Trinity Behavioral Health

Services

Phone- 931-919-2641

Fax- 931-919-2643

Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that attending sessions is important to my progress, and overall well-being, Due to appointment times being scheduled specifically for me, I **must** call to cancel an appointment at least **24 hours before** the time of the appointment. If the appointment is scheduled for a **Monday, I must call no later than Friday** before the appointment. **If I do not cancel and do not show up, I will be charged the full rate for that appointment ($130.00)**. Missed appointments are not paid by insurance and are not subject to contracted reduction rates, and is still billable if not cancelled appropriately within the timeframe stated. This fee may be charged to my credit card number on file within 7 days of the charge, if I have not made other arrangements to pay the fee with the Administrative Director and/or Owner/Director of TBHS. The therapist is not authorized to forgive missed appointment fees.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

____ ________________________

Signature of client (or person acting for client) Date

____ ________________________

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____ ________________________

Signature of therapist Date

❑ Copy accepted by client

Copy to medical record

ALL FEES ARE DUE AT TIME OF SERVICE

Trinity Behavioral Health
Services

Registration Form

Client Name (Last, First, Middle Initial):	Social Security Number:	Date of Birth:	Age:

Occupation/Employer:	Referred By:	Gender: ☐Male ☐Female

Relationship Status: ☐Single ☐Single, Intimately Involved ☐Married ☐Divorced ☐Separated ☐Widowed	Cultural Affiliation *(Check all that apply)*: ☐African American ☐American Indian ☐Asian ☐Caucasian ☐Hispanic ☐Other:

Home Address:

E-mail Address:	Other Family Members Seen Here?	DCS/Court Involvement: Yes No If yes, provide contact info:

Do you wish to receive text message reminders? Yes No	Home Phone: Work Phone: Cell Phone:

May we leave a message? Home: ☐No ☐Yes Work: ☐No ☐Yes Cell: ☐No ☐Yes
Email: ☐No ☐Yes Other: ____________________

Cell Phone Carrier:

INSURANCE INFORMATION (Please give card to receptionist)*

Person Responsible for Bill:	Relationship to Client: (Self or Parent)	Date of Birth:	Address:	Phone:

Name of Primary Insurance:	Policy Number:
Group Number:	Name of Employer:
Policy Holder's Name:	Policy Holder's DOB:

Policy Holder's SSN:	Relationship to Client:	Policy Holder's Address:

Secondary Insurance Name:	Secondary Insurance Policy/Group #:
Secondary Group Number:	Type of Secondary (Medicaid, Non-Custodial Parent, Retiree, etc):
Secondary Policy Holder's Name:	Secondary Policy Holder's DOB:

Secondary Policy Holder's SSN:	Relationship to Client:	Secondary Policy Holder's Address:

In Case of Emergency: Spouse (if married)/Parent (if minor) Information/Local Friend (if unmarried)

Name of Spouse/Parent/Friend (Last, First, Middle Initial):	Social Security Number (N/A for Friend only):	Date of Birth:

Address:	Phone Number:

*Please advise reception/office staff of ALL medical/behavioral health insurance. The office staff can help you determine if an insurance is primary vs. secondary. Failure to provide all insurance information may lead to insurance denials, and subsequently TBHS billing the responsible person for the full rate of services provided.

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Phone: 931-820-1021 FAX: 931-820-1031

Fee Schedule for Services NOT Covered by Insurance

In many cases, health insurance is utilized by our clients to cover their mental health counseling/therapy expenses. However, insurance companies often only cover select services to include the following: Initial Intake Session, Individual Psychotherapy, and Family Psychotherapy. Occasionally, your insurance may cover crisis intervention, which includes an appointment provided within a specific time frame with a focus on intervening when a consumer is in crisis as an attempt to divert from a higher level of care, such as hospitalization.

Your health insurance, **WILL NOT** cover the following services, often requested by consumers: correspondence between consumer, family members, and other interested parties (i.e. lawyers, case managers, family therapists/counselors, etc), case write ups and/or treatment summaries, court appearances and/or testifying in court, and a variety of other circumstances, not included in this description.

Our practice can assist by discussing your options for you and/or your families' therapeutic issues, answer basic questions, and provide basic correspondence with no additional cost to you with a focus on providing you and your family quality care. However, due to the multitude of requests that our office often receives with regards to requests by our consumers to perform duties that require a significant amount of time, and is not covered by insurance, we have developed the following fee schedule to be followed by all therapists/staff.

If you have any questions regarding our fee schedule, please do not hesitate to speak to La Vaun Kelley, LPC-MHSP, Owner/Clinical Director and/or Ian Corland, Director of Operations for further information.

Service	Unit of Measure	Minimum Charge	Basis of Charge
Telephone Calls, conferences, meetings, etc	Time (First 15 minutes/day per client are free of charge)	15 minutes increments (beyond the first 15 free minutes/day per client)	Hourly Rate
Copies (to include copy of chart)	Per Page	None	$.30/page
Fax (more than 5 pages)	Per Page (first 5 are free of charge)	None	$1.00/page
Psychoeducational Group	Per session	$30.00	Group Rate/Discounted
Court Appearance	Time	1 hour (a deposit of $500 is required at time of initial request for court appearance)	Hourly rate
Travel (to include court appearances outside of Montgomery County)	Time	Mileage plus hourly rate	$.55/mile plus hourly rate based on Mapquest from office location to destination.

Hourly Rate : $130/hr

_______________________ _______________________

Client Signature Date

_______________________ _______________________

Staff Signature Date

PT ID	Therapist	Date :

Trinity Behavioral Health Services

PSYCHOSOCIAL HISTORY & ASSESSMENT

Please complete the following information so that we may conduct a thorough assessment and better serve you and your family. Place a check mark or "x" in the boxes, and answer all questions as thoroughly as possible. *Please feel free to ask for assistance, if needed.*

SECTION I – IDENTIFYING DATA

Name (Last, First, Middle Initial):		Social Security Number:	Today's Date:
Referred By:	Date of Birth/Age:	Gender: ☐Male ☐Female	

Relationship Status:
☐Single Single, Intimately Involved ☐Married
☐Divorced ☐Separated ☐Widowed

Cultural Affiliation *(Check all that apply)*:
☐African American ☐American Indian ☐Asian
☐Caucasian ☐Hispanic ☐Other:

Spouse/Significant Other

Name (Last, First, Middle Initial):	Age:
Gender: Male Female	Contact Number:

May we leave a message? **Home:** yes no **Cell:** yes no

CHILDREN:

Name (Last, First, Middle Initial)	SSN	Sex	Age / Date of Birth	Race	Grade/School	Living with you?
		☐M ☐F	/			
		☐M ☐F	/			
		☐M ☐F	/			
		☐M ☐F	/			

SECTION II - MEDICAL

Primary Care Physician:

Primary Care Phone:

Primary Care Address/Practice Location:

Other Providers (Psychiatrist, Other Specialist, etc):

SECTION IV – PRESENTING PROBLEM(S)
ISSUES & GOALS

In order to help us determine the best treatment plan, please list the main issues and related goals you would like assistance with:

Issue	Goal
Issue 1:	Goal 1:
Issue 2:	Goal 2:
Issue 3:	Goal 3:
Issue 4:	Goal 4:

STRESSORS (*Circle all that apply*)

Marital/Relationships: Divorce Separation Infidelity Abuse Fighting/Disagreements Alcohol/Drugs Sexual Death Birth

Social: Loss of friend(s) Broken romance Loneliness Lack of Social Support Transportation Religious/Spiritual Neighbor/Housing Illness Other

Legal: Arrested DUI Protective Order Child Custody Family Probation/Parole Criminal Charges Article 15 Court Martial

Military: Deployment Recent Move Pending Move Job Related ETS/Retirement Chapter/Separation Promotion Issues Weight/PT Problems

Personal: Financial Physical Assault Sexual Assault Other ______________________________

Occupational: Conflict with supervisor(s) Discrimination Excessive hours Harassment Fired/Relieved Boring/Meaninglessness

SECTION V – BEHAVIORAL HEALTH
DEPRESSION

What is your current level of emotional pain or distress?

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10

Pain Free Mild Moderate Severe Totally Disabling

During the past month, have you been bothered by feeling down, depressed, or hopeless?	Yes	No
During the past month, have you often been bothered by little interest or pleasure in doing things?	Yes	No
In the past have you suffered any emotionally or physically traumatic event?	Yes	No
Have you experienced a recent loss (including separation/divorce?)	Yes	No

SELF HARM

Are you having thoughts of harming or killing yourself?	Yes	No
Do you have a plan to harm yourself (shoot self, overdose, cut self, hang self, etc.)?	Yes	No
Do you have access to means to carry out a plan to hurt yourself (knives, rope, gun, drugs/medications, etc.)?	Yes	No
Have you EVER deliberately hurt yourself physically (e.g., punched yourself, cut yourself, burned yourself)?	Yes	No
Are you hopeful about your future?	Yes	No

How often do you perceive you have failures in your life? Never Rarely Occasionally Frequently

Have you ever been diagnosed with a mental health condition/illness by a health care provider?	Yes	No

MSE

During the past week, have you had thoughts "racing" through your head?	Yes	No
Do you believe you have special powers?	Yes	No
Do you hear voices or are you "seeing things"?	Yes	No
Do you believe that people are watching you (paranoia)?	Yes	No

Do you often see things as good or bad, right or wrong, or black and white? Yes No

ANXIETY/ PANIC

Do you have any problems with anxiety, "nerves", or panic attacks? Yes No

Have you ever experienced a sudden surge of overwhelming discomfort or extreme "anxiety" that came on without any warning or for no apparent reason? Yes No

Do you avoid certain people, places, conversations, or other non-combat situations because you are concerned that you may experience a sudden surge of overwhelming discomfort or "anxiety"? Yes No

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that <u>in the past month, you…</u>

Have had nightmares about it or thought about it when you did not want to? Yes No

Tried hard not to think about it or went out of your way to avoid situations that remind you of it? Yes No

ANGER / AGGRESSION INCLUDING DOMESTIC VIOLENCE

Are you currently angry at anyone or about any situation Yes No

Do you have thoughts or plans to harm or kill another person? Yes No

Have you recently broken objects or hurt yourself, others (emotionally, physically, sexually), or an animal due to your anger? Yes No

Are you currently involved in physical, emotional, or sexual abuse of anyone (including family members)? Yes No

Do you currently have a restraining or protection order in place against you? Yes No

Have you ever been charged or convicted of an offense of assault, battery or abuse? Yes No

Do you have weapons in your home (firearms, switchblade, knife collection, etc.? Yes No

Have you recently had a relationship break-up, separation, or divorce due to you or your partner's anger/aggressive behavior? Yes No
If yes, are you in agreement with the break-up/separation/divorce? Yes No

SUBSTANCE USE

Have you ever felt you should cut down on your drinking? Yes No

Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt guilty or bad about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes No

Do you drink alcohol or use drugs to cope with stress? Yes No

Are you currently using any controlled or illegal substances? Yes No

Are you currently misusing prescribed medications, herbal supplements/remedies, sports nutritional supplements? Yes No

Have you been involved in any alcohol or drug treatment? Yes No

BEHAVIORAL / MENTAL HEALTH HISTORY

Have you ever received counseling or mental health services? Yes No

Diagnosis

	Location	Hospitalized?	Date Began	Date Ended

SECTION VI – PSYCHOSOCIAL HISTORY

EARLY CHILDHOOD & FAMILY RELATIONSHIPS

Where were you born?

Current age of mother: Occupation:

Current age of father: Occupation:

Is either parent deceased?

Are your parents still married to each other?	
If they are divorced, how old were you when they divorced?	
Who raised you?	
How many biological brothers do you have?	Where were you raised?
How many step-brothers do you have?	How many biological sisters do you have?
What number child are you in the birth order?	How many step-sisters do you have?

What was it like in your childhood home? Loving Comfortable Supportive Chaotic Abusive Other

Was your family: 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10
Poor Middle Class Wealthy

Were you adopted? Yes No
If yes, at what age?

Did your parents physically fight? Never Rarely Sometimes Often

Were you emotionally, physically or sexually abused, neglected, or sexually assaulted as a child or an adult? Yes No

Please identify any mental health issues that seem to "run in the family" or have occurred in family members in the past:
Alcoholism/Drug Addiction Anxiety Attention Deficit Hyperactivity Disorder Depression
Hyperactivity Manic-Depression/Bi-polar Disorder. Schizophrenia Sexual Abuse Suicide
Other:

MARRIAGE & RELATIONSHIPS

A. Are you currently married? Yes
No

How long have you been married? ____Years _____Months

Are you currently living with your spouse? Yes No

How many time have you been married? ______ How many time has your partner been married? ______

Date of Marriage

	Spouse Name	Date of Divorce or Death of Spouse	Reason the Relationship Ended
If not married, are you currently in a relationship? Yes No			

If "yes", how long have you been with that person? ___*Years* ____*Months*

Please rate your satisfaction with the marriage/relationship: Rating _____
0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10
Completely Satisfied Satisfied Dissatisfied

Are you experiencing any problems with your spouse or in your relationship? Yes No

Have past deployment(s) impacted your marriage, relationship, and family? Yes No

Do you and your children feel safe from domestic abuse at home? Yes No

Have any of your closest relationships been troubled by a lot of arguments or repeated breakups? Yes No

Have you made desperate attempts to avoid feeling abandoned (e.g., repeatedly called someone to assure yourself that he or she still cared, begged them not to leave you, clung to them physically)? Yes No

CHILDREN & HOME

Are you currently having any problems with your children? N/A Yes No
Abuse Neglect Behavior Illness/Disability/EFMP Child Care School Problems Special Issues
Parenting/Nurturing Mental Health Other:

Have you, your family, or a person you are currently in a relationship with ever been to counseling or had involvement with any agency such as Child Protective Services or Family Advocacy due to physical, sexual, or emotional abuse or neglect? Yes No

Are you involved in the care of any family member for illness or otherwise? Yes No

EDUCATION

Highest level of education completed: Elementary Junior High High School Technical School 2-year College Degree 4-year College Degree Other:

If you did not graduate from high school, did you get your GED? N/A Yes No

Did you repeat any grades? Yes No

Were you ever in special education classes or did you have a learning disability? Yes No

Did you have any disciplinary problems in school? Yes No

Were you ever suspended or expelled? Yes No

FINANCIAL

Do you currently have any financial problems? Yes No

Are you currently having any of the following problems? *(Select all that apply)*
Garnished Wages Filed Bankruptcy Bounced Check No Money for Food Late on Payments or Loans Item Repossession Disciplined for Debts or Bad Checks Having "No Pay Due" Pawning Items to Make Ends Meet Other:

Do you need a referral to an agency for financial assistance/counseling? Yes No

ENVIRONMENT / SUPPORT SYSTEMS

Do you have good social support systems (friends, family, neighbors, co-workers, organizations, etc.)? Yes No
List your support systems:

Are you having trouble in your relationships with family or friends? Yes No

Do those surrounding you have sufficient knowledge about your condition? Yes No

Do you have adequate housing or a place to live? Yes No

Who do you rely on for help with problems? (e.g., family, friends, extended family) Names:

Circle any services you are currently receiving:
Alcohol and Drug Army Community Services Chaplains Child Care/CYS Child and Adolescent Counseling Child Protective Services/DCS Community Mental Health Court Mandated Counseling English as a Second Language Legal Services Respite Care Marriage and Family Counseling New Parent Support Program School Counselor Social Work Services Counseling/Psychiatric Care Use of Shelter Victim Advocate Other:

EMPLOYMENT

Are you currently employed? Yes No

Length of Employment: _____years ______months

Partner's Occupation:	If unemployed, how long? _____years _____months
If unemployed, how long? _____years _____months	Length of Employment: ______years _____months

LEGAL

Do you presently have any legal problems? Yes No

Have you ever had any administrative or legal action taken against you? Yes No
(If yes, please circle all that apply)
Letter of reprimand Article 15 Court Martial Chapter Arrest DUI Other______________________

LEISURE AND RECREATION

Please list activities which you enjoy or have enjoyed in the past, including hobbies, volunteer work, sports, etc. :

SPIRITUAL AND CULTURAL

What is your religious or spiritual affiliation?

Are you an active participant with your religious/spiritual affiliation?	Yes	No
What is your cultural affiliation/heritage (i.e., American Indian, Asian, Irish, Hispanic, etc.)?		
Do you have any religious or spiritual practices that the provider needs to be aware of during treatment?	Yes	No

SECTION VII – HEALTH HISTORY

PHYSICAL HEALTH

How would you describe your physical health? Excellent Good Fair Poor

Current medical treatment: None Inpatient Outpatient with follow up Outpatient without follow up

MEDICAL HISTORY: List any medical conditions you have or have had:

Medical Diagnosis	Diagnosis Date	Treatment Completion Date	Provider
What physical limitations do you have as a result of your injury/illness(s)?			

MEDICATIONS

List **ALL** medications, over-the-counter or herbal supplements/remedies you are currently using, the dosage and the prescribing provider, if applicable:

Medications	Dosage	Prescribing provider
Are you currently taking your medications as prescribed? Yes No		

Are you satisfied with how your medications are working? Yes No

TRAUMATIC BRAIN INJURY (TBI) & CONCUSSION

Have you ever received an injury that resulted in being dazed, confused, or "seeing stars", not remembering injury, losing consciousness (knocked out), having symptoms of concussion (headaches, dizziness, memory problems, balance problems, ringing in ears, irritability, sleep problems, etc.)? Yes No

Have you had previous history of a TBI or concussion? Yes No

PAIN

Are you experiencing physical pain today? Yes No

Please rate the severity of your pain: rating injury/ illness #1______ rating injury/illness #2______

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10

Pain free Mild Moderate Severe Totally Disabling

If you have physical pain, are you being treated for that pain? Yes No

SLEEP

Are you experiencing difficulty sleeping? Yes No
(If yes, please describe):

Are you taking medications (over-the-counter or prescribed) to help you sleep? Yes No

NUTRITION

Have you ever had problems with your weight or eating habits? Yes No
(If yes, please explain- include weight and loss and body image issues):

Have you ever had problems with binge eating or compulsive over eating, or purging?	Yes

SECTION VIII – ADDITIONAL INFORMATION

Please use the back of this paper to fill out any additional information you'd like or your provider to know.

Person filling out this form:

I have completed all information accurately and completely.
Signature of patient/family member/ guardian / caregiver:

Date:

Reviewed by:	**Assigned Therapist:**
Date:	**Date:**

NOTES: