CLIENT INFORMATION/ADULT

Legal Name:_____ Date____/____/____

Preferred Name:_____ Legal Gender:___M ___F

Affirmed Gender: ___ M ___ F ___ Other (describe):_____

Address:_____

Email:_____ Preferred Phone:_____

DOB:_____/_____/_____

Occupation:_____ Highest Grade in School:_____

Who else lives in your household?_____

If couples/relationship therapy, partner's name:_____

Emergency Contact Name:_____ Phone:_____

Briefly describe your reason for contacting us:_____

_____

_____

_____

Current or past outpatient therapy before? ____no ____yes ____current ____past

If past, when/why?_____

_____

If Current, name/phone of provider:_____

Have you ever been hospitalized for mental health or substance abuse? ____no ____yes If yes, when and where?_____

_____

Have you ever made a suicide attempt? ____no ____yes If yes, when and what happened?

_____

_____

Current or past psychotropic medication? ____no ____ yes ____current ____past

If past, when and what medication?_____

If current, what medication, dose, provider's name and phone:_____

_____

_____

Describe any medical problems and any medications taken for them:_____

_____

_____

Current self-help or peer support programs? ____no ____yes If yes, describe:_____

_____

Is there a family history of:

No	Yes	
____	____	**Drug or Alcohol Abuse (who?)**_____
____	____	**Other addiction problems (who/what?)**_____
____	____	**Psychiatric problems (who/what?)**_____
____	____	**Suicide/suicide attempts (who?)**_____
____	____	**Criminality (who/what?)**_____
____	____	**Abuse? (who/what?)**_____
____	____	**Use of Psychotropic Meds? (who/what?)**_____

Additional Space for Info on Above:_____

_____

_____

Below is a list of problems and symptoms. Please check any you are experiencing now or have experienced recently.

____ Excessive or uncontrollable anger

____ Frequent crying or sadness

____ Periods of mania, over-excitement

____ Depression, lethargy

____ Frequent mood swings

____ Anxiety, agitation, and fear

____ Panic attacks

____ Agoraphobia (fear of leaving home)

____ Obsessive compulsive disorder (OCD)

____ Extreme social isolation

____ Poor self-esteem, low self-confidence

____ Feelings of guilt, shame, self-hatred

____ Persistent loneliness

____ Cutting or other self-harming

____ Grief, bereavement

____ Work stress

____ Problems with alcohol

____ Problems with drugs

____ Partner with drug, alcohol, other addiction problem

____ Problems with partner or spouse

____ Problems with children

____ Other family problems

____ Eating disorder: bingeing, anorexia, bulimia

____ Strange thoughts, hearing voices, seeing things

____ Uncertainty about sexual orientation

____ Uncertainty about gender identity

____ Uncertainty about other sexuality

____ Being sexually abused/memories of abuse

____ Being physically abused/memories of abuse

____ Being emotionally abused/memories of abuse

____ Abusing others physically

____ Abusing others sexually

____ Abusing others emotionally

____ Sexual problems, sexual dysfunction

____ Sex Addiction

____ Other addiction: specify_____

____ Other Describe:_____

_____

Do you currently think about killing yourself or dying? ____ no ____ yes

If yes, check all that apply: ____ thoughts of dying ____ thoughts of killing myself

____ partial plan to kill myself ____ fully formed plan to kill myself

Have you ever been given a mental health diagnosis by any professional?

____ no ____ yes ____ don't know

If yes, what diagnoses, when, and by whom?_____

_____

_____

CLIENT'S INFORMED CONSENT

I have chosen to receive psychological treatment from the Institute for Personal Growth and (therapist name)_____ for myself and/or my minor child. My choice has been voluntary and **I** understand that I may terminate therapy at any time.

Because psychotherapy is a joint effort between my therapist and myself, I will work with my therapist in a cooperative manner to resolve my difficulties. I understand there is no assurance that **I** will feel better.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and this may be necessary to help me resolve my problems.

I understand that confidentiality of records of information collected about me will be held or released in accordance with state and/or federal laws regarding confidentiality of such records and information.

I understand that state laws require that my therapist report all cases of abuse or neglect of minors or of the elderly.

I understand that state laws require that my therapist take mandated steps where there exists a danger to myself or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information and **I** will be informed of such circumstances prior to the disclosure.

I give permission to my therapist to disclose information and records necessary for continuation of treatment and processing of medical claims under current limits of state and federal law. I give permission for my therapist to file insurance forms on my behalf if requested, including electronic forms.

I understand that over the course of my treatment electronic communications may occur between myself and my IPG therapist and/or IPG's office staff, in the form of emails and/or or text messages, and that these communications may contain sensitive information about my healthcare. I understand that electronic communication, though encrypted for security, is not 100% secure.

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I understand that the Institute for Personal Growth is a group practice and that my therapist will participate in group and individual supervision where my case may be discussed with other therapists.

If, during my treatment at IPG, I transfer to a different therapist, or if I terminate treatment and return to IPG at a later time to see a different therapist, I give permission for my file, including clinical information, to be given to the new therapist.

I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one (1) year after all claims for treatment have been paid or treatment has been terminated, whichever is latest.

My signature attests that I have read the Informed Consent form and understood this information. I have received the attached forms.

Name of Client	Date
Signature of Client (if 14 yrs. or older)	Date
Parent/Guardian Name (if client is < 18)	Date
Signature of Parent/Guardian (if client is < 18)	Date

NOTICE OF PRIVACY PRACTICES

The Institute for Personal Growth and (Therapist Name) _____ are committed to keeping everything you share completely confidential. Whatever you speak about will not be shared with anyone else, outside IPG, without your written permission. However, there are certain limits to this confidentiality that you should know about.

1) If you have been referred by the court or any agency of the court, we may be required to furnish information to them.

2) If you are involved in certain kinds of litigation, such as worker's compensation, and inform the court of the services you have received from us, you may be waiving your right to have your records remain confidential. This would need to be clarified with your attorney.

3) If you threaten to harm yourself or someone else, we are obligated to inform potential helpers or victims. Information would be divulged only if we perceive that there is imminent danger to a readily identifiable victim, yourself, or the public. I am obligated to warn and protect if I believe you intend to carry out serious violence, even if you have not made a specific verbal threat.

4) If we have reason to suspect there is child abuse or neglect, we are obligated by law to report this to the appropriate state agency.

5) If we reasonably believe that a vulnerable adult is being abused, neglected, or exploited, we may report this information to the county adult protective services provider.

6) If you are a minor, your parents or guardians will be informed of your progress, if they ask. However, we will not reveal specific details of our conversations without your permission unless we determine that your safety is at risk.

7) Your health care insurance may require information to process claims or to authorize benefits.

8) If the New Jersey State Board of Psychological Examiners, the Board of Social Work Examiners, or the Board of Professional Counselor Examiners issues a subpoena, we may be compelled to testify before the Board and produce your relevant records and papers.

If you are concerned about some of your information, you have the right to ask us not to use or share it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we may not be able to agree to these

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limitations. However, if we do agree, we promise to comply with your wishes. You will be told if your information is shared per the privacy limitations listed above.

You have the right to request to receive confidential communication by alternative means and at alternative locations. For example, you could request that bills/statements be sent to a different address if you did not want a family member to know about them.

You can request to inspect, obtain a copy of, or amend information about yourself in our mental health or billing records. Under certain circumstances, your request may be denied, but you may be able to have this decision reviewed.

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, please discuss them with your therapist or Dr. Margaret Nichols, the Executive Director. You can also send a written complaint to the Secretary of the US Department of Health and Human Services.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent), and we will comply with your wishes about using or sharing your information from that time on. However, if we have already used or shared some of your information, we cannot change that. This form complies with federal regulations (HIPAA).

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Please sign and date this sheet to acknowledge that you have read and understood this notice of privacy policies.

Name of Client	Date
Signature of Client (if 14 yrs. or older)	Date
Parent/Guardian Name (if client is < 18)	Date
Signature of Parent/Guardian (if client is < 18)	Date

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COLLATERAL CONTACT POLICY
Institute for Personal Growth

A collateral contact is either a third party contacted by your therapist on your behalf with your permission for the benefit of your therapy, or personal contact with your therapist that is not during your scheduled session time. This contact may be in the form of a letter, a telephone call, a fax or in rare occasions a face to face meeting. No third party collateral contacts will be made by your therapist without your prior written consent in the form of an authorization form provided by IPG and signed by you giving permission for the contact. No personal collateral contact will be billed to you without your prior knowledge and consent.

Collateral contacts of either kind will be billed at the discretion of your therapist at a rate of $40.00 per hour ($10.00 per 15 minutes, $20 per 30 minutes etc.) You cannot use your health insurance to pay for collateral contacts. In the event of a collateral contact, your therapist will prepare a bill for you outlining the contact and the cost. You will never be billed for a collateral contact without your prior knowledge and consent.

[ ] I have read and understand this policy.

_____

Clients Name (please print)

_____ _____

(Client's Signature) (Date)