Hullistic Therapy, LLC
28 Lee Rd., Lisbon, CT 06351
860-367-5343

ADULT CLIENT INFORMATION:

Client Name: _____ Date:

Gender: _____ Date of birth: _____Age: _____

SS#: _____ Driver's License #: _____

Issuing State: _____

Form Completed by (if someone other than client): _____

Address: _____
City: _____ State: _____ Zip: _____ Phone (home):

_____ (cell) _____ (work) _____ Text: _____

(Email): _____

Which number(s) can I contact you on?

_____

Can I leave a message? _____ Do I have permission to text? _____ Best way to send you an appointment reminder?

Home Phone: _____ Text: _____ Email: _____

Single: _____ Married: _____ Divorced/Separated: _____

_____

Spouse's or Significant Other's Full Name:_____ Gender: _____

Date of Birth: _____ Age: _____

Address: _____ Phone (home):

_____ (cell) _____ (work) _____

Emergency Contacts:

Person to contact in an emergency:

Name: _____ (Relationship) _____

Phone (home): _____ (cell) _____

Name: _____ (Relationship) _____

Phone (home): _____ (cell) _____

Primary Insurance Information:

Insurance Company: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____

Policy Holder's DOB: _____ Policy Holder SS#: _____

Policy Holder's Employer: _____

Client's Relationship to Policy Holder: _____

Insurance Company Phone Number: _____

Secondary Insurance Information:

I do not have Secondary Insurance _____ (Please initial)

Insurance Company: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____

Policy Holder's DOB: _____ Policy Holder SS#: _____

Policy Holder's Employer: _____

Client's Relationship to Policy Holder: _____

Insurance Company Phone Number: _____

Employment:

Client's Place of Employment: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

========== OFFICE USE ONLY

Primary Dx Code:_____ Secondary Dx Code: _____

Co-payment Due: _____ Prior Auth/# Sessions approved: _____

Effective Dates: _____ to _____

Credit/Debit Card Payment Consent

Client name:

(Card holder) Name on card if different than client:

Card Type:

Last 4 digits of card number:

Expiration Date:

I authorize Kathleen Hull, LCSW, to charge my credit/debit/health savings account card for professional services on the day of our scheduled appointment. I further agree that a transaction fee of 3% will be added to my professional service charge when I pay by credit/debit/ health savings account.

If I do not cancel 24 hours before my appointment time, I recognize that Kathleen Hull LCSW will charge my card as a late cancel or no show if I do not show up for the appointment.

I will be billed $ 25 for the first missed appointment and $ 75 for a second and subsequent missed appointment. I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature:

Family Information:

Please include significant others, step-relatives, siblings, parents and grandparents, or babysitters if they live in your household, help you raise your children, or you and your family spend much time with.

_____

_____

_____

_____

_____

_____

Which hobbies or favorite pastime do you or your family have?

_____

_____

Adult Health Questionnaire:

Client's Name: _____ Date: _____

Primary Reason(s) for Seeking Treatment
(please circle all that apply)

___ Anger Management ___ Anxiety ___ Coping/Stress ____ Depression ____

___ Loneliness ___ Eating Disorder ____ Fear/Phobia ___ Mental Confusion

___ Sexual Issues ___ Self-Esteem. ___ Mood Swings. ____ Nervousness

___ Sleeping Problems ____ Addictive Behaviors. ___ Alcohol/Drugs ___

___ ADD/ADHD ____ Couples ___ Parenting ___ Divorce. ____ Bipolar

___ Paranoia ____ Seasonal Depression. ___ Grieving/Loss. _____

___ Other Mental Health Concerns (specify):

_____

Do you feel suicidal at this time: ____ Yes _____ No If yes, please explain:

_____ Medications:

I, _____ am not taking any medication at this time.

Please, list any medication that is being prescribed to you for mental health reasons:

Name of medication: _____ Dosage: _____ Reason for Prescription (e.g. depression, anxiety):

_____

Prescribing Physician: _____ Next scheduled visit: _____ Is medication working well for you?

_____

Current Symptoms and Behaviors:

___ Aggression ___ Alcohol Dependence ___ Anger.
___ Antisocial Behavior ___ Anxiety ___ Avoiding People
___ Chest Pain ___ Cyber/Internet Addiction ___ Depression
___ Disorganization ___ Distractibility ___ Dizziness
___ Drug Dependence ___ Eating Disorder ___ Elevated Mood
___ Fatigue ___ Gambling ___ Hallucinations
___ Heart Palpitations ___ High Blood Pressure ___ Hopelessness
___ Impulsivity ___ Irritability ___ Judgement Errors
___ Loneliness ___ Memory Impairment ___ Mood Swings
___ Panic Attacks ___ Phobias/Fears ___ Recurring Thoughts
___ Sex Addiction ___ Sexual Difficulties ___ Sick Often
___ Sleeping Problems ___ Speech Problems ___ Suicidal Thoughts
___ Trembling ___ Withdrawing ___ Worrying
___ Other (specify)

_____

_____

How do symptoms impair your ability to function effectively?

_____

_____

_____

Medical/Physical Health:

P = Past C = Current PC = Past and Current

___ AIDS ___ Dizziness ___ Nose Bleeds
___ Alcoholism ___ Drug Abuse ___ Pneumonia
___ Abdominal Pain ___ Epilepsy ___ Rheumatic Fever
___ Abortion ___ Ear Infection ___ STDs
___ Allergies ___ Eating Problems ___ Sleeping Disorders
___ Anemia ___ Fainting ___ Sore Throat
___ Appendicitis ___ Fatigue ___ Sore Throat
___ Arthritis ___ Frequent Urination ___ Sinusitis

___ Asthma
___ Bronchitis
___ Bed Wetting
___ Cancer
___ Chest Pain
___ Chronic Pain
___ Colds/Coughs
___ Constipation
___ Chicken Pox
___ Dental Problems
___ Diabetes
___ Diarrhea
___ Headaches
___ Hearing Problems
___ Hepatitis
___ High Blood Pressure
___ Kidney Problems
___ Measles
___ Mononucleosis
___ Mumps
___ Menstrual Pain
___ Miscarriages
___ Neurological Disorders
___ Nausea
___ Smallpox
___ Stroke
___ Sexual Problems
___ Tonsillitis
___ Tuberculosis
___ Toothache
___ Thyroid Problems
___ Vision Problems
___ Vomiting
___ Whooping Cough
___ Other

_____

Please, list any recent health or physical changes:

_____

_____

_____

Client Signature_____ Date _____

Informed Consent for Treatment:

General Information:

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing this document.

The Therapeutic Process:

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality:

The session content and all relevant materials to the client treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner which likely will result in substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
8. Further limitation to confidentiality are specified in commonly used Notice of Privacy Practices (HIPAA) and may be emailed to you upon request.

Appointments and Cancellations:

Please remember to cancel or reschedule 24 hours in advance. The standard meeting time for psychotherapy is 50 minutes. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.
A $10.00 service charge will be billed for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to charges as stipulated below if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time. You agree to be charged $ 25 for your first missed appointment and $ 75 for a second and subsequent missed appointments.

Telephone Accessibility:

If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that face-to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or go any local emergency room.

Electronic Communications:

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Court ordered Appearances and Documentation:

I charge a flat fee of $400 per clinical hour for any court ordered appearances, including travel time, such as but not limited to divorce and custody hearings. Furthermore, I charge a flat fee of $ 250 per hour to prepare requested court documentation.

Termination:

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Financial Agreement:

I understand that it is my responsibility to know my insurance benefits, coverage of services, co-payments, and deductibles. Benefits and eligibility information obtained online is not a guarantee of payment. Payment, benefits, plan deductibles, co-pay or co-insurances are determined when a claim is processed. Although I strive to receive current policy information at time of your initial visit, I am not responsible for inaccurate or incomplete benefit plan coverage. It is ultimately your responsibility to be aware of your own policy plan information, changes or updates, and to inform us of any. I hereby authorize payment of insurance payments

for therapeutic services provided made directly to Kathleen Hull, LCSW. I authorize the release of information regarding my (or my child's) healthcare for the purpose of processing insurance benefits. I agree that a photocopy of my signature can be used for any outside medical records release. In the event that insurance benefits by my insurance carrier do not cover received psychotherapy services, I agree that I am financially responsible for the entire cost, including but not limited to collection costs and reasonable attorney's fees.

_____ Client Signature / Date