

Today's Date: Referred by:

Name: Last First MI Maiden Name

Address: Street City State Zip E-Mail Address

Telephone: work home pager cellular

Birth Date: Age: Gender: SS#: Living Situation/Dates: married, single, other arrangement

Previous Marriage(s): Education /Training: dates/length/name of spouse(s) years/degrees/institutions/dates

Military Service/Dates: Religion: branch/dates childhood present

Employer: How Long? Occupation:

Employer's Address: Street City State Zip

Emergency Contact: Relationship: Phone:

INSURANCE INFORMATION

(Please give us your insurance information even if you are here on an Employee Assistance Plan)

If your insurance company requires prior authorization, have you obtained it? Yes No Not Required authorization code

Insurance Company: Phone:

Address: Street City State Zip

Policy Holder: Birth Date: Relationship to Client: SS#:

Employer: Group Number: ID Number:

Secondary Insurance: Phone:

Address: Street City State Zip

ID Number: Group Number:

PATIENT OR AUTHORIZED PERSON'S SIGNATURE (Required): I authorize the release of any medical or other information necessary to process a claim. I authorize payment of medical benefits to the provider of services. I accept responsibility for paying any amount not covered by insurance.

Signed: Date:

For Office Use Only

Dx: DSM-IV: Ins. card to billing Face sheet to billing

Special Instructions: Auth. to billing No. of visits auth'd

Presenting Problems

Describe the problem(s) that brought you here today:

Symptoms Check any symptoms that you are having/or have had recently:

- | | | |
|---|--|---|
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Extreme sadness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Feeling of extreme happiness | <input type="checkbox"/> Feeling stressed | <input type="checkbox"/> Self-esteem problem |
| <input type="checkbox"/> Lack of enjoyment of usual activities | <input type="checkbox"/> Easily irritated | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Feeling keyed up/on edge | <input type="checkbox"/> Feeling guilty | <input type="checkbox"/> Feeling nervous or anxious |
| <input type="checkbox"/> Fear of situations where escape is difficult | <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Sudden feelings of panic |
| <input type="checkbox"/> Not getting along with friends/family | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Obsessions or compulsions |
| <input type="checkbox"/> Change in sleeping habits | <input type="checkbox"/> Trouble performing your job | <input type="checkbox"/> Self-starvation |
| <input type="checkbox"/> Paranoid thoughts | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Reckless behavior |
| <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Mind going blank | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Increased use of alcohol/drugs | <input type="checkbox"/> Avoiding things | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Thoughts about hurting yourself | <input type="checkbox"/> Thoughts about killing yourself | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Thoughts about hurting others | <input type="checkbox"/> Thoughts about killing others | <input type="checkbox"/> Acting violently |
| <input type="checkbox"/> Problems with anger | <input type="checkbox"/> Intrusive thoughts | <input type="checkbox"/> Poor interpersonal skills |
| <input type="checkbox"/> Physical complaints of pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Low energy |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Numbness | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Stomach or bowel problems | <input type="checkbox"/> Change in eating habits |
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Chronic weakness | <input type="checkbox"/> Nerve problems |
| <input type="checkbox"/> Exaggerated startle response | <input type="checkbox"/> Trembling/twitching | <input type="checkbox"/> Muscle tension/aches |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heart symptoms | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sweating/clammy hands | <input type="checkbox"/> Change in sexual function | <input type="checkbox"/> Change in sexual interest |
| <input type="checkbox"/> Gender issues | <input type="checkbox"/> Fatigue | |

Goals for Therapy

What are your goals for treatment?	How would you measure improvement?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

MEDICAL INFORMATION

What medical health problems do you have? (Please explain)

--

Do you have any allergies (e.g. to prescription meds, over-the-counter meds, other things)? Yes No

What are you allergic to and what kind of reaction do you have?

--

Have you seen a doctor within the past year? Yes No

Name of Doctor	Phone	Diagnosis	Purpose of Visit	Outcome

Are you taking any medication (Prescription, over-the-counter or herbal remedy)? Yes No

Medication	Purpose	Dosage	Start Date	Prescribed By

SUBSTANCE USE HISTORY

Have you ever used tobacco in any form? Yes No

(Please describe the history and current pattern of your tobacco use.)

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Have you ever used alcohol? Yes No

(Please describe the history and current pattern of your alcohol use.)

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Have you ever used caffeine (any form, including cola drinks)? Yes No

(Please describe the history and current pattern of your caffeine use.)

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Have you ever used illegal drugs of any kind? Yes No

(Please describe the history and current pattern of your drug use including which drugs.)

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Client-Therapist Agreement

Confidentiality:

All information you share with me remains confidential with the following exceptions. Oregon law stipulates that if I believe you are a physical danger to yourself or others or that there is physical abuse of a child or an elderly person I must report it to the proper authorities. Also, your insurance company has the right to request information to determine your eligibility to receive insurance benefits.

If either you or I believe it would be helpful for me to exchange information with another professional, your physician for example, We can discuss this and if we agree, then you will need to sign an authorization for this to occur and I will then contact that person.

Fee Schedule:

My standard fee for a 50-minute session is \$120. The initial session on insurance is considered an assessment and is \$180. Longer sessions are charged proportionately. I also charge at the same rate for significant amounts of time spent on phone calls, report preparation or contacting other professionals, family members, etc. Travel time to home visits, hospital visits, etc. is charged at 50% of the usual rate.

Additional fees are as follows: (None of these fees can be paid for through your insurance benefit.)

- After hours: Any session that begins before 8:40 AM or after 4:30 PM, or that occurs on the weekend is \$12 extra, \$18 for an extended session.
- Early Cancellation: A cancellation with more than 48 hours notice is \$24. This fee is waived if you reschedule within the same week and there is no rescheduling fee.
- Late cancellation: A cancellation with less than 48 hours notice is \$48. This fee is waived and you only have to pay a \$12 rescheduling fee if you reschedule within the same week.
- Failed appointment: If you do not come to your appointment and do not notify me in advance the fee is \$72. This fee is waived and you only have to pay a \$12 rescheduling fee if you reschedule within the same week.
- Group: My standard fee for group therapy is \$60 per session and sessions run about an hour and 45 minutes.

Please pay all fees at the beginning of each session. Client who are not on insurance and pay in full at the time of service will receive a 10% discount. If you believe that your insurance will pay for part of your therapy you need only pay your deductibles and copays instead of the full fee for the session. Bank fees for returned checks will be billed to you. If you have more than one returned check you will be required to pay in cash or money order at the beginning of each session.

Urgencies and Emergencies:

If it is important that you reach me on an urgent matter, please call my office number, 503 228-7574. If I do not answer, your call will be sent directly to my voice mail. If you leave a message on my voice mail I will automatically be paged and I will respond as soon as possible. I also carry a cellular phone for this purpose. Of course, if your matter is an emergency, dial 911.

Termination:

You have the right to either terminate therapy or request referral to another therapist at any time. If you are considering either possibility, it is important that you discuss that decision in the therapy session. Since therapy is a cooperative and often emotional venture, please raise any such thoughts that you have so that we can consider them together. Also, if you find yourself reacting to me in any way, it is enormously helpful to discuss this in the session.

I have read and understand the above information. I understand that if for any reason my insurance company does not pay any portion of my bill it will be my responsibility to pay it and I will do so in a timely manner and not more than 60 days from notification by the insurance company of nonpayment. I recognize that these policies are subject to change without notice. I have received a copy of this document and I agree to abide by the terms set forth herein:

Client's Signature: _____ Date: _____

(This form must be read, signed, and dated in order to receive treatment.)

Health Care Coordination Form

Because of my commitment to improving my clients' overall health and because physical and mental health profoundly affect one another, I encourage the notification of significant health care providers that therapy is taking place. This form serves to allow me to exchange information and ideas with a provider in order to maximize the quality of care for the client.

Health Care Professional:

Name: _____ Clinic Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Patient/Client:

Name: _____ DOB: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____
work. home pager/cellular

Presenting Problems:

- Alcohol, Depression, Anxiety, Drugs, Job/School, Legal, Marital/couple, Family/parenting, Financial, Trauma history, Stepfamily issues, Other

Current Psychotropic Medications:

Table with 5 columns: Medication, Purpose, Dosage, Start Date, Prescribed By

Release of Information:

I understand that this form serves as notification to my medical provider that I am currently in therapy. I hereby give permission for my health care provider and my therapist, John C Flanagan, LCSW to exchange any information that in their judgment will enhance my overall health and well being.

Signature: _____ Date: _____
(Please note that failure to sign this authorization will not prevent you from receiving therapy.)

Treatment Information:

Outpatient care is being delivered and the treatment plan includes the following modalities:
Individual therapy, Couples Therapy, Family Therapy, Group Therapy, Frequency: _____

Dx: _____ Date of First Session: _____
Therapist's comments: _____

Therapist's Signature: _____ Date: _____

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Client's copy. Please keep this copy to refer to when you have questions!