

Costa Clinical Psychology, LLC
625 Spruce St. #7666
Brookings, OR 97415
(541) 412-0700

Patient Registration

Date: _____

Patient Full Name _____ SS# _____

Mailing Address: _____ Zip _____

Phone Numbers: Home _____ Cell _____

Gender: _____ Gender Identity: _____ Sexual Orientation: _____

DOB: _____ Email: _____

Patient Employer: _____ Work Number: _____

If Student, School: _____ Grade: _____

Family Physician: _____ Referred By: _____

Other Current Mental Health Providers: _____

Insured/Responsible Party Information

Please complete regardless of insurance coverage

Full Name of Insured: _____ Relationship to Patient: _____

Home Address: _____ Phone: _____

Employer Address: _____

Work Phone: _____ Insured's SS# _____ DOB: _____

Primary Insurance: _____ I.D.#: _____ Group#: _____

Secondary Insurance: _____ I.D.#: _____ Group#: _____

Workman's Compensation: _____ yes _____ No; Company _____

Office Billing and Insurance Policy

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company.
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of the original.
6. I understand and accept use of Therapy Notes for my electronic health record and as a billing vendor.

Printed Name: _____

Signature: _____ Date: _____



Costa Clinical Psychology, LLC



INFORMED CONSENT TO TREATMENT

Welcome

Welcome to Costa Clinical Psychology, LLC. This document provides information about Teresa I. Costa, PsyD; Jeanne Bisson, LMFT and our practice. This will explain the services we provide, our business policies, and your rights as a client. Please read it carefully and ask any questions you may have about the information presented to you. When you sign this document, it will constitute an agreement between us and mark the beginning of our therapeutic relationship.

About Costa Clinical Psychology, LLC

We are located at 625 Spruce St. in Brookings, Oregon between Wharf and Fern Streets. When you arrive, we ask that you park on the right side of the parking area in front of the purple sign. If there is not enough parking, then please park along the street. The left side of the parking area is for the owner of the building. There is a handicapped parking space on the west side of the building. We currently employ two clinicians, and their information is below. We have a certified therapy dog by the name of Maddie that belongs to Dr. Costa. She is a mixed breed 8-10-pound dog. If you are allergic to pet fur or would rather not be around her, please let us know in advance so we can make arrangements to put her in another room while you are being seen.

Teresa I. Costa, PsyD;

I am a clinical psychologist residing and practicing in the state of Oregon and licensed by the Oregon Board of Psychologist Examiners. I earned my doctorate in clinical psychology from the California School of Professional Psychology at Alliant International University. My first career was in the area of special education after earning my Master's in Early Childhood Special Education from the University of Oregon and my Child Development Bachelor's Degree from Humboldt State University. For many years I have specialized with children and their families helping them to negotiate difficulties with school and home due to Autism, ADHD, mood disorders, Oppositional Defiant Disorder or other issues causing school to be more difficult than it needs to be. Since opening my private practice, I have also supported local veterans and adults with disabilities or the elderly on Medicare.

Jeanne Bisson, LMFT

I received my Master's Degree in Counseling from John F. Kennedy University in Campbell, California in 2003. I am a Licensed Marriage & Family Therapist in Oregon and Hawaii. I have over 17 years of experience using a client-centered and strength-based approach when working with children and families struggling with Autism, ADHD, Anxiety, Anger, Grief, Loss, Divorce, Step-family issues, Mental Illness, Physical and Emotional Abuse, Healthy relationships & Social

Skills. I utilize Play Therapy and Cognitive Behavioral Therapy. On a personal note, I love the beach, hiking and other outdoor activities.

Understanding Psychotherapy

Psychotherapy is an unusual health care relationship, and more than most health care you may receive, the relationship is likely to be an important part of the treatment. Treatment itself may vary depending on characteristics of the client, therapist, and issues worked on. Additionally, Psychotherapy requires you to engage with the process, including working actively and fully on the things we talk about both in-session and in your everyday life.

Like most health care treatments, psychotherapy can have benefits as well as risks. Since our work will likely involve talking about unpleasant aspects of your past and current life, you may experience unpleasant emotions like loneliness, sadness, regret, guilt, grief, anger, and frustration. However, research has demonstrated that engaging in therapy is usually more effective than doing nothing and that most people benefit from therapy. Benefits may include greater happiness or contentment; increased self-knowledge and self-awareness; more satisfying relationships; and solutions to specific problems. Please keep in mind that there are no guarantees of what you will experience; each person's therapy experience and outcome is unique.

Philosophy & Approach

We seek to build collaborative relationships with our clients to understand the issues more effectively they may be dealing with and to help find ways to resolve them. We use our clinical expertise to integrate various psychological theories and techniques, tailoring the therapy experience to each client's needs and personality. As part of this process, we consider our client's culture to be central to understanding their lives and issues, as well as learning how culture and community may support and/or hinder our efforts. The techniques we use are grounded in classic and contemporary psychological theory and supported by current psychological research. We value and encourage continual feedback from clients about how the therapy experience and relationship is working for them.

Scheduling & Cancellation Policy

Sessions are made by appointment only and typically last 45-50 minutes. We work with most clients weekly, but we will collaboratively agree on how often we meet based on factors particular to your situation. Once you have scheduled an appointment, you are expected to be on time for that appointment.

Missed or Cancelled Sessions:

We truly understand that life happens and can disrupt the best laid plans. We ask that if you cannot make a scheduled appointment that you contact us as soon as possible so that we might use your time slot for someone that may need an extra session or be in crisis. If you miss your sessions frequently, we will work with you to try and find a better time to reduce your absences.

However, if the cancelations or no shows persist we will cancel your recurring appointment so that someone else can make use of the time.

Appointment Reminders

We do not call clients to remind them of upcoming appointments. As a courtesy, We can enroll you in our reminder system, which is a service of our HIPAA compliant electronic health records provider. The System will send you a message (2 days prior) via email, text message, or voice message (your choice) reminding you of upcoming appointments. If you wish to be enrolled in this system, please authorize us to leave messages via the appropriate method on your Registration Form. You may request that we remove you from the reminder system at any time. Please note: failure to receive an automated reminder does not relieve you of the responsibility of attending the session.

Contacting Us

We are typically in the office from 10:00 AM to 5:00 PM on Monday through Friday, except for major holidays. However, it is our policy, to not answer the phone when we are with a client, so we are often not immediately available. When we are unavailable, our phone will be answered by our Medical Administrative Assistant. If in the event that he/she is not available, please leave a message and we will return your call as soon as possible. You may also contact us via e-mail at costaclinicalpsychology@gmail.com and we will respond in kind and in the same timeframe as a phone message. **Please do not include confidential information in your voice message, or e-mail.** In the digital era, it is safest to consider only face-to-face contact as confidential.

Emergencies:

If you need support immediately and cannot wait for us to return your message, please call the **Curry County Crisis Line at 877-519-9322**. If you believe you may be a risk to the safety of yourself or others, please call 911 or go to the nearest emergency room or hospital.

Professional Records

The laws and standards of my profession require that we keep treatment records, including diagnoses, treatment plans, and progress notes. Your mental health records are maintained as an electronic record in a secure, HIPAA compliant, medical records system called TherapyNotes. You have a right to receive a copy of your records, or we can create a summary if you prefer. We recommend that you review them in my presence so that we can discuss the contents, as this will help avoid misinterpretation, confusion, and unnecessary distress. Please note, we charge an appropriate fee for any professional time spent in responding to information requests.

You have the right to fully understand your treatment plan and to ongoing review of your treatment plan. We will collaboratively generate initial goals for therapy, and we will periodically review the plan both independently and with you.

If you are under thirteen years of age, please be aware that the law may provide your parents the right to examine your treatment records.

Confidentiality - Rights & Limitations

Information that you share in treatment is held in the strictest confidence possible under law, However, there are some limitations to address at the time of consent. As noted in my Notice of Privacy Practices, the following exceptions to confidentiality apply:

Abuse of Children, Elderly Persons, Mentally Ill Adults, Developmentally Disabled Adults, or Animals:

If we have reasonable cause to believe that a child or elderly person has been abused (by you or another party), we may be required to report the abuse.

Domestic Violence:

If we have reasonable cause to believe you are the victim or perpetrator of domestic/partner violence that is impacting children, we may have an ethical obligation to disclose your PHI to prevent harm to you or others.

Serious Threat to Health or Safety:

We may disclose confidential information when we judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. We must limit disclosure of the otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.

Judicial or Administrative Proceedings:

If (a) You become involved in a lawsuit, and your mental or emotional condition is an element of your claim; or (b) A court orders your confidential information to be released or orders your mental evaluation.

Health Oversight:

The Oregon State Board of Psychologist Examiners may subpoena relevant records from me should we be the subject of a complaint.

Worker's Compensation:

If you file a worker's compensation claim, this constitutes authorization form to release your relevant mental health records to involved parties and officials. This would include a past history of complaints or treatment of a condition similar to that involved in the worker's compensation claim.

Even in these cases we will preserve your privacy to the best of our ability. Any third-party requests to release your information will need to be reviewed and approved by you. You have the right to request and understand information shared, with whom it is shared, and for what reason it is shared. Please see your notice of privacy rights for more information.

If you are using health insurance to pay for therapy, your insurance company may ask for information about your symptoms, your diagnosis, and our treatment methods. If they do, we will inform you of the information they have requested. We will provide only as much information as the insurance company requires to grant your benefits. Please note that we have no control over how these records are handled at the insurance company.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have as soon as they arise.

Scope of Practice

Our role in your therapy relationship is strictly to provide mental health services. Any and all medical questions, including those pertaining to medications, must be directed to a medical professional. We will provide referrals to appropriate providers if you wish. It is our policy to collaborate with your other providers to help ensure you receive comprehensive, informed, integrated care. Doing so requires your written consent on a separate release of information. You are free to decline or revoke such consent at any time within the provisions noted in our Notice of Privacy Practices.

Outside of Office Contacts

Being a small town there is a high possibility of seeing each other outside of the office. Rest assured you being a patient will never be disclosed to anyone outside of the office/practice. If you are comfortable saying hello feel free to interact with us in the same manor you would any other person in the community or conduct any associations or business relationship that has to do with living in the same community. However, therapeutic discussions shall never take place outside the office or other predetermined therapeutic venues. Nor will we ever disclose that you are in therapy through this practice.

Client Rights

If at any time you feel that this psychotherapy relationship is not beneficial, you have the right to seek other services to best help with your needs. We will provide resources should you need them. You have the right to be fully informed before you begin a psychotherapy relationship. Any questions or concerns are welcome and encouraged.

Consent to Treatment

Your signature below indicates that you have read and understood this document. Your signature also indicates that you have received and reviewed a copy of the Notice of Privacy Practices, and that any questions you may have were answered to your satisfaction. Further, your signature indicates your agreement with the terms of this document and your desire to enter into therapy with me. Thank you for inviting me to embark on this journey of exploration and growth with you.

Client's Signature

Date

Client's Printed Name

Costa Clinical Psychology
Representative

Date



FEE POLICY

Fees (Costa Clinical Psychology)

The fees for our services are as follows:

- Initial consultation (30 minutes): No charge
- Intake session (60 minutes): \$300
- Individual session (60 minutes): \$225
- Couples/Family session (60 minutes): \$225
- Crisis session (50 minutes): \$250
- Group session (120 minutes): \$45/participant
- Phone calls longer than 5 minutes: Hourly rate (prorated)

All other services requested by you or performed for your benefit will be charged the appropriate hourly fee, prorated to reflect the actual time spent. This includes, but is not limited to copying, faxing, or phone calls after treatment is established that last 5 minutes or longer. (I.E.

Conversations between sessions, attending school meetings or conducting observations of your child within the school setting on behalf of your child, consultations with other health providers, or preparing written treatment summaries.

On a limited basis, we may agree on a reduced fee if your financial status warrants it. The reduced fee will be within an established “sliding scale” of payment and is only available to a very limited number of clients at a time. If you are encountering a financial hardship, please talk to our office and see if we can accommodate a new fee agreement. We will want to know the nature of the hardship (lost your job, medical bills, etc.) and the expected duration of the hardship. Typically, we will only allow sliding fees for 6 months. Payment agreements outside of our normal fees will be documented, kept on file, and reviewed quarterly to determine continuing eligibility.

If you become engaged in legal proceedings and request or require our participation, please understand that this detracts from our regular work and other clients. Thus, our legal fee of \$150 per hour applies to any time spent on the entire court process, including but not limited to consultation with attorneys, travel time, waiting to testify, preparing written briefs, and actual testimony. Also, be advised that your insurance may not cover these fees and you may be solely responsible for payment.

Insurance, & Billing

Dr. Costa participate in Medicare, Blue Cross/Blue Shield, ODS, Magellan, TriWest Healthcare Alliance, ChampVA, Moda, Tricare, Aetna, Providence, Cigna, and AllCare Health (OHP) provider networks, and it is considered “out of network” for all other insurance plans at this time. *Please be advised that other clinicians in this office do not accept all the same insurances as Dr. Costa. Please be sure to double check with us that the clinician you are planning to see can accept your insurance.* Costa Clinical Psychology, LLC is happy to bill insurance companies for whom we are in network with, and we will provide a receipt that you may submit to out-of-network insurance plans for reimbursement. It is important that you contact your insurance company to inquire about mental health benefits before we begin working together; as well as understanding how much of our fee your insurance will reimburse to you. Please remember that your insurance policy is an agreement between you and your insurance company, and that you are ultimately responsible for paying the fees we have agreed upon.

Non-Covered Services

Any or all portions of a bill may be denied for payment by the insurance carrier because services are not covered under a patient’s health plan, have been applied to the patient’s deductible or co-insurance portion, or because the patient is not eligible or has exhausted their benefits. Any or all non-covered portion of the bill are expected to be paid in full by the patient within 30 days of the date of service.

In the event that your account becomes past-due by more than 30 days and we have not agreed on a payment plan, we have the option to use legal means to secure payment, including hiring a Collection’s agency or using small claims court; the costs of pursuing such options will be included in the claim. Generally, the only health information that we will release is your name, the nature of the services provided, and the amount due.

Payment

Payment of our agreed upon fee or copay is due at the time of service. We prefer payments made via credit card (MasterCard, Visa, Discover) or cash; however, we will also accept checks.

Please be advised that this office bills you as a courtesy. *If at any time your balance exceeds more than \$300, we reserve the right to withdraw from treatment.* Please contact our office to arrange for a new fee agreement/payment plan. We are willing to work with your situation, but we will need to sign a new fee agreement. If payment is not made at the time of service, we reserve the right to reschedule the appointment. Any past due balances that are not subject to a

new fee agreement within 30 days of initial bill or are not paid pursuant to the terms of the fee agreement may be sent to collections. By signing below, you agree to these terms.

If you would like to avoid the hassle of remembering copayments for each appointment, then we will be happy to store your Visa or Mastercard in your patient file. *At no time will your card information be visible to any Costa Clinical staff.* This will allow us to run your copay off the saved card when you arrive for each appointment without you having to stop by the reception area. We will be happy to provide a receipt for each payment upon request.

By checking the box below, you are giving permission for Costa Clinical Psychology, LLC and their office staff to run your copay at the time of service without verbal confirmation from you. If at anytime you would like to revoke this privilege, please inform the office staff.

☐ Yes! Please fast track my copayments.

Client's Signature

Date

Client's Printed Name

**Your Information.
Your Rights.
Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

**Your
Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ **See page 2** for more information on these rights and how to exercise them

**Your
Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ **See page 3** for more information on these choices and how to exercise them

**Our
Uses and
Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ **See pages 3 and 4** for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
-

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 02/24/2020

This Notice of Privacy Practices applies to the following organizations.

Costa Clinical Psychology, LLC

(Patient Signature)

(Date)

(Printed Name)

Costa Clinical Psychology, LLC. 625 Spruce St., PO Box 7666, Brookings, OR. 97415
T: (541) 412-0700 F: (541) 412-0711 *Costaclinicalpsychology@gmail.com*



Adult Psychosocial History

Identifying Information (age, ethnicity, religion, marital status, occupation): _____

Presenting Problem (what brings you here today):

History of Presenting Problem (prior treatments, onset, frequency duration): _____

What stressors do you have currently in your life (describe where the stress is coming from): _____

Are there financial problems currently (describe): _____

Past Psychiatric History: Prior Treatments: _____

Type of Treatments: _____

Duration of Treatments: _____

Outcome: _____

Diagnosis: _____

Psychiatric Hospitalizations: _____

Do you have thoughts of hurting yourself or others? _____

Traumatic History (nature of trauma, when it occurred, people involved): _____



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Family Psychiatric History:

Family members: _____

Diagnosis: _____

Types of treatment: _____

Medical Conditions/History:

Current medical problems (include treatments): _____

Past medical problems (include treatments): _____

Allergies: _____

List current medications and what they are used to treat: _____

Substance Use (describe any history of current or past drug or alcohol use, abuse or addictions): _____

Have you ever been treated for substance problems (where, when, outcome): _____

Any past or present legal problems related to substance use: _____

Family history of Substance Use (include who, when and where): _____



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Social History: (significant relationships, social history, nature/quality of relationships)

Describe the present living arrangements (including with whom you are living with and a brief description of these relationships): _____

How long have you been married/dating/living together: _____

Previous Relationships/marriages: _____

Occupation of significant others: _____

How many children do you have (include age, name, sex and name of mother if applicable):

Are there any significant problems with any or your children: _____

Was there any type of abuse (emotional, physical, sexual) in current or previous relationships: _____

Developmental History: (milestones/delays)

Describe your childhood and adolescence (include home atmosphere, relationship with parents): _____

Any history of significant life events such as death, abuse (physical, emotional, sexual) _____



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Were your parents, divorced/separated: _____

What was your relationship like with each of the significant adults in your life (parents, step parents, grandparents, uncles or aunts): _____

Parents ages, include occupations: _____

List siblings by age and describe how you relate to them (past and present): _____

Educational History (describe all school experiences, high school, college, vocational school. Were there any problems with truancy, suspensions, or learning): _____

Employment History (what is your current employment status? What types of work have you done in the past? Do you like your present work status and did you like the previous work you have done?): _____

If you are on leave or disability do you plan to return to work (is so describe what type of work you would like to do?): _____

Legal History: (Arrests, Incarcerations, Problems with the legal system, current or past): _____



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Strength/limitations: _____

List clubs and organizations you belong to: _____

What do you do for pleasure (fun): _____

What limitations do you have that prevent you being happy: _____

Military Service: _____

Branch: _____

Length of time served (dates approximately): _____

Enlisted or drafted: _____

Beginning and ending rank: _____

Type of Discharge: _____

Duties/specialties: _____

Describe your experience in the military: _____

Any traumatic events during your service time: _____

Other (is there anything else you wish to share): _____



Costa Clinical Psychology, LLC



During your first session your therapist will discuss with you the limits of confidentiality, reasons for termination of therapy and cancellation policy. Being a small town there is a high possibility of seeing each other outside of the office. Rest assured you being a patient will never be disclosed to anyone outside of the office/practice. If you are comfortable saying hello feel free to interact with us in the same manor you would any other person in the community or conduct any associations or business relationship that has to do with living in the same community. However, therapeutic discussions shall never take place outside the office or other predetermined therapeutic venues. Nor will we ever disclose that you are in therapy through this practice.

Name

Signature

Date

SELF - ASSESSMENT

What is happening in your life which resulted in this appointment? _____

What would you like to see accomplished in this therapy? _____

CHIEF COMPLAINT (CHECK ALL THAT APPLY TO YOU):

- | | |
|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling that you are not real |
| <input type="checkbox"/> Low Energy | <input type="checkbox"/> Feeling like things around you are not real |
| <input type="checkbox"/> Low Self Esteem | <input type="checkbox"/> Lose track of time |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Unpleasant thoughts that won't go away |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Anger/frustration |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Easily Agitated/annoyed |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Defies rules |
| <input type="checkbox"/> Sleep disturbance (more/less) | <input type="checkbox"/> Blames others |
| <input type="checkbox"/> Appetite disturbance (more/less) | <input type="checkbox"/> Argues |
| <input type="checkbox"/> Thoughts of hurting yourself | <input type="checkbox"/> Excessive use of drug and /or alcohol |
| <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Excessive use of prescription medications |
| <input type="checkbox"/> Isolation/social withdrawal | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Sadness/loss | <input type="checkbox"/> Physical abuse issues |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sexual abuse issues |
| <input type="checkbox"/> Anxiety/panic | <input type="checkbox"/> Spousal abuse issues |
| <input type="checkbox"/> Heart Pounding/racing | <input type="checkbox"/> Other problem/symptoms: |
| <input type="checkbox"/> Chest Pain | _____ |
| <input type="checkbox"/> Trembling/shaking | _____ |
| <input type="checkbox"/> Sweating | _____ |
| <input type="checkbox"/> Chills/hot flashes | _____ |
| <input type="checkbox"/> Tingling/numbness | _____ |
| <input type="checkbox"/> Fear of dying | _____ |
| <input type="checkbox"/> Fear of going crazy | _____ |
| <input type="checkbox"/> Nausea | _____ |
| <input type="checkbox"/> Phobias | _____ |
| <input type="checkbox"/> Obsessions/compulsive behaviors | _____ |
| <input type="checkbox"/> Thoughts racing | _____ |
| <input type="checkbox"/> Can't hold on to an idea | _____ |
| <input type="checkbox"/> Self Harming Behaviors | _____ |
| <input type="checkbox"/> Excessive behaviors (spending | _____ |
| <input type="checkbox"/> Gambling) | _____ |
| <input type="checkbox"/> Delusions/hallucinations | |
| <input type="checkbox"/> Not thinking clearly/confusion | |

Continued on other side

Previous outpatient therapy? ____ Yes ____ No, with _____

What was accomplished? _____

List medications: _____

Previous hospitalization? ____ Yes ____ No. Number of hospitalizations ____ ECT? _____

If yes, when? _____

Printed full name: _____

Signature of patient/parent/guardian: _____ Date: _____

[illegible]