FREMOUW, SIGLEY & BAKER PSYCHOLOGICAL ASSOCIATES, PLLC

Independent Licensed Psychologists

Adult Information Form

1224B Pineview Drive
Morgantown, WV 26505
Email: Fremouw-sigley@comcast.net

Telephone: (304) 598-2300
Fax: (304) 598-2307
Website: www.fsbpsych.com

CLIENT INFORMATION

Name: _____ Date: _____ Sex: M____ F___
Birth Date: _____ Address : _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____ Next of Kin: _____
Relationship: _____ Phone of Kin: _____
Address of Kin: _____

HEALTH INSURANCE INFORMATION

Primary Care Physician Name: _____
Name of Policy Holder: _____ Birth Date of Policy Holder: _____
Address of Policy Holder: _____
Sex of Policy Holder: M __ F ___ Relationship to Policy Holder: Self ___ Spouse ___ Child____ Other____
Insurance Company Name: _____
Insurance Mailing Address: _____
ID Number: _____ Group Number: _____ Ins Co Phone: _____
Employer: _____ Ins. Phone Number for Mental Health: _____
Is there another health benefit plan? Yes _____ No _____ If yes, please provide:
Name of Other Insured: _____ Date of Birth: _____
Other Insurance Company Name: _____

CONTACT INFORMATION AND PERMISSION

Email: _____
I authorize: (Please indicate YES or NO for each option)

YES NO Leave a message on my home answering machine
YES NO Leave a message on my work voicemail
YES NO Leave a message on my cell phone voicemail
YES NO Leave a message with a family member/friend at my home
Only the following: _____
YES NO Contact me by mail at the following address (to include billing):
_____

BASIC BACKGROUND INFORMATION OF CLIENT

☐ I received an informed consent form and was given the opportunity to ask questions.
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐Separated ☐ Other ☐ N/A
Spouse/Partner's First/Last Name: _____
Children (First name, age): _____
Religious Affiliation: _____
Military history of client or immediate family members: _____
Persons living in my home: _____
Education (highest grade completed): _____ School: _____ Current grades: _____
What type of work do you do? _____
How long? _____ Employer: _____

YOUR COUNSELING HISTORY, NEEDS, AND GOALS

What is your most pressing reason for seeking counseling?:_____

What are your other concerns?: _____

How did you find out about our practice?: ☐ Website ☐ Search Engine ☐ Friend

Is counseling or evaluation requested?: ☐ Evaluation ☐ Counseling

Please tell me about your previous counseling experiences:

Provider	Where	When	How long	Useful? Y/N

Are you currently having suicidal thoughts? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever made a suicide attempt? ☐ Yes ☐ No When?_____

If yes, please explain: _____

Has anyone related to you ever attempted suicide?(☐Yes ☐No) or completed suicide?☐Yes ☐No

If yes, please explain: _____

Are you currently having homicidal thoughts? ☐ Yes ☐ No

If yes, please explain: _____

Have you or anyone related to you ever attempted a homicide? ☐ Yes ☐ No: When?_____

If yes, please explain: _____

Do you worry about your safety in your current living situation?: ☐ Yes ☐ No

If yes, please explain: _____

Have you ever struck or threatened people or animals or broken things in your home? ☐ Yes ☐ No

If yes, please tell me about it: _____

Have you engaged in any self-injurious behavior? ☐ Yes ☐ No

If yes, please explain: _____

What are your strengths? (check all that apply)

☐ Bright	☐ Insightful	☐ Motivated	☐ Active
☐ Have self-control	☐ Have friends	☐ Can calm myself	☐ Mostly healthy
☐ Can ask for help	☐ Keep my boundaries	☐ Have moral ethics	☐ Can solve problems
☐ Can forgive	☐ Can express feelings	☐ Have enough money to meet my needs	☐Resourceful
☐ Sense of humor	☐ Compassionate	☐ Patient	☐ Good listener
☐ Stable employment	☐ Satisfied with employment	☐ Willing to learn new attitudes and behaviors	☐ Can accept love and care from others

CLIENT SOCIAL HISTORY

How many times have you been married and for how long?_____

Is there anything unusual about your childhood that I should know?

_____

_____

Please list significant traumatic events or losses: _____

Please list brothers and sisters and their ages: _____

Please describe any significant legal history (i.e. arrest, bankruptcy): _____

Is there anything else significant that you want me to know?: _____

CURRENT SYMPTOMS

Current symptoms: (Please check all that apply and add details you believe are relevant in the blanks.)

- ☐ Depression _____
- ☐ Sleep Changes _____
- ☐ Appetite Change _____
- ☐ Crying _____
- ☐ Energy level _____
- ☐ Weight change _____
- ☐ Odd beliefs _____
- ☐ Memory problems _____
- ☐ Pain _____
- ☐ Thoughts to harm others _____
- ☐ Irritability _____
- ☐ Confusion _____
- ☐ Anxiety _____
- ☐ Anger problem _____
- ☐ Impulsivity _____
- ☐ Violent behavior _____
- ☐ School Problems _____
- ☐ Panic _____
- ☐ Self-injuries _____
- ☐ Racing thoughts _____
- ☐ Hearing voices _____
- ☐ Poor Concentration _____
- ☐ Seeing things _____
- ☐ Paranoia _____
- ☐ Suicidal thoughts _____
- ☐ Avoiding people/places _____
- ☐ Preoccupations/rituals _____
- ☐ Running away _____
- ☐ Sexual problems _____
- ☐ Mood swings _____
- ☐ Loss of pleasure _____
- ☐ Other _____

MEDICAL HISTORY

Family Physician: _____ Date of last physical examination: _____

Please check any illness client currently has or has had in the past:

☐ Diabetes	☐ High blood pressure	☐ Lung disease	☐ Venereal Disease
☐ Asthma	☐ Low blood pressure	☐ Cancer	☐ Head injuries
☐ Arthritis	☐ Heart disease	☐ Kidney disease	☐ Injuries
☐ Anemia	☐ Tuberculosis	☐ Cirrhosis	☐ Muscular Disorder
☐ Ulcer	☐ Colitis	☐ Bone disorder	☐ Obesity
☐ Seizures	☐ Nerve disorder	☐ Anorexia	☐ AIDS/HIV
☐ Alcohol/Drug Problems	☐ Migraines	☐ Urinary Tract Infection	☐ Headaches
☐ Constipation	☐ Thyroid Issues	☐ Surgeries:	

Is there any history of depression, mental illness, or alcohol/drug problems in your family of origin?:
☐ Yes ☐ No If yes, please explain: _____

Do you have any history of depression, anxiety, or mental illness? ☐ Yes ☐ No
If yes, please explain: _____

Please tell me about past hospitalizations (include psychiatric or substance abuse treatment):

Date	Reason	Hospital	Physician

Are you taking any medications now? ☐ Yes ☐ No If yes, please list below and include any over the counter medicines and supplemental herbs taken regularly:

Medication/Supplement	Dosage	How often?	Reason for Medication

Do you have any allergies? ☐ Yes ☐ No If yes, please list: _____
Do you use nicotine? ☐ Yes ☐ No Type: _____
How much caffeine do you consume?:
Estimated daily consumption of coffee or tea: _____ cups/day
Estimated daily consumption of soda or pop: _____ ounces/day

SUBSTANCE USE INFORMATION

Do you have a history of IV drug use? ☐ Yes ☐ No
Have you ever felt the need to cut down on alcohol consumption? ☐ Yes ☐ No
Have people annoyed you by criticizing your drinking habits? ☐ Yes ☐ No
Have you ever felt guilty about drinking? ☐ Yes ☐ No
Have you ever needed a drink first thing in the morning (eye-opener) to steady nerves or to get rid of a hangover? ☐ Yes ☐ No
Do you drink socially? ☐ Yes ☐ No If yes, how often?_____ how much? _____
How old were you when the first alcohol was consumed? _____
Have you ever attended: ☐ A.A. ☐ Alanon ☐ N.A.
Ever had a D.U.I.? ☐ Yes ☐ No If yes, how many? _____
Have you ever been arrested for a drinking or drug related offense of any kind? ☐ Yes ☐ No
If yes, please explain:

_____

★ CLIENT SIGNATURE

Signature of the client or authorized person allows release of information necessary to process insurance claims and authorizes direct payment of health insurance benefits to Fremouw, Sigley & Baker Psychological Associates. THIS INFORMATION WILL INCLUDE DIAGNOSIS, DATES OF TREATMENT, AND SOMETIMES TREATMENT PLAN.

_____ _____
Client Signature Date

FREMOUW, SIGLEY, & BAKER PSYCHOLOGICAL ASSOCIATES

(FSBPA)

Informed Consent to Service

11.1.18

We are a group of independent mental health professionals, under the name of Fremouw, Sigley, & Baker Psychological Associates. This group shares office space and secretarial/administrative resources. While we share a name and office space, we are completely independent in providing you with clinical services and **I ALONE AM FULLY RESPONSIBLE FOR YOUR SERVICES**. Our professional records are separately maintained and no other member of the group can have access to them without your specific, written permission.

Service

We provide both short and long term treatment for a variety of problem areas such as Behavioral Problems; Anxiety/Mood Disorders; Interpersonal Relationships; Grief/Loss; Family and Parenting; and Trauma.

Our professionals also conduct comprehensive evaluations in the following clinical areas: ADHD/Learning Disability, Gifted Program, Psychological Evaluations, and Bariatric Surgery Psychological Evaluations.

Forensic evaluations are conducted to address specific legal issues such as competency for involvement in the legal system, criminal responsibility, fitness for duty, risk assessment, parental fitness, and other issues.

Confidentiality

Our services are confidential. Visits to Fremouw, Sigley, & Baker Psychological Associates, PLLC are protected by the highest professional standards of confidentiality as specified by the Health Insurance Portability and Accountability Act (HIPPA, 1996), West Virginia state law, and the American Psychological Association's "Ethical Principles of Psychologists and Code of Conduct".

No records or information about you will be released without your consent, **except under the following circumstances:**

- When doing so is necessary to protect clients or someone else from imminent physical and/or life-threatening harm.
- When a client lacks the capacity or refuses to care for him/herself and such lack of self-care presents substantial threat to his or her well-being.
- When abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected.
- When a client pursues civil or criminal legal action against FSBPA or its staff, or when a client makes a complaint to a Professional Board about a clinician.

- When a client is involved in a legal proceeding and there is a court order for the release of records, or when a release is otherwise required by law.

Financial Policy

Payment for Services: YOU ARE ALWAYS RESPONSIBLE FOR YOUR BILL. There are payment options available: Insurance, check, cash, or credit card. In most cases FSBPA will be able to bill your insurance company directly. *However, this is a service we provide for you and it carries no guarantee of third party coverage.*

Fees & Explanation of Some Procedures:

Individual Therapy Intake: ($275 per session): This session will focus on diagnostic assessment.

Individual Psychotherapy: ($150 for 45 minutes session) ($xxx for 60 min).

Assessment/Testing: Includes the materials used for the assessment and the costs of scoring. ($175 - $275 per hour). Estimates will be provided prior to the evaluation.

Gifted Evaluations: ($375) These are not covered by insurance.

Forensic Evaluations: ($300 per hour) Estimates will be provided prior to the evaluation.

Insurance: Most insurance does not cover 100%; therefore, full payment (or co-payment if covered by insurance and the deductible has been satisfied) is expected at the beginning of the hour of the Date of Service (DOS). If you elect to have us bill your insurance company, you will have 90 days from the DOS to pay the balance in full, regardless of whether or not your insurance company has responded (most insurance companies reimburse within 60 days of billing). Deductibles that are not met require payment in full on the DOS. Insurance requires a medical diagnosis for each procedure – your plan may exclude certain diagnoses and, if so, you will be responsible for charges. We will do what we can to assist you with this, but ultimately it is your responsibility.

Insurance Confidentiality Limits: When insurance is used for therapy services, you should be aware of the limits of confidentiality. Typically, insurance companies only require the following information: length of illness, psychiatric diagnosis, dates of service, and the names of persons being treated. More and more managed care companies require additional information such as family abuse history, alcohol and drug history, treatment goals/interventions, the details of the treatment sessions, and on some occasions, treatment notes. In addition, providers are now required to sign waivers that allow the payers to audit client records. What this means is, if you utilize your insurance benefits for therapy services, you may not have the extent of confidentiality you would otherwise expect.

Cancellations: 24-hour notice must be given to cancel an appointment without charge. ***Note this does not include holidays. In the event of a late cancellation (less than 24 hours' notice) or a missed appointment, you may be charged a fee of $75.*** This is standard practice and is intended to preserve the time for those who may need it. The only exception to this policy are if the school

districts in your area is closed or Monongalia County school district is closed; or if client is hospitalized for any medical reason. Insurance companies do not pay for failed or late cancel or missed appointment fees. Client is required to pay this fee prior to or at the client's next scheduled appointment.

Contacting FSBPA

We are usually in the office Monday – Thursday between 8AM and 5PM, and Friday 8AM to 12PM. We probably will not answer the phone when with a client. When unavailable, the telephone will be answered by our secretary or an answering service. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please provide some times when you will be available.

In some emergencies, you might need more immediate help and cannot wait for us to return your call. These emergencies might involve:

- Suicidal thoughts of yourself or family member
- Thoughts of hurting yourself, family members, or others
- Other dangerous behavior by yourself or a family member

If an emergency like these, or some other crisis occurs when we are not immediately available, you should contact one of the following 24-hour emergency lines:

- Valley Health Center in Morgantown: 304-296-1731
- Valley Health Center in Fairmont: 304-366-7174
- Chestnut Ridge Hospital Helpline: 1-800-458-4898
- Rape and Domestic Violence Information Center: 304-292-5100
- Suicide Hotline: 1-800-273-8255 (TALK)

When you call these 24-hour emergency lines, tell them you are a client of FSBPA and that your therapist is unavailable at the time. Tell them the nature of the emergency so that they can determine how to advise you. The counselors working on these emergency lines will assist you with the crisis over the phone and/or might schedule an emergency appointment. They might also suggest you go to the emergency room at **Ruby Memorial Hospital, Monongalia General Hospital**, or some other facility so that someone can see you personally to offer help during non-business hours. When we have been informed of the emergency, we will discuss the crisis with the agencies you contacted.

Client Rights

HIPPA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting or most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected

information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and privacy policies and procedures. We are happy to discuss any of these rights with you.

Minors & Parents

If a child requests it and we believe that the child is sufficiently mature to make an independent decision about treatment, that child may have the right to independently consent to and receive mental health treatment without parental consent and, in that situation, information about that treatment cannot be disclosed to any without the child's agreement. While privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment, especially with younger children. Therefore, it is our policy not to provide treatment to a child under 14 unless he/she agrees that we can share whatever information we consider necessary with his/her parents. For children 14 and over, who are entitled to independently consent to treatment, it is our policy to request an agreement between the client and his/her parents allowing us to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Social Media Policy[1]

The following outlines office policies related to the use of Social Media. Please read it to understand how we use the Internet as a mental health professional and how you can expect us to respond to various interactions that may occur between us on the Internet.

Friending

We do not accept or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Interacting

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact us. These sites are not secure and we may not read these messages in a timely fashion.

Use of Search Engines

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with us via our usual

means (coming to appointments, phone, or email) this *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as a part of ensuring your welfare. These are unusual situations and if we ever resort to such means, we will fully document it and discuss it with you when we next meet.

Location-Based Services

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place our practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from our office or if you have a passive LBS app enabled on your phone.

Email

The use of email that is not encrypted does not protect your privacy. We prefer using email only to arrange or modify appointments if necessary. Never email us content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with us by email, be aware that all emails are retained in the logs of Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails we receive from you and any responses that we send you become part of your legal record.

Conclusion

Thank you for taking the time to review our Social Media Policy. If you have any questions or concerns about any of these policies and procedures or regarding our potential interaction on the Internet, please bring them to our attention so that we can discuss them.

1. Reproduced with permission of Keely Kolmes, Psy.D. – Social Media Policy – 4/26/10

FSBPA

Client Consent

I have read and agree with the information outlined in the Informed Consent (11.1.18) regarding my use of FSBPA Services. I hereby give my consent to authorize FSBPA to evaluate, treat, and/or refer me to others as needed. I have had the opportunity to discuss any questions regarding the above information.

PRINTED NAME:

_____

First Middle Last

Signature: _____ Date: _____

- ☐ **I have been provided with and read this Informed Consent.**
- ☐ **I have reviewed the HIPAA (Health Insurance Portability and Accountability Act).**

11.1.18

FSBPA

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_____

First Middle Last

Signature: _____ Date: _____

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FSBPA

Client Consent

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- ☐ **I have been provided with and read this Informed Consent.**
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