NEW BEGINNINGS THERAPY SERVICES
616 HARRISON ST
PRINCETON, WV 24740
304-487-3487

Date of appointment: _____ **Time of appointment:** _____

Client Name: _____ **Age:** _____ **DOB:** _____

Gender: ☐ Male ☐ Female ☐ Transgender **Preferred Name/Nickname:** _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** _____

Current Marital/Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Name of Person completing form: _____ **Relationship to client:** _____

PRESENTING PROBLEM (Briefly describe the issues/problems which led to your decision to seek therapy services):

_____

_____

_____

How severe, on a scale of 1-10 (with 1 being the most severe), **do you rate your presenting problems?**

MOST SEVERE 1 2 3 4 5 6 7 8 9 10 LEAST SEVERE

PRESENTING PROBLEM CATEGORIZATION: (Please check all the apply and circle the description of symptom)

Symptoms causing concern, distress or impairment:

☐ **Change in sleep patterns** (*please circle*): sleeping more sleeping less difficulty falling asleep difficulty staying asleep difficulty waking up difficulty staying awake

☐ **Concentration:** Decreased concentration Increased or excessive concentration

☐ **Change in appetite:** Increased appetite Decreased appetite

☐ **Increased Anxiety** (describe): _____

☐ **Mood Swings** (describe): _____

☐ **Behavioral Problems/Changes** (describe):

_____

_____

☐ **Victimization** (*please circle*): Physical abuse Sexual abuse Elder abuse Adult molested as child Robbery victim Assault victim Dating violence Domestic Violence Human trafficking DUI/DWI crash Survivors of homicide victims

Other: _____

Other (Please describe other concerns): _____

_____

How long has this problem been causing you distress? (please circle)

One week One month 1 – 6 Months 6 Months – 1 Year Longer than one year

How do you rate your current level of coping on a scale of 1 – 10 (with 1 being unable to cope)?

UNABLE TO COPE 1 2 3 4 5 6 7 8 9 10 ABLE TO COPE

EMPLOYMENT:

Currently Employed? ☐ Yes ☐ No **If employed**, what is your occupation? _____

Where are you working? _____

How long? _____ Days/Months/Years

Do you enjoy your current job? ☐ Yes ☐ No What do you like/dislike about your job? _____

_____

_____

If you are not currently employed, how long has it been since you last worked? _____ Months/Years

What was your occupation before becoming un-employed? _____

What led to becoming un-employed? _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Are you currently being seen by a counselor? ☐ Yes ☐ No

If yes, name of current counselor _____ Length of Treatment _____

Are you currently being seen by a psychiatrist? ☐ Yes ☐ No

If yes, name of current psychiatrist _____ Length of Treatment _____

Have you ever been diagnosed with a mental health, emotional or psychological condition?

☐ Yes ☐ No

If yes, what diagnosis were you given? _____

When? _____

By Whom? _____

Previous counseling/hospitalizations for mental health/drug and alcohol concerns

Dates of Service	Place/Provider	Reason for treatment	Were the services helpful

SAFETY CONCERNS:

Are you presently suicidal? ☐ Yes ☐ No If Yes, please explain _____

Have you ever attempted to commit suicide? ☐ Yes ☐ No If yes, when and how? _____

_____

Is there a history of suicide in your immediate and/or extended family? ☐ Yes ☐ No

Are you presently homicidal? ☐ Yes ☐ No If Yes, please explain _____

_____

Additional Information: (please add additional information as needed to address past and current safety issues)

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

Please identify if any members of your family have had a history of any of the following mental health/drug abuse/legal concerns.

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ADD	Trauma History	Abusive Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Self										
Mother										
Father										
Sister										
Brother										
Maternal Uncle										
Paternal Uncle										
Maternal Aunt										
Paternal Aunt										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										
Biological Child										

RELATIONSHIP/MARITAL STATUS

Current Marital/Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Live-In Partner ☐ Significant Other (Not Living Together)

If applicable, list divorces and separations:

_____

How do you identify yourself: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Questioning

What do you think is important for us to know about your significant relationships – current & past?

_____

_____

FAMILY COMPOSITION

Spouse/Significant Other's Name: _____ **Age:** _____ ☐ **Living with client** ☐ **Not living with client**

Employed Currently: ☐ Yes ☐ No If Yes, place of employment: _____

Occupation: _____

Please list the names, ages, relationships and other relevant information regarding all immediate family members whether living in- or outside the home. Please include all members currently residing in YOUR household.

Name	Gender	Age	Relationship To Client	Living With Client
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

What else do you feel/believe would be helpful, or important for us to know/understand about your relationships with your family or about your family members?

_____

_____

RECENT LOSSES:

☐ Family Member ☐ Friend ☐ Health ☐ Lifestyle ☐ Job ☐ Income ☐ Housing ☐ None

Who? _____ When? _____ Nature of Loss? _____

Other Losses: _____

HOUSING:

Would you consider your housing to be: ☐ **stable** ☐ **unstable**

Do you currently:

☐ Own ☐ Rent ☐ Live with relatives/friends (temporary) ☐ Emergency Shelter

☐ Live with relatives/friends (permanent) ☐ Homeless ☐ Transitional Housing

How long have you lived in your current living situation? _____

How often have you moved in the past two years? _____

What else do you think is important for us to understand about your housing/living situation?

_____

_____

FOSTER CARE INVOLVEMENT:

Have you ever been in foster care? ☐ Yes ☐ No From _____ age to _____ age

Reason: ☐ Familial Placement ☐ Non-Familial Placement

HEALTH HISTORY

How would you describe your overall health? _____

Do you have any health issues? ☐ Yes ☐ No If Yes, please list below.

Do you have any recurrent medical conditions such as allergies or asthma? ☐ Yes ☐ No

If yes, please list: _____

Please list below current medical problems, physical limitations, sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood infections, eating disorders, knee or back injuries, asthma, etc.

Medical Conditions	Are you currently receiving treatment?	Provider	Does this condition cause stress or impairment at this time?	What have you found that helps?

Do you currently take any medications? ☐ Yes ☐ No

Please list medications (including psychotropic, over-the-counter, herbal remedies) that you have taken in the past 6 months

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

Are you taking the medications as prescribed? ☐ Yes ☐ No If No, please explain: _____

_____

Additional information (if needed):

_____

_____

Have you ever had a serious accident/illness or hospitalization? ☐ Yes ☐ No

Please list all past hospitalizations, surgeries, accidents, or illnesses in the chart below.

Reason for Previous Hospitalizations, Accident, Illness	Date/Location of Hospitalization

Primary Care Doctor: _____ Facility: _____ Phone Number: _____

Do you ever drink or use more than you intend to? ☐ Yes ☐ No If yes, how often: ☐ Almost every time

☐ Occasionally ☐ Seldom ☐ More often lately ☐ When under stress ☐ Other: _____

Have you ever had to increase the amount of alcohol/drug you consume to get the same effect?

☐ Yes ☐ No If Yes, when did you first notice this change? _____

Do you have a history of overdosing on alcohol/drugs? ☐ Yes ☐ No If yes, when was the last OD? _____

Have you ever experienced a black out? ☐ Yes ☐ No If Yes, how often: ☐ Almost every time

☐ Occasionally ☐ Seldom ☐ More often lately ☐ When under stress ☐ Other: _____

Do you have a history of seizures while under the influence? ☐ Yes ☐ No

With whom do you typically consume alcohol? ☐ Friends ☐ Family ☐ N/A-Alone ☐ Strangers ☐ Other

Have you ever experienced problems related to your alcohol use? ☐ Yes ☐ No

☐ Legal ☐ Social/Peer ☐ Work ☐ Family ☐ Friends ☐ Financial

If yes, please describe: _____

If yes, have you continued to drink/use drugs? ☐ Yes ☐ No

LEGAL INVOLVEMENT:

Please indicate by checking below your legal status.

☐ No Involvement ☐ Probation | Length: _____ ☐ Parole | Length: _____

☐ Charges Pending ☐ Prior Incarceration ☐ Law Suit or other Court Proceeding

Charges: _____ Probation/Parole Officer's Name: _____

Contact #: _____

Additional Information: _____

HISTORY OF ABUSE/NEGLECT:

Have you ever been abused or assaulted? ☐ Yes ☐ No If Yes, please complete the chart below.

Type of Abuse	By Whom?	At What Age?	Was it Reported?
☐ Sexual			☐ Yes ☐ No
☐ Physical			☐ Yes ☐ No
☐ Emotional			☐ Yes ☐ No
☐ Verbal			☐ Yes ☐ No
☐ Abandoned/Neglected			☐ Yes ☐ No

Do you feel like you are in danger now? ☐ Yes ☐ No

What else do you feel is important for us to know?

_____

_____

HISTORY OF VIOLENCE:

Have you ever been accused of abusing or assaulting someone? ☐ Yes ☐ No If yes, please complete chart below.

Type of Abuse	To Whom?	At What Age?	Was it Reported?
☐ Sexual			☐ Yes ☐ No
☐ Physical			☐ Yes ☐ No
☐ Emotional			☐ Yes ☐ No
☐ Verbal			☐ Yes ☐ No
☐ Abandoned/Neglected			☐ Yes ☐ No

What else do you feel/believe is important for us to know? _____

_____

STRENGTHS/RESOURCES/SUPPORTS:

What limitations do you have (if any)? _____

What strengths do you have? _____

What resources do you have to help with your current problem?

_____

What experiences (past & present) will help you in improving the current situation?

_____

_____

What are you (and your family) already doing to improve the current situation?

_____

Who can you count on for support? ☐ Parents ☐ Boyfriend/Girlfriend ☐ Siblings ☐ Pastor
☐ Extended Family ☐ Friends ☐ Neighbors ☐ School Staff ☐ Church ☐ Therapist ☐ Group
☐ Community Services ☐ Doctor ☐ Other: _____

CURRENT NEEDS/GOALS

What do you feel is your biggest need right now? _____

What do you most hope to gain from coming to counseling? _____

If you were to pick three goals to work on, what would they be?

Goal 1: _____

Goal 2: _____

Goal 3: _____

What else would you like for us to be aware of?

_____

_____

_____

INDIVIDUAL COMPLETING ASSESSMENT

Printed Name _____ Date: _____

Signature X _____

Relationship to client _____

Kathy Wyrick, LPC # 1868
616 Harrison Street
Princeton, WV 24740 • 304-487-3487

REGISTRATION FORM

PATIENT'S NAME_____**Today's Date** _____

Social Security #_____Birthdate_____Marital Status oS oM oD oW

Address_____City_____Zip _____

Reason for appointment? _____

How were you referred?_____May we thank them? oY oN

May I send statements or other information to your home? oYes oNo

Mobile phone: _____ Messages: o Okay voicemail o Okay other person o No messages
Home phone: _____ Messages: o Okay voicemail o Okay other person o No messages
Work phone: _____ Messages: o Okay voicemail o Okay other person o No messages
Other phone: _____ Messages: o Okay voicemail o Okay other person o No messages

SPOUSE /SIGNIFICANT OTHER / OTHER PARENT INFORMATION:

Name_____Birthdate_____Social Security #_____

Address_____City_____Zip _____

Mobile phone: _____ Messages: o Okay voicemail o Okay other person o No messages
Home phone: _____ Messages: o Okay voicemail o Okay other person o No messages
Work phone: _____ Messages: o Okay voicemail o Okay other person o No messages
Other phone: _____ Messages: o Okay voicemail o Okay other person o No messages

OTHERS LIVING IN THE HOME, AND ALL CHILDREN:

Name_____Birthdate_____ Name_____Birthdate _____

Name_____Birthdate_____ Name_____Birthdate _____

INSURANCE INFORMATION – PRIMARY INSURANCE – PLEASE PROVIDE CARD FOR COPY PURPOSES

Insured Name_____Birthdate_____Ins ID#_____

Insurance Co._____Employer_____Group #_____

INSURANCE INFORMATION – SECONDARY INSURANCE– PLEASE PROVIDE CARD FOR COPY PURPOSES

Insured Name_____Birthdate_____Ins ID#_____

Insurance Co._____Employer_____Group #_____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY, OTHER THAN FAMILY:

Name_____Phone_____Relationship _____

Informed Consent & Agreement For Psychotherapy Services

Introduction. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

Information about Your Therapist. Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns.

New Beginings Therapy Services is owned by Kathy Wyrick, M.A., Licensed Profesisonal Counselor #1868. The therapists here share office space and some advertising. Each therapist's practice is separate, and each is solely and entirely responsible for any liabilities resulting from that practice.

Fees. The fee for service is $ 200.00 per 50 minute therapy session. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure.

If there is a need for telephone contact, with you or a third-party, other than for scheduling purposes, you understand that you are responsible for payment of the agreed-upon fee (on a pro rata basis) for any calls lasting longer than 10 minutes.

Appointment Scheduling and Cancellation Policies. Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. Scheduled appointment times are reserved especially for you. If an appointment is missed, or canceled with less than 24 hours notice, you (not your insurance company) may be charged the full fee for that missed session. **Exceptions may be made if you are sick or have an unavoidable emergency.**

Insurance. Please inform me if you wish to utilize health insurance to pay for services. I will discuss the procedures for billing your insurance. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan.

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions, which then become part of your medical record. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. You are responsible for obtaining prior authorization for treatment from your insurance carrier. Please discuss any questions or concerns that you may have about this with me.

If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you to consider any other options that may be available to you at that time.

Delinquent Accounts. You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay interest at 1.5% per month, and if it becomes necessary for the account to be referred for collection action, you agree to pay the actual balance due plus any collection expenses of 30-50% of any balances owing, and any attorney's fees.

Risks and Benefits of Therapy. Psychotherapy is a process in which we will discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so that you can experience your life more fully. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties you may be experiencing. Psychotherapy is a joint effort between us. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and

anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, anxiety, etc. There may be times in which I will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is your sole responsibility.

During the therapeutic process, many people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You should discuss with me any concerns you have regarding your progress in therapy. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Discussion of Treatment Plan. It is my intention to provide services that will assist you in reaching your goals. Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various treatment approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, developmental, Gesalt, TA, and/or psycho-educational techniques.

I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Termination of Therapy. The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

Professional Consultation. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your situation.

Collaboration with Other Professionals. In order to provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases, I may not be able to provide services without this.

Records and Record Keeping. I may take notes during session, and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under WV law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I typically maintain records for ten years following termination of therapy. After ten years, your records may be destroyed in a manner that preserves your confidentiality.

Confidentiality. The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which I am court-ordered to testify or produce records; or as outlined in the "Notice of Privacy Practices" (copies available on my website and in the waiting room).

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that I utilize a "no secrets" policy when conducting family or marital/couples therapy**. This means that I do not keep secret information gathered in individual conversations (whether on the phone or in an individual session) if the information revealed in some way violates the integrity of the couples/family therapy (such as revealing an affair, substance problem, or intent to leave the relationship). Such information will need to be revealed to the other partner for therapy to effectively continue. Please feel free to ask me about my "no secrets" policy and how it may apply to you.

Psychotherapist-Patient Privilege. The information disclosed by you, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. **You should be aware that you might be waiving the psychotherapist-patient privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal proceeding.** You should address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

Patient Litigation. I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with patients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient's legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services of $200.00 per hour.

E-mail and Phone Communication. Some patients prefer to communicate about appointment times or other administrative issues via e-mail. Although information stored on my computer is encrypted, e-mail transmitted through regular services is not encrypted. This means that a third party may be able to access information in an e-mail and read it, since it is transmitted over the Internet. In addition once the e-mail is received by you, someone may be able to access your e-mail account and read it. This may include your employer if you use a work-related e-mail address. E-mail should be considered to be more similar to a "post-card" than to a sealed letter, and for that reason I discourage sending any clinical or other sensitive information via e-mail. **Please use the telephone for anything urgent or time- sensitive**, as I cannot guarantee that I will see an emergency email.

Also please be aware that phone messages are stored on a password-protected server for up to 30 days, similar to a cell-phone server. Please ask if you have questions about this.

Please initial the options that meet your needs. You can change this at any time by communicating to me in writing.

___I do not wish to receive any treatment-related information via e-mail.

___I understand the risks of unencrypted e-mail, and do hereby give permission for Deborah Tucker to contact me or to reply to me via unencrypted e-mail. Please provide preferred e-mail address_____

Occasionally, we e-mail newsletters or similar informational material. We do not share our lists with anyone. Would you like to receive these? o Yes o No If yes, please provide preferred e-mail address_____

Therapist Availability / Emergencies. You may leave a message for me at any time on my confidential voicemail at 304-487-3487. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Friday). **Please understand that as a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, go to the nearest emergency room.** For other types of urgent situations, please follow any **The main voicemail is where I also provide on-call information in the event I am on vacation or unexpectedly called away.** I will do my best to return your call. Please do not use email for urgent situations.

Acknowledgement

By signing below, Patient(s) acknowledge that Patient(s) have reviewed and fully understand the terms and conditions of this Agreement. Patient(s) have discussed such terms and conditions with the therapist, and have had any questions with regard to its terms and conditions answered to Patient(s)' satisfaction. Patient(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Therapist. Moreover, Patient(s) agree to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Patient Name (please print)	Signature of Patient (or authorized representative)	Date
Patient Name (please print)	Signature of Patient (or authorized representative)	Date

I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf.

Name of Responsible Party (Please print)	Signature of Responsible Party	Date

Consent to Treatment of Minors

This section must be completed by the parent or legal guardian of each child who attends session. Some custody agreements require the signatures of both parents for treatment. Because of this, it is generally my policy to require the signature of both parents in any divorce situation.

Confidentiality with Minors

The State of WV provides significant confidentiality to minors seeking mental health treatment. In fact, minors over 12 years of age have many privacy rights similar to those of adults. My role as a therapist is to help minors learn to communicate openly and directly with their parents, and thus, I typically involve parents in the counseling process. That said, when children are making poor and dangerous decisions parents will be brought into the conversation as soon as possible, which in the case of many situations – such as suicidal ideation or attempts – is immediately.

I hereby consent to treatment of my child(ren) per the terms outlined in the above pages of this document:

Name_____Birthdate_____ Name_____Birthdate _____

Parent / Guardian Name (please print)	Parent / Guardian Signature	Date
Parent / Guardian Name (please print)	Parent / Guardian Signature	Date

DISCHARGE SUMMARY

CLIENT: _____

DATE OF DISCHARGE: _____

1. Initial diagnosis
   _____

2. Discharge diagnosis
   _____

3. Services and termination status
   Date Services Started: _____
   Date of Termination: _____
   No. of Sessions: _____

4. Which of the following services were used?
   A. Individual
   B. Family
   C. Group
   D. Marital
   E. Psychiatric Testing
   F. Other
5. Overall status at termination
   A. Marked Improvement
   B. Moderate Improvement
   C. No change
   D. Regressed
   E. Unknown
6. Reason(s) for termination
   A. Discharged as planned
   B. Referred for other services
   C. No longer making appointments
   D. Has missed several appointments
   E. Termination against Therapists recommendations
   F. Therapist is leaving the company
   G. Client is leaving the area
   H. Insufficient progress in therapy
   I. Other: _____
7. Presenting problem and assessment
   _____
   _____
8. Medical/Psychiatric status _____
   _____
9. Post-termination plan
   _____
10. Client's statement regarding satisfaction of treatment rendered
    _____
    _____

Cheat Sheet ICD 9/ ICD 10: Mental and Behavioral Health Comparison

ICD-10	ICD -9	Description
F90.0	314	ADHD (attention deficit hyperactivity disorder), inattentive type
F10.20	303.9	Alcohol dependence
F41.9	300	Anxiety
F90.1	314.01	Attention deficit disorder with hyperactivity
F90.2	314.01	Attention deficit hyperactivity disorder (ADHD), combined type
F84.0	299	Autism spectrum disorder
F31.81	296.89	Bipolar 2 disorder
F31.13	296.43	Bipolar affective disorder, manic, severe
F31.2	296.44	Bipolar affective disorder, manic, severe, with psychotic behavior
F60.3	301.83	Borderline personality disorder
F12.29	304.3	Cannabis dependence, abuse
F14.20	304.2	Cocaine dependence, uncomplicated
Z30.02	V25.04	Counseling for birth control, natural family planning
Z71.41	V65.42	Counseling on substance use and abuse
F31.30	296.5	Depressed bipolar disorder
F34.8	296.99	Disruptive mood dysregulation disorder
Z55.9	V62.3	Educational problem
Z30.018	V25.02	General counseling for initiation of contraceptive measures
F41.1	300.02	Generalized anxiety disorder
F63	312.3	Impulse control disorder
G47.00	780.52	Insomnia
F32.9	296.3	Major depression, recurrent, chronic
F33.1	296.32	Major depressive disorder, recurrent episode, moderate
F33.2	296.33	Major depressive disorder, recurrent episode, severe
F33.3	296.34	Major depressive disorder, recrt episode, severe, psychotic behavior
F72	318.1	Mental retardation, severe (I.Q. 20-34)
F33.8	296.9	Mood disorder
Z23	V05.3	Need for hepatitis B vaccination
F17.200	305.1	Nicotine dependence
F42	300.3	OCD (obsessive compulsive disorder)
F91.3	313.81	ODD (oppositional defiant disorder)
F11.20	304	Opioid type dependence, uncomplicated
Z59.8	V60.89	Other problems related to housing and economic circumstances
Z71.89	V61.20	Other specified counseling
Z65.8	V62.89	Other specified psychosocial
F41.0	300.01	Panic disorder without agoraphobia

Patagonia Health 1915 Evans Road, Cary, NC 27513 | 919.238.4780 | Email: info@patagoniahealth.com

New Beginnings Therapy Services

Suboxone –

New Patient Intake

Patient:_____

DOB:_____

Today's Date:_____

Vital Signs:

Pulse_____

BP_____

Weight_____

Pulse Ox:_____

Reason for Today's Visit: _____

Opiate Use History:

- How many yrs/months of use:_____
- When was your last use?_____
- Opiate Based Substance Used?_____
- Route of Administration:_____
- Amount of current use and how often? _____
- Have you ever taken Suboxone/Methadone/Subutex in the past, either prescribed or purchased off streets?_____

- Do you have any planned medication procedures over the next year? If so, What?_____

_____

History of drug abuse treatment:

_____

_____

_____

Is anyone else in your home actively using or addicted to drugs or alcohol?

_____

_____

Social History:

Graduated High School? _____ Highest Grade: _____ GED?:_____

Currently Employed? _____ Barriers to Employment:_____

_____

Married?_____ Number of Children:_____

Who do you currently live with?_____

What family members or significant others will be part of your support team during your treatment?_____

Is there any family members that you give us permission to discuss your care with in the event of an emergency?_____

_____

Any current pending legal charges?_____

History of legal charges related to Drug Use, or DUI/DWI?_____

_____

Substance Abuse History

	No	Yes/Past Or Yes/Now	Route	How Much	How Often	How long ago was last use?	Quantity last used?
Alcohol							
Caffeine							
Cocaine							
Meth							
Heroin							
Inhalants							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants							
Sleeping Pills							
Nicotine							
Other							

History of:

Hepatitis A/B/C_____ HIV_____ TB_____ STD_____

Mental Health History:

Currently being treated for any mental health conditions, including depression, anxiety, insomnia, etc.? _____

_____

Every been admitted to a hospital for psychiatric care? _____

Suicide attempts?:_____

Any family history of Mental Health Disorders in your mother, father, or siblings?_____

What are some major stressors in your life? _____

Do you have a history of or experienced any of these frequently over the past 2 months? Circle all that apply.

Sadness

Trouble falling asleep

Sleeping too much

Crying spells

Poor concentration

Feelings of hopelessness

Thoughts of self-harm

Feelings of helplessness

Anger outburst

Agitated more than usual

Seeing things that are not there

Hearing things that are not there

Poor Appetite

Eating frequently

Poor energy

Increasing thoughts of Death

Loss of interest in things I usually like

*Name:*_____

*Allergies:*_____

Medical History

Current Medications:

Personal Health History

Have you EVER HAD, or do you have, any of the following? Check EACH item. If yes, specify by number and explain.

	No	Yes
1. Chicken pox or shingles	☐	☐
2. Measles	☐	☐
3. Mumps	☐	☐
4. Skin problems or chronic rash	☐	☐
5. Eye problems	☐	☐
6. Hearing loss or ear problems	☐	☐
7. Chronic cough	☐	☐
8. Asthma	☐	☐
9. Shortness of breath	☐	☐
10. Lung problems	☐	☐
11. Tuberculosis or positive TB skin test	☐	☐
12. Chest pain	☐	☐
13. Heart trouble/attack	☐	☐
14. Palpitations/irregular heart beat	☐	☐
15. Heart murmur	☐	☐
16. High blood pressure	☐	☐
17. Stroke or paralysis	☐	☐
18. Stomach or intestinal problem	☐	☐
19. Liver disease/hepatitis	☐	☐
20. Kidney disease	☐	☐
21. Weight change	☐	☐
22. Thyroid problems	☐	☐
23. Shoulder/elbow/wrist/hand pain	☐	☐
24. Numbness/tingling of arms or hands	☐	☐

	No	Yes
25. Broken bones	☐	☐
26. Bone or joint problems	☐	☐
27. Arthritis/gout	☐	☐
28. Back pain/injury	☐	☐
29. Numbness/tingling legs or feet	☐	☐
30. Knee pain/injury	☐	☐
31. Foot pain/injury	☐	☐
32. Neck pain/injury	☐	☐
33. Loss of limb	☐	☐
34. Severe headaches	☐	☐
35. Dizziness or fainting	☐	☐
36. Epilepsy or seizures	☐	☐
37. Severe weakness or tiredness	☐	☐
38. Depression or anxiety	☐	☐
39. Emotional or psychiatric problems	☐	☐
40. Drug or Alcohol dependency	☐	☐
41. Eating disorder	☐	☐
42. Bleeding or blood disorder	☐	☐
43. Immune suppression	☐	☐
44. Chronic/recurrent infection	☐	☐
45. Tumor/cancer	☐	☐
46. Anemia	☐	☐
47. Diabetic	☐	☐
48. Any other illness not listed	☐	☐

Continues on next page

New Beginnings Therapy Services

Acknowledgement of HIPPA/Privacy Notice

I hereby acknowledge that I have received and have been given an opportunity to read and copy of New Beginnings Therapy Services' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Secretary Of Health and Human Services at 200 Independence Ave., S.W. Washington, D.C. 20201 or by calling 202-619-0257.

_____

Signature of Patient Date

_____

Signature of Parent/Guardian/Representative Date

_____

Legal authority to sign on behalf of patient (Parent, Power of Attorney, etc.)

☐ Patient refuses to acknowledge receipt of Notice

_____

Signature of Provider/Approved Staff Date

New Beginnings Therapy Services

616 Harrison St.
Princeton, WV 24740

Explanation of Treatment

Intake

You will be given a comprehensive substance dependence assessment, as well as an evaluation of mental status and physical exam. The pros and cons of the medication, SUBOXONE, will be presented Treatment expectations, as well as issues involved with maintenance versus medically supervised withdrawal will be discussed.

Induction

You will be switched from your current opioid (heroin, methadone, or prescription painkillers) on to SUBOXONE. At the time of induction, you will be asked to provide a urine sample to confirm the presence of opioids and possible other drugs. You must arrive for the first visit experience mild to moderate opioid withdrawal symptoms. Arrangements will be made for your receive your first dose shortly after your initial appointment. Your response to the initial dose will be monitored. You may receive additional medication, if necessary, to reduce your withdrawal symptoms.

Since an individual's tolerance and reaction to SUBOXONE vary, daily appointments may be scheduled and medications will be adjusted until you no longer experience withdrawal symptoms or cravings. Urine drug screening is typically required for all patients at every visit during this phase.

Stabilization

Once the appropriate dose of SUBOXONE is established, you will stay at this dose until steady blood levels are achieved. You and your doctor will discuss your treatment options from this point forward.

Maintenance

Treatment compliance and progress with be monitored. Participation in some form of behavioral counseling is strongly recommended to ensure best chance of treatment success. You are likely to have scheduled appointments on a weekly basis, however, if treatment progress is good and goals are met, monthly visit will be determined by you and your doctor, and, possibly, your counselor. Your length of treatment may vary depending on your individual needs.

It is very important to arrive for your 1st visit already experiencing mild to moderate opioid withdrawal symptoms. If you are in withdrawal, buprenorphine will help lessen the symptoms. However, if you are not in withdrawal, buprenorphine will "override" the opioids already in your system, which will cause severe withdrawal symptoms.

Patient Signature: _____

☐ Yes	☐ No	7. I have a means to store take-home prescription supplies of buprenorphine/naloxone safely, where it cannot be taken accidentally by children or pets, or stolen by unauthorized users. I agree that if my buprenorphine/naloxone pills are swallowed by anyone besides me, I will call 911 or Poison Control at 1-800-222-1222 immediately and I will take the person to the doctor or hospital for treatment.
☐ Yes	☐ No	8. I agree that if my doctor recommends that my home supplies of buprenorphine/naloxone should be kept in the care of a responsible member of my family or another third party, I will abide by such recommendations.
☐ Yes	☐ No	9. I will be careful with my take-home prescription supplies of buprenorphine/naloxone, and agree that I have been informed that if I report that my supplies have been lost or stolen, that my doctors will not be requested or expected to provide me with make-up supplies. This means that if I run out of my medication supplies it could result in my experiencing symptoms of opiate withdrawal. Also, I agree that if there has been a theft of my medications, I will report this to the police and will bring a copy of the police report to my next visit.
☐ Yes	☐ No	10. I agree to bring my bottle of Buprenorphine/naloxone in with me for every appointment with my doctor so that remaining supplies can be counted.
☐ Yes	☐ No	11. I agree to take my Buprenorphine/naloxone as prescribed, to not skip doses, and that I will not adjust the dose without talking with my doctor about this so that changes in orders can be properly communicated by to my pharmacy.
☐ Yes	☐ No	12. I agree that I will not drive a motor vehicle or use power tools or other dangerous machinery during my first days of taking Buprenorphine/naloxone, to make sure that I can tolerate taking it without becoming sleepy or clumsy as a side-effect of taking it.
☐ Yes	☐ No	13. I agree that I will arrange transportation to and from the treatment facility during my first days of taking Buprenorphine/naloxone so that I do not have to drive myself to and from the clinic or hospital
☐ Yes	☐ No	14. I want to be in recovery from addiction to all drugs, and I have been informed that any active addiction to other drugs besides heroin and other opiates must be treated by counseling and other methods. I have been informed that buprenorphine, as found in Buprenorphine/naloxone, is a treatment designed to treat opiate dependence, not addiction to other classes of drugs.
☐ Yes	☐ No	15. I agree that medication management of addiction with buprenorphine, as found in Buprenorphine/naloxone, is only one part of the treatment of my addiction, and I agree to participate in a regular program of professional counseling while being treated with Buprenorphine/naloxone.
☐ Yes	☐ No	16. I agree that professional counseling for addiction has the best results when patients also are open to support from peers who are also pursuing recovery.
☐ Yes	☐ No	17. I agree to participate in a regular program of peer/self-help while being treated with Buprenorphine/naloxone.
☐ Yes	☐ No	18. I agree that the support of loved ones is an important part of recovery, and I agree to invite significant persons in my life to participate in my treatment.

New Beginnings Therapy Services

616 Harrison St.
Princeton, WV 24740

Schedule II Narcotics Contract

The purpose of this Agreement is to give you information about the controlled substances you will be taking, and to assure you and your Medical Provider comply with all State and Federal regulations concerning the prescribing of controlled substances. Your Provider's goal is for you to have the best quality of life possible given the reality of your clinical condition(s). The success of your treatment depends on mutual trust and honesty in the Provider/Patient relationship and the full agreement and understanding of the risks and benefits of using controlled substances to treat your medical condition(s).

As a patient of New Beginnings Therapy Services and its medical staff and a recipient of a prescription(s) for a Schedule II narcotic medication and as evidenced by your signature below, you agree and consent to the following terms and conditions:

By continuing to receive your health care from the AccessHealth medical staff, and as evidenced by your signature below, you agree and consent to the following terms and conditions:

1. I understand that controlled substances are strong medications for pain relief, and I have been informed of the risks and side effects involved with taking them. In particular, I understand that my medications could cause physical dependence. If I suddenly stop or decrease my medications, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that such withdrawal is quite uncomfortable, but not a life-threatening condition.

   Overdose on my medication(s) may cause death by stopping my breathing. This condition can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. I acknowledge that is has been suggested that I wear a medical alert bracelet or necklace that contains this information.

   If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.

   I understand that, if I am a female patient, my pregnancy may warrant the discontinuance of medication therapy at the discretion of my Provider or my obstetrician. I understand that, if I am pregnant or become pregnant while taking these medication, my child would be physically dependent on them and withdrawal can be life-threatening for a baby.

2. I understand that if I breach the Agreement, my Provider will stop prescribing these medications. In this case, the medication may be tapered over a period of several days to weeks to avoid withdrawal. A drug-dependence treatment program may be recommended. A breach of this Agreement may also result in dismissal from -- New Beginnings Therapy Services. . The following will be considered breach of agreement.

   - I give away, lend, sell, divert, or misuse any my prescription medication(s).
   - My Provider finds me noncompliant with any of the terms and conditions of this Agreement.
   - I develop rapid tolerance or a loss of effectiveness from this treatment.
   - I develop side effects that are significant in the view of Provider.
   - My functional activities decrease.
   - I obtain controlled medications from sources other than the below-named Provider.
   - I fail a drug screen.
   - I display behaviors indicative of narcotics addiction

3. I understand that all prescriptions for controlled substances must come from my Provider or, in his/her absence, from a covering physician, unless specific authorization is obtained for an exception.

4. I understand that I must select one pharmacy from which to obtain all controlled medications prescribed by my Provider. If I have my medications filled at a different pharmacy than the one set forth below, I must notify my Provider within seventy-two (72) hours.

   My Pharmacy: _____ Phone #: _____

   I understand that a copy of this Agreement may be sent to this pharmacy. I authorize my Provider and his/her staff to speak to any pharmacy regarding my prescriptions and to query the database maintained by the West Virginia Board of Pharmacy.

5. I understand that I must be seen on a regular basis and that I will only be given enough medication to last from appointment to appointment, plus two (2) or three (3) days extra. I understand and agree that this extra medication is not to be used without the explicit permission of the prescribing Provider unless an emergency requires my appointment to be deferred for one (1) or two (2) days.

6. I understand and agree that prescriptions for controlled substances will only be done during an office visit or during regular office hours with seventy-two (72) hours advance notice. I understand that repeatedly calling for refills during that seventy-two (72) hours period and/or any harassment of the staff for the refill of controlled medications will not

be tolerated and may result in a change to my treatment plan, including the safe discontinuation of my medication(s) or the complete termination of my Provider/Patient relationship.

7. I understand that I must bring all medication(s) prescribed by my Provider, in their original bottles, when instructed to do so. I understand that a pill count will be done in my presence and that, if less than the expected amount remains, I will be considered in violation of this Agreement. I further understand that, if I fail to bring any medication bottle(s), as instructed, I may not receive my prescription(s).

8. I understand and agree that changing the dose(s) or frequency of my medications, without first contacting my Provider, will terminate the prescribing relationship. I agree to take my medication(s) as prescribed and not to change the amount or frequency of the medication without discussing it with my Provider. Running our early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for my Provider to discontinue prescribing to me. I understand and agree that lost, stolen, or damaged drugs or prescriptions will not be accepted as a reason for refill prior to the appropriate time. I agree to keep my medication in a safe and secure place, as lost, stolen, or damaged medication will not be replaced.

9. I understand that, if I am seen by another medical provider, I must inform them as to what medications I am being prescribed by my Provider under this Agreement. I further understand that, if I receive a prescription for a controlled substance from any other facility (including but not limited to an Emergency Room or a dentist), I must alert my Provider within seventy-two (72) hours. I understand that, if I fail to notify my Provider within 72 hours I will be in violation of this Agreement.

10. I understand and agree that my Provider reserves the right to perform unannounced pill counts and urine or serum (blood) drug testing. If I am requested to provide a urine or blood sample, I agree to cooperate fully with that request. I understand and agree that, if I decide not to provide a urine or blood sample, my Provider may change my treatment plan, including the safe discontinuation of my controlled medication when applicable, or the complete termination of the Provider/Patient relationship. I understand that the presence of any non-prescribed or illicit drug(s) in my urine or blood sample is a violation of this Agreement and may be grounds for the termination of the Provider/Patient relationship.

11. I understand and agree that I may be called upon to provide a urine or blood sample at any time and that I will be required to provide said sample within a reasonable period of time following my Provider's request to do so. I hereby authorize my Provider's request to do so. I hereby authorize my Provider or his/her staff to telephone me the following telephone number. I am providing this number because it I the best method of reaching

me. I understand and agree that I am responsible for any messages left for me at this number. I understand and agree that my failure to respond in a timely fashion to messages from my Provider or his/her staff will be considered a violation of this Agreement and may be grounds for the termination of the Provider/Patient relationship. I understand and agree that, should my preferred telephone number change, it shall be my responsibility to notify my Provider of this change within seventy-two (72) hours.

My Telephone Number:

I understand that, under West Virginia Code 60A-4-412, it is a crime to try to defeat a urine drug test by tampering with my urine or providing a false urine sample. I understand and agree that, if I am caught attempting to defeat a requested urine test, by any mechanism whatsoever, I may be terminated from t... ... s. Moreover, I understand and agree that my provider may report my conduct to the police and that I may be subject to criminal prosecution.

12. I understand and agree that, if I have a history of alcohol or drug misuse/addiction. I must notify my Provider of that history because treatment with a controlled substance may increase the possibility of relapse. I understand that a prior history of drug addiction will not necessarily disqualify me as a patient of New Beginnings Therapy Services, ... s but that I may be required to start or continue in an addiction recovery program. I further understand that there is a small risk of addiction could occur as a result of me taking my medication(s). This means that I might become psychologically dependent on the medication, using to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. I understand and agree that, if this occurs, my medication(s) will be discontinued, and I will be referred to a drug treatment program for help with this program.

    I further understand that, under West Virginia Code 60A-4-410, it is a crime to withhold requested information from a physician in order to obtain a prescription for a controlled substance I understand and agree that, if I am caught engaging in such behaviors, I may be terminated from the Community Health Systems, Inc., d.b.a. AccessHealth medical practices. Moreover, I understand and agree that my provider may report my conduct to the police and that I may be subject to criminal prosecution.

13. I understand and agree that my Provider/Patient relationship must be based upon trust and that that relationship will be irrevocable damaged if I engage in any form of criminal behavior. I understand and agree that the Provider/Patient relationship may immediately terminate, in the sole discretion of my Provider, if I am charged with <u>any</u> drug-related criminal offense, even if I am never convicted of the offense. I further understand and agree that my Provider, in his sole discretion, may terminate the Provider/Patient relationship if I am convicted of any felony or misdemeanor crime of dishonesty or moral turpitude.

14. I authorize my Provider to cooperate fully with any local, State, or Federal law enforcement agency, as well as the West Virginia Board of Pharmacy and Medicine, in the investigation of any possible misuse, sale, or other diversion of my controlled medication(s). Furthermore, I authorize my Provider to cooperate fully with any local, State, or Federal law enforcement agency, as well as the West Virginia Boards of Pharmacy and Medicine, in the investigation of any possible conduct that leads my provider to believe that I am attempting to obtain a prescription for a controlled substance under false pretenses. While I understand that HIPAA specifically allows my provider to take the actions set forth in this section, I expressly agree to waive any applicable privilege or right of privacy and/or confidentiality, whether actual or perceived relating to my care at New Beginnings Therapy Services and any prescribed medication(s) to the extent my Provider, in his/her sole discretion, deems it necessary to cooperate with said law enforcement agencies.

15. I authorize my Provider to contact any healthcare professional, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care at New Beginnings Therapy Services if my Provider, in his/her sole discretion, feels it is necessary for my continued treatment.

I CONSENT TO THE USE OF CONTROLLED MEDICATIONS UNDER THE TERMS AND CONDITIONS OUTLINED IN THIS AGREEMENT.

By signing this Agreement, I acknowledge that I have read the above, have had all of my questions answered to my satisfaction, and fully understand and agree to be bound by all of the terms and conditions contained herein.

Patient's signature: _____ Date: _____

Chart # _____ DOB: _____

Provider's Signature: _____ Date: _____

Witness Signature: _____ Date: _____