Grief Recovery Center
Client Contact Information Form

First Name _____ MI ____ Last Name _____

Address _____

City _____ St _____ Zip _____

Phones: H (____) _____ W (____) _____ Cell (___) _____

Email Address _____

Language: ___ English _____ Other (please specify) _____

Preferred Method of Contact: ___ Cell Phone ___ Home Phone ___ Work Phone ____ Email*

Emergency Contact _____
Name

_____
Address City State Zip

(_____)_____ _____ _____
Phone Relationship to Client Emergency Contact Date of Birth

Release Statement

I understand that by signing this statement I give Grief Recovery Center permission to contact me in the manner I have indicated below. I understand that this consent may be revoked by me or by my representative in writing at any time.

Grief Recovery Center may send correspondence to:

_____ my address

_____ my e-mail *I understand that Grief Recovery Center CANNOT assure confidentiality with email*

When calling the contact numbers listed on this application Grief Recovery Center staff may:
(Check all that apply)

_____ leave messages on home answering machine

_____ leave voice mail and text on cell phone

_____ leave messages on work voice mail

_____ not leave voice messages

_____ speak with anyone who answers the phone(s)

_____ speak with the following person(s): (please list the individual names)

_____

_____

Client Signature: _____ **Date:** _____

If client is unable to sign, client's personal representative, parent, or guardian must sign

Representative, Parent or Guardian Signature: _____ **Date:** _____

Reason that client is unable to sign: _____

Office Use: Administrative – Reminder Call Release

2a

Grief Recovery Center
4939 Jamestown Avenue, Suite 101
Baton Rouge, LA 70808
P: (225) 924-6621 F: (225) 924-6627

Medical Insurance and Release of Information

Client's Name: _____

Name of Primary Insurance: _____

Group #: _____ Member ID #: _____

Policy Holder's Name: _____
(Last) (First) (Middle)

Policy Holder's Address: _____
(Street) (City) (State) (Zip)

Relationship to Client: _____ Date of Birth: _____

Employer's Name: _____ Phone #: _____

Name of Secondary Insurance: _____

Group #: _____ Policy/Plan #: _____

Policy Holder's Name: _____
(Last) (First) (Middle)

Relationship to Client: _____ Date of Birth: _____

Employer's Name: _____ Phone #: _____

_____ **(Initial) I understand that a fee of $50.00 will be charged for any NSF check.**

_____ **(Initial) I authorize the release of any and all information necessary for collection purposes in the event of non-payment for services rendered, including the mailing of invoices and statements to the address I have provided.**

_____ **(Initial) I Understand That I May Be Responsible for the Full Appointment Fee for All Appointments Which I Do Not Cancel At Least 24 Hours in Advance**

_____ **(Initial) I understand that I have a choice of providers and may exercise that choice at any time.**

I hereby authorize the release of any medical or other information necessary to process my medical insurance claim. I further hereby authorize the assignment of payment by my insurance company of medical benefits to the Grief Recovery Center, Inc. for services rendered. I understand and accept responsibility for any payments due for any services not covered or denied by insurance, including co-payments and deductibles.

SIGNATURE REQUIRED _____ Date _____

____ **Yes** ____ **No** **Grief Recovery Center may send basic billing correspondence by email to our billing service.**

SIGNATURE REQUIRED _____ Date _____

2b

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavior health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow Grief Recovery Center to share your protected health information (PHI) to your Primary Care Physician (PCP). ***This information will not be released without your authorization.*** *This PHI may include diagnosis, treatment plan, and progress, if necessary.*

I, _____ _____ authorize Grief Recovery Center
Client Name – Please Print Date of Birth – MM/DD/YYYY
to release protected health information related to my evaluation and treatment to:

PCP Name:_____ PCP Phone: _____

PCP Address: _____

Information to be completed by Behavioral Health Provider

I saw _____ on _____ for
_____.
Client Name – Please Print Date Reason/Diagnosis

Treatment recommendations: _____ psychotherapy sessions.
If you have any questions or would like to discuss this treatment, please call me at: **225-924-6621**

_____ _____
Provider Signature Provider Printed Name
_____
Licensure

Client Rights

- **You make request to end this authorization at any time by contacting our Office Manager.**
- **You cannot be required to sign this form as a condition of treatment.**

Client Authorization

I, the undersigned, understand that I may revoke this consent at any time. This consent shall expire 12 months from signature. I have read and understand the above information and give my authorization:

_____ To release information to my PCP that I have been seen by a therapist at Grief Recovery Center for treatment of a specific reason/diagnosis.

_____ To release information to my PCP that I have been seen by a therapist at Grief Recovery Center for treatment of a specific reason/diagnosis and my treatment plan.

_____ **I DO NOT** give my authorization to release any information to my primary care physician.

_____ _____ _____ _____
Client Signature Date Signature of Representative Date

Office Use: Administrative – PCP Release

3a

Grief Recovery Center
Clinical Intake Form

Today's Date: _____

First Name _____ MI ____ Last Name _____

Address _____

City _____St ____ Zip _____ Parish_____

Phones: H (____) _____ W (____) _____ Cell (____) _____

Email Address _____

Gender _____ Birth Date _____ Race_____ Religion _____

Relationship Status: Single_____ Married_____ Separated_____ Divorced_____

Widowed_____ Domestic Partnership _____

Occupation _____ Education _____

Place of Employment _____

Who referred you or how did you hear about us _____

Briefly describe your reasons for seeking therapy now_____

_____

_____

_____

List family members and all others living in your home:

Name(s) M/F Age Relationship Occupation

_____

_____

_____

_____

_____

3b

Clinical Intake Form – Cont'd

Personal Physician _____ Last Visit _____

List any medications you are now taking, including medication, frequency taken, and strength _____

_____

List any health problems _____

_____

Do you smoke? Yes____ No ____ If yes, how much per day _____

Do you drink alcoholic beverages? Yes _ No ____ If yes, how much _____

Any previous treatment for substance abuse? Yes _____ No ___ If yes, when_____

Any previous psychotherapy counseling? Yes ___ No ____When_____

Please Circle Any Of The Following Items Which Pertain To You:

Nervousness	Depression	Fears	Finances
Sexual Problems	Relaxation	Unhappiness	Sleep
Suicidal Thoughts	Alcohol Use	Tobacco Use	Drug Use
Legal Matters	Making Decisions	Separation	Divorce
Self-Control	Headaches	Stress	Work
Concentration	Inferiority	Loneliness	Shyness
Health Problems	Tiredness	Insomnia	Anger
My Thoughts	Career Choices	Education	Ambition
Stomach Problems	Bowel Troubles	Appetite	Energy
Death in Family	Elderly Parent(s)	Parenting	Children
Nightmares	Marriage	Friends	Memory
Irritability	Gambling	Crime	Temper
Relationship	Aggression	Resentment	Nightmares

_____**(Initial) In an instance of repeated non-compliance with scheduled appointments the Grief Recovery Center reserves the right to discontinue treatment.**

Signed: _____ Date: _____

4a

Grief Recovery Center
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P: 225-924-6621 F: 225-924-6627

LCSW/LPC/LFMT Disclosure Statement

Each client has the right to:

1. Expect that the social worker or counselor has met the minimal qualifications of education, training, and experience required by state law;
2. Examine public records maintained by the Board which contain the social worker's or counselor's qualifications and credentials. Social Work Board is located at 18550 Highland Road, Suite B, Baton Rouge, LA (225) 756-3470); the LPC and LMFT Boards are located at 8631 Summa Ave., Ste. A, Baton Rouge, LA
3. Obtain a copy of the standards of practice upon request for a nominal fee;
4. Report a complaint about the social worker's or counselor's practice to their respective Boards;
5. Be informed of the range of fees for professional services before receiving the services (standard fee $100.00 per one-hour regular session and $120.00 for initial session);
6. Privacy as allowed by law, and to be informed of the limits of confidentiality,
   Exceptions to confidentiality are:
   A. Intent to harm yourself or others,
   B. Physical and/or sexual abuse of a minor(s),
   C. Physical and/or sexual abuse of an elderly person(s)
   D. Commission of a crime;
7. Expect that the social worker or counselor will take reasonable measures consistent with the social worker's or counselor's duty of confidentiality to limit access to client information and any expressed waivers or authorizations executed by the client. Reasonable measures include restricting access to client information to appropriate agency or office staff whose duties require such access.
8. Receive information that a social worker or counselor is receiving supervision and that the social worker or counselor may be reviewing the client's case with the social worker's or counselor's supervisor or consultant. Upon request, the social worker or counselor shall provide the name of the supervisor and the supervisor's contact information.
9. Be free from being the object of discrimination while receiving social work or counseling services; and
10. Have access to records as allowed by law.
11. I understand that my file will be closed three (3) months after my last visit and that if I return after that time a new file will be opened.

I have reviewed this Disclosure Statement and have received a copy for my records.

Signature: _____ Date: _____

Print Name: _____

Office Use – Administrative – HIPAA

4b

Privacy Policy

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This form is a shorter version of the full, legally required NPP (Notice of Privacy Practices) and you may have a copy of this to read and to refer to it for more information. However, we can't cover all possible situations so please talk to a staff member about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations.

If you do not consent and sign this form we may not be able to treat you.

Of course, we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public
    a. Intent to harm yourself or others,
    b. Physical and/or sexual abuse of a minor(s),
    c. Physical and/or sexual abuse of an elderly person(s)
    d. Commission of a crime

    We will only share information with a person or organization that is able to prevent or reduce the threat.
2. Some lawsuits and legal court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which do not happen very often. You can ask about these situations.

Your rights regarding your health information.

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you such as your routine medical and billing records. The client does not have access to Psychotherapy Notes. You can even get a copy of these records but we may charge you. Contact a staff member to arrange how to see your records.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our office. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always obtain a copy of the NPP from a staff member.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with a member of our staff and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. Someone from our office will be happy to discuss these situations with you as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact one of staff members at 225-924-6621.

Signature: _____ Date _____

Print Name: _____

Grief Recovery Center, 4939 Jamestown Ave., Suite 101 Baton Rouge, LA 70808
Phone: (225) 924-6621 Fax: (225) 924-6627

Client Copy

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Client Copy (Please keep for your records)

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	