Hopi L. Hall

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2900 Nojoqui Ave, Los Olivos, CA 93441

(805) 598-1281

Welcome to my practice. I look forward to helping you reach your goals. This form requests information about your needs and informs you of my services and polices. Please take a few moments to complete this form. The questions on the following pages are designed to help me best meet your treatment needs. If the person seeking care is a child, the parent or guardian should complete this form. If you have any questions, I will be happy to answer them.

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: F M

Client SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship Status: Single Married Separated

 Domestic Partner Divorced Widowed

Mental Health Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full Time Student? Y N

Medical Health Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone

Your Phone # (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home: OK to contact there? Y N Work: OK to contact there? Y N

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Relationship to client Phone number

Please list other persons living in your household and their relationship to you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Primary Insurance Information Secondary Insurance Information

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payer/Health Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payer/Health Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Relationship to the Insured: Client’s Relationship to the Insured:

Self Spouse Dependent Self Spouse Dependent

Member # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

 No Little Some Much Significant Not

 effect effect effect effect effect Applicable

Marriage/Relationship 1 2 3 4 5 N/A

Family 1 2 3 4 5 N/A

Job/School performance 1 2 3 4 5 N/A

Friendships 1 2 3 4 5 N/A

Financial situation 1 2 3 4 5 N/A

Physical health 1 2 3 4 5 N/A

Anxiety level/Nerves 1 2 3 4 5 N/A

Mood 1 2 3 4 5 N/A

Eating habits 1 2 3 4 5 N/A

Sexual functioning 1 2 3 4 5 N/A

Alcohol/Drug use 1 2 3 4 5 N/A

Ability to concentrate 1 2 3 4 5 N/A

Ability to control

your temper 1 2 3 4 5 N/A

3. What result(s) do you expect from treatment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. Have you received mental health treatment before? If so, please list dates, provider name, and the issue for which treatment was sought:

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5. Please list any medications you’re currently taking:

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**TREATMENT PHILOSOPHY**

I believe in providing goal-directed treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishment of that goal. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. You can expect to benefit from therapy, although there is no guarantee that you will.

**CONFIDENTIALITY**

All communications between provider and patient is held strictly confidential unless:

 1. The client authorizes release of information with his/her signature.

 2. The client presents a physical danger to self.

 3. The client presents a danger to others.

 4. Child/elder abuse/neglect are suspected

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

**FINANCIAL TERMS**

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and I will be paid directly by your carrier. You will be responsible for any applicable deductibles and co-payments. Co-payments must be paid at the time services are rendered. If you are not eligible at the time services are rendered, you are responsible for full payment. Individual Sessions and conjoint (marital/family) sessions are 45 to 50 minutes in length.

**CANCELLED/MISSED APPOINTMENTS**

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24 hours notice, you will be billed directly according to the scheduled fee or according to the rules of your health plan. Your health plan does not cover payment for missed appointments; therefore you are responsible for payment in full.

**EMERGENCY PROCEDURES**

If you need to contact me, leave a message according to the instructions on my phone service and your call will be returned. If an emergency arises, follow the emergency procedures. Please do this for true emergencies only. Non urgent phone calls are returned during normal workdays (Monday through Friday) within 48 hours.

**RELEASE OF INFORMATION**

I, the client, authorize the release of information regarding my care to my health plan for the payment of claims, certification/case management decisions, and other purposes related to the administration of benefits for my health plan. I have read and understand the HIPAA Notice (available on hopihall.com).

**CONSENT FOR TREATMENT**

I, the client, or in the case of a minor, the client’s guardian, further authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

*I understand and agree to all the above information.*

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Client (or Parent/Guardian) Name---Printed Date

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Client (or Parent Guardian) Name---Signature Date