Bill Bray M.A., D.Min., LPC

Sunbird Office Park 4820 Rusina Road, Suite B, Colorado Springs, CO 80907 . Phone: 719 – 641 – 5188 . bill@drbillbray.com

Patient Information

Date _____

Name _____ Home Phone _____

Address _____
Street City State Zip

Birth date _____ Age _____

Place of Work _____ Work Phone_____ Cell _____

Email *(optional)* _____(Gives permission to be sent appointment information, notices of new therapy groups and learning opportunities, or therapy assignments. *Your email address will NEVER be shared.*)

Spouse/Partner Information

Name _____ Home Phone _____

Place of Work _____ Work Phone _____Cell _____

Are you married? _____ For how long? _____ Have you been divorced? _____ How many times?_____

List the names of children in your family, their ages, and who they live with if other than parents.
Also list others who live in the home.*(Use back as needed)*

_____ _____
_____ _____
_____ _____
_____ _____

Have you experienced any deaths of family members or others close to you? Briefly describe. *(Use back as needed)*

Primary Care Physician (and/or Psychiatrist if applicable) _____Last time seen _____

List any medications you are presently taking _____

Have you been hospitalized in the last four years? _____ If yes please describe reason and date of hospitalization. *(Use back as needed)*

Have you gained or lost more than 5 pounds in last six months? _____ Do you smoke? _____
How many packs per day?_____

How much alcohol do you consume on a daily basis? _____On a weekly basis?_____

Do you consider yourself an alcoholic? _____ How many cups of coffee do you drink on a daily basis? _____

Have you ever used illegal drugs? _____

How many jobs have you held in the past 5 years? _____ Have you ever been suicidal? _____

If you have been to counseling before, briefly describe when, who the counselor was, and the reason for counseling. *(Use back as needed)*

How did you learn of my services?

May I send a verbal or written thank you to this individual or organization?

HISTORY

NAME: **DATE:**

Read the following and check (√) all items related to the problem(s) that bring you to counseling.

FAMILY PROBLEMS	√	EMOTIONAL ISSUES	√	MEDICAL/PHYSICAL PROBLEMS	√
Unstable Home Environment		Fear, Phobia, Nightmares		Acute or Chronic Illness	
Custody Issues		Anxious, Nervous, Worry		Permanent, Temporary Disability	
No Family Contact		Sad, Hurt, Lonely		Digestive	
Domestic/Family Violence		Uncontrollable Crying		Rapid Heartbeat	
Parenting or Parents		Anger, Frustration, Rage		Sleep Disturbance	
Personal Relationship Difficulty		Depressed, no Energy, Motivation		Weight Loss Or Gain	
Family Relationship Difficulty		Trouble Concentrating		**FAMILY/SELF HISTORY OF:**	
Weak Social Skills		Compulsive Behaviors		Alcoholism/Drug Abuse	
WORK/ ISSUES		Repetitive Behaviors or Thoughts		Chronic Physical or Mental Illness	
Can't hold a Job		Lying		Criminal Activity	
Poor Attitude		Perfectionist		Depression	
Terminated from Job		Needing To Be Right		Eating Disorders	
SCHOOL ISSUES		Procrastination		Abuse	
Absenteeism		Feeling Hopeless		Suicide/Suicide Attempts	
Learning Disabilities		Feeling Like A Victim		Violence	
Poor Attitude		Victim of Violence		**SUPPORT**	
Behavior, Discipline Problems		Feeling Misunderstood		People in My Life are Supportive	
ADDICTIONS		Feeling Out Of Control		**EVENTS OF THE PAST YEAR**	
Drugs		Feeling Unfriendly		Alcohol or Drug Treatment	
Alcohol		Feeling Worthless		Bankruptcy	
Gambling		Feelings Of Guilt		Death of Significant Other	
Legal Problems		Holding Grudges		Psychiatric Treatment	
Job Jeopardy		Jealousy		Divorce	
		Blaming Yourself or Others		Job Change, Retirement	
		Withdrawing From Others		Marriage, Remarriage	
		Fear of Being Alone, Abandoned		Move	
		Dislike Being Touched		Serious Injury, Surgery, Illness	
		Excessive Risk-Taking		Stillbirth, Miscarriage, Abortion	
		Believing "Not Good Enough"			

PLEASE COMPLETE

Briefly describe the problem that brings you here today:_____

_____

Please provide any additional information you think might be helpful. _____

_____

COUNSELOR NOTATIONS

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NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures without Your Written Authorization. I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: I may use and disclose PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.

2. Payment: I may use or disclose PHI so that services you receive are billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Healthcare Operations: I may use and disclose PHI in conjunction with my health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: I may use, or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

1. Psychotherapy Notes: Notes recorded by clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. Marketing Communications. I will not use your health information for marketing communications without your written authorization.

Other Uses and Disclosures: Uses and disclosures other than those described above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, school, or to your attorney. You may revoke any such authorization at any time.

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YOUR INDIVIDUAL RIGHTS

1. Right to Inspect and Copy: You may request access to your medical record and billing records maintained by me in order to inspect and request copies of records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your record. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

2. Right to Alternative Communications: You may request and I will accommodate any reasonable written request for you to receive PHI by alternative means of communication or at alternate locations.

3. Right to Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to me at the address listed in this form. I am not required to agree to any such restriction you may request.

4. Right to Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restriction and limitations.

5. Right to Request Amendment: You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

6. Right to Obtain Notice: You have the right to obtain another paper copy of this Notice by submitting a request to me at any time.

Questions and Complaints: If you desire further information about your privacy right, or are concerned that I have violated your privacy rights, you may contact me at the address listed in this form. You may also file written complaints with the Director, Office for Civil Rights of the U. S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or myself.

EFFECTIVE DATE AND CHANGES TO THIS NOTICE

This Notice is effective April 14, 2003. I may change the terms of this Notice at any time. If I change this Notice, I may make the new Notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new Notice. If I changed this Notice, I will post the revised Notice in the waiting room. You may also obtain any revised Notice by contacting me.

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Licensed Professional Counselor
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Adapted from Miller Nash, LP, 2002

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Privacy Notification

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Bill Bray.

_____ _____

Signature of Client (or personal representative) ***Date***

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

I attempted to obtain written acknowledgement of the receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented me from obtaining acknowledgement

_____ Other (Please specify) _____

This form will be retained in your medical record.

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Your Rights as a Client

The practice of both licensed and unlicensed persons in the field of psychotherapy including psychological testing is regulated by the Colorado State Department of Regulatory Agencies. Any questions, concerns or complaints regarding the practice of mental health counseling may be directed to the State Grievance Board, 1560 Broadway, Suite 1340, Denver, CO 80202; (303) 894-7766.

You are entitled to receive information from me about my methods of therapy, techniques I use, duration of therapy, if I can determine it, and my fee structure. Please ask if you would like to receive this information. You may seek a second opinion from another therapist or may terminate therapy at any time.

You should know that in a professional relationship, sexual intimacy between a therapist and a client is never appropriate. Sexual indiscretion should be reported to the State Grievance Board.

Information provided by a client during therapy sessions is legally confidential except for certain legal exceptions which include: 1) I am required to report suspected child abuse or neglect to the appropriate law enforcement agency; 2) If I receive information from a client concerning a serious threat of imminent physical violence against a specific person, I must inform that person of the threat, and also notify law enforcement authorities; 3) I am required to initiate a mental health evaluation of a client who is dangerous to self or others due to a mental disorder. You should be aware that legal confidentiality does not apply in a criminal or delinquency proceeding. You should also be aware that confidentiality does not apply if I become aware that you are physically or sexually abusing another individual, or that you plan to hurt yourself or someone else, or that you plan to commit suicide.

I am licensed to practice psychotherapy in the state of Colorado as a Licensed Professional Counselor, Colorado License #5267. I have a Master of Arts in Counseling Psychology from the University of Colorado (1990) and a Doctorate in Applied (Practical) Theology from Phillips University Graduate Seminary (1985), now known as Phillips Theological Seminary. You should be aware that it is usual and customary for mental health professionals to seek peer consultation on cases and this is done in a manner that protects the confidentiality of the client. You should be aware that when you sign your request for reimbursement from your insurance company that you give permission for them to obtain information about your diagnosis and the progress of your therapy. In addition, you should understand that if either one of us uses cellular telephones, information transmitted by one or both of us may be intercepted by a third party.

Also, you authorize with your signature below that in the event of my death or grave disability, one or more of my selected colleagues may review confidential information I have collected about you or your dependent(s) in order to advise you of options for the continuity of treatment.

I have been informed of my counselor's degrees, credentials, and licenses. I have also read the preceding information and understand my rights as a client.

_____ _____

Client Signature (Parent or Guardian for minor) ***Date***

_____ _____

Bill Bray, M.A., D.Min., LPC ***Date***

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Insurance Information

General Client Information

Name_____ Age_____ Sex____ Date of Birth_____

Street Address_____

City_____ State_ _____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

Insurance Information

Member ID #_____ Group #_____

Plan Name_____

Insured Name & Address *(if different than above)* _____

_____

Insured Date of Birth *(if different than above)* _____

Insured's Employment_____

Is there another Health Benefit Plan? _____ If yes, please name_____

Authorization I.D. #_____

Number of Sessions Authorized _____

Payment Authorization

I authorize payment of medical benefits from my insurance plan to Bill Bray, LPC for psychotherapy services rendered. I accept responsibility for making the appropriate co-payments.

Also, I authorize the release of any medical or other information necessary to process insurance claims.

In the event that Bill Bray, LPC is not reimbursed by my insurance company for services rendered, I accept responsibility for payment of psychotherapy charges.

Signed_____ Date_____

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Office Policies and Information

As we consider entering into a therapeutic arrangement, I would like to provide you with information that familiarize you with my services and procedures. I encourage you to seek clarification and discuss my policies or ask any other questions that you may have.

Appointments:

Individual and family therapy sessions are 50 minutes in length. Some sessions may be longer, however, dependent on several factors. It is necessary to notify me at least 24 hours in advance if you must cancel your appointments. You will be charged your full fee for failure to cancel prior to 24 hours in advance unless you were in an emergency situation. If you anticipate being late for a session, I would appreciate a call to let me know. Unless I hear from you, I will consider the session canceled after 20 minutes. If you miss a session, you will need to reschedule or confirm our next appointment.

Inclement Weather:

Please consider your safety in the event of severe weather. Please do not attempt to come to your appointment if the weather could pose hazardous driving conditions. You will NOT be charged for a missed session if it is due to severe weather, but I do expect a call to let me know.

Payment for Services:

If I will not be billing your insurance, your fee will be discussed with you at the time your appointment is scheduled, and again during the first session. *You will be responsible for payment of services at the beginning of each session unless prior arrangements have been made.* I work on a sliding scale **based on annual household income**. Please circle your income.

Annual Income
$30,000 or less
$31,000 - $50,000
$51,000 - $70,000
$71,000 - $90,000
$91,000 or more

Session Fee:_____

My signature constitutes the acceptance of conditions set forth in this agreement.

_____ _____
Signature of Client/Responsible Party Date

PATIENT HEALTH QUESTIONNAIRE - PHQ-9 [15]

Nine Symptom Depression Checklist

Patient Name: _____ Date: _____

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all 0	*Several days* 1	*More than half the days* 2	*Nearly every day* 3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

Total # Symptoms: _____ Total Score: _____