gain/loss
- ☐ Other_____

Any other current health concerns:_____
_____

Medications	Dosage	Date first prescribed	Prescribed by

Current over-the-counter medications: _____
_____

Please list any allergies or adverse reactions to medications: _____

_____

Do you smoke? Yes ☐ No ☐ Amount:_____

Drink alcohol? Yes ☐ No ☐ Type & Amount:_____

Use illegal drugs? Yes ☐ No ☐ Substances & Amounts:_____

Daily intake of caffeine:_____

Do you exercise regularly? Yes ☐ No ☐ Amount & Type:_____

Please list top 3 stressors in order of most to least:

1._____

2._____

3._____

Denise E. Turner
Licensed Clinical Social Worker

Informed Consent and Disclosure

Please read the following information and initial after each section. If you have any questions, please wait to initial and sign this form and we can go over it together.

Limits of Confidentiality

Information discussed with you as a client is confidential and cannot be released without your written permission. There is a separate Consent to Use or Disclose Clinical Information sheet attached, and an in depth Notice of Privacy Practices as required by federal HIPAA is available for you to keep. Some legal exceptions to confidentiality apply:

1. The client authorizes in writing by signing a release of information to communicate with an identified person or organization.
2. The disclosure is allowed by court orders.
3. The disclosure is made to medical personnel in a medical emergency.
4. The client commits or threatens to commit a crime against any individual.
5. The client threatens to seriously harm him or her self.
6. The client is suspected of abusing or neglecting a child, elder, or developmentally disabled person.

State law requires informing potential victims and appropriate state and local authorities so protective measures can be taken. If your records are subpoenaed, or you testify in court about treatment or evaluation, or report to an agency which requires a response, the privileged nature of communications between us may be compromised.

There may also be partial disclosure for the purpose of consultation or supervision with another professional.

INITIAL HERE _____ (CLIENT)

FINANCIAL RESPONSIBILITIES

Some insurance carriers may cover therapeutic services. The client is responsible for obtaining prior authorization for treatment from their insurance carrier. I will bill your insurance company; however, you are responsible for co-payment and deductible as set by your benefit plan. Payments are due at the time of service.

If you are not using insurance for services or become ineligible for insurance coverage, you are responsible to pay the session rate due on the day of service.

INITIAL HERE _____ (Client/and/or responsible party)

CANCELLATIONS/MISSED APPOINTMENT POLICY

Please call to cancel or reschedule appointments 24 hours prior. If an appointment is missed or cancelled with less than 24 hour notice, you will be billed the regular scheduled fee. You will receive a courtesy reminder call when able. You are responsible for keeping or canceling your scheduled appointment. Your insurance company will not be billed for fees associated with missed or canceled appointments.

INITIAL HERE _____ (CLIENT/responsible party)

CONSENT FOR TREATMENT

By signing this agreement you authorize and request Denise E. Turner, LICSW, LCSW, to carry out treatment and/or diagnostic procedures, which now or during the course of your treatment become advisable. You have the right and responsibility to be active in treatment planning and can refuse therapy at any time. The purpose of procedures will be explained to you upon request and are subject to your agreement. While the course of treatment is designed to be beneficial, Denise Turner cannot guarantee the outcome of treatment. Furthermore, the process of psychotherapy can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. This is a normal response to working through unresolved life experiences and these reactions will be addressed in therapy. If you have any question, or need clarification, please let me know.
INITIAL HERE _____ (CLIENT)

CLIENT RESPONSIBILITIES

It is the responsibility of the client to make and keep appointments (if you need an appointment during high stress times, please call to make an appointment prior to our regularly scheduled appointment); to arrive on time; to do any homework assignments to the best of your ability; to be honest and open to communicate difficulties; and to let the therapist know when a procedure or assignment is or is not working well for them.

INITIAL HERE _____ (CLIENT)

I AGREE, UNDERSTAND, AND WILL COMPLY WITH THE ABOVE STATEMENTS. I ATTEST THAT THE INFORMATION LISTED ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____	_____
Client Signature	Date
_____	_____
Parent/Legal Guardian Signature	Date
_____	_____
Denise E. Turner, LCSW, LICSW	Date

Denise E. Turner, LICSW, LCSW

CONSENT TO RELEASE INFORMATION TO INSURANCE COMPANY OR THEIR DESIGNATED MANGAEMENT ORGANIZATION

This document provides the authorization for the release of relevant information to your insurance company or to their designated management or review organization if one exists. This information may be required in order to authorize treatment or services to pay benefits.

_____ _____ _____

Client Name Date of Birth SS#

_____

Client Address City State Zip

_____

Client Phone

I, the undersigned, hereby authorize Denise E. Turner, LICSW, LCSW to send information:

Primary Insurance: _____Subscriber:_____

Address:_____

ID or SS#_____Group Policy #_____

Phone ( )_____DOB: _____

_____ _____

Signature Date Signed

Responsible Party (if different from primary insured):_____

SS#_____DOB: _____

Address: _____

_____ _____

Signature Date Signed

This authorization for release covers all dates of treatment.

This written consent is subject to revocation by the undersigned at anytime, except to the extent that the action has been taken in reliance heron. If not earlier revoked, or by other agreement specified below, this consent shall expire one year after termination of treatment.

Your signature below will authorize the insurance companies to make payment directly to Denise E. Turner, LICSW, LCSW.

_____ _____

Signature of client, parent or legal guardian Date Signed

_____ _____

Denise E. Turner, LICSW, LCSW Date Signed

Denise E. Turner, LICSW, LCSW
Release of Information

I, _____ whose Date of Birth is _____,

authorize Denise E. Turner, LICSW, LCSW to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Please initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than marketing, sale of information, research or as specified above, please specify: _____
_____

Marketing

- □ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by Denise E. Turner, LICSW, LCSW in exchange for disclosing the information.$_____

Sale of Information

- □ If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.

Research

- □ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

  _____.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer at Cascade Center for Wellness. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Conditions

I further understand that Denise E. Turner, LICSW, LCSW will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____
_____
[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I may be given a copy of this authorization for my records.

_____

Client Signature Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if client refuses to sign authorization

_____

Signature of Denise E. Turner, LICSW, LCSW Date

Denise E. Turner, LICSW, LCSW

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Denise E. Turner, LICSW, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at Cascade Center for Wellness.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Denise E. Turner, LICSW, LCSW **Date**

Denise E. Turner, LICSW, LCSW

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious

threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Cascade Center for Wellness

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be

handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Cascade Center for Wellness (360) 906-7156 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.