**Background Information**

**Full Name:**

**Street Address:**

**City:** **Zip Code:**

**Phone Numbers that Allow for Messages Left:**

| | |
|---|---|
| **Home:** | **yes / no** |
| **Cell:** | **yes / no** |
| **Work:** | **yes / no** |

**Date of Birth:**

**Age:**

**Purpose of the Visit:**

**Referred by:**

**Reason for referral:**

**Length of symptoms:**

**Please list any prior psychological or psychiatric treatment (dates, provider names, type of service)**

**Medical History:**

**Primary Care Provider:**

**Date of Last Physical:**

**Current or Chronic Medical Conditions:**

**Surgeries:**

**Significant Injuries:**

**Non-Psychiatric Medications:**

**Psychiatric Medications:**

**Medication Allergies:**

**Any psychiatric medications tried in the past? If yes, please indicate how they worked and significant side effects.**

**Psychiatrist/Managing Physician for Medications:**

**Do you smoke: yes / no**

**Do you consume alcohol: yes no**

**If so, what is the typical range of drinks you consume in one week (1 glass wine=1 shot hard alcohol=1 beer): _____ to _____**

**School History:**

**Highest grade completed:**

**Degrees:**

**Other Activities While in School:**

**Any learning/emotional/peer/significant other issues while in school?**

**Work History:**

**Type of work:**

**Work history:**

**Level of stress associated with work:**

**Family history:**

**Members of family-of-origin (household in which you were raised):**

| Family member | Age | Nature of Relationship |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

**Any treated of suspected emotional conditions in your family? Please include cousins/aunts and uncles/grandparents.**

**Any alcohol or substance abuse issues in the family-either suspected or treated?**

**Any history of suicide attempts in the family (if so please provide information)?**

**<u>Support Network:</u>**

**Marital status/Partner:**
**single married partner divorced separated widowed**

**Any children (if yes, please list ages):**

**Religious affiliation:**

**Interests:**

**Other sources of support:**

**Emotional Symptoms:**

| | CURRENT: | PAST: | NOTES: |
|---|---|---|---|
| **Depression** | | | |
| **Anxiety** | | | |
| **Panic Attacks** | | | |
| **Obsessional Thoughts** | | | |
| **Moodiness** | | | |
| **Rage** | | | |
| **Aggressive Behavior** | | | |
| **Difficulty Sleeping** | | | |
| **Agitation** | | | |
| **Concentration Issues** | | | |
| **Motor Slowing** | | | |
| **Tearfulness** | | | |
| **Hallucinations** | | | |

| | | | |
|---|---|---|---|
| **Thoughts of Self-Harm** | | | |
| **Thoughts of Other Harm** | | | |
| **Suicide Attempts** | | | |
| **Other** | | | |

**Any history of partial or inpatient treatment for emotional issues?**

**Have these symptoms interfered with work, relationships, or other important aspects of your life?**

**Have I missed anything?**

**Your goals for treatment:**

**1.**

**2.**

**3.**

**Other:**

**Emergency Contact Person (Name/Telephone Number):**

**WASHINGTON DC AND VIRGINIA NOTICE FORM FOR HIPAA:**
**Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information**

**Uses and Disclosures for Treatment, Payment, and Health Care Operations:**

I may use or disclose your protected health Information (PHI) for your treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations"

Treatment is when I provide, coordinate or manage your healthcare or other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or other psychologist.

Payment is when I obtain reimbursement for your healthcare. Examples of payment are when you disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health care operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and coordination.

"Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

"Authorization" is your written permission to disclose confidential mental health information. All authorization to disclose must be on a specific legally required form.

**Other Uses and Disclosures Requiring Authorization:**

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances, when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during private, group, joint, or family counseling sessions, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization of PHI or Psychotherapy Notes at any times, provided each revocation is in writing. You may not revoke an authorization to the extent that: I have relied on that authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, or if the law provides the insurer the right to contest the claim under the policy.

**Uses and Disclosures with Authorization:**

I may use of disclose PHI without your consent or authorization in the following circumstances-

Child Abuse: If I know, or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being mentally, physically abused or neglected, I must immediately report such knowledge or suspicion to the appropriate authority.

Adult and Domestic Abuse: If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must immediately report this belief to the appropriate authorities.

Health Oversight Activities: If the DC Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.

Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information Ion is privileged under DC law, and I will not release information without the written authorization of you, your legally appointed representative, or a court order. The privilege does not apply when a third party is evaluating you, or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If I believe that disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose PHI to the appropriate individuals.

Worker's Compensation: If I am treating you for Worker's compensation purposes, I must provide periodic progress reports, treatment records, and bills upon request to you, THE DC Office of Hearings and Adjudication, your employer, your insurer, or their representatives.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization, and I expressly reserve the right to make such disclosures, as appropriate and necessary; the disclosures listed about are the most common.

**Patient's Rights and Psychologist's Duties:**

Patient's Rights:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you requested.

Right to Receive Confidential Communications by Alternative Means and at Alterative Locations: You have the right to refuse and receive confidential communications of PHI by alterative means and at alternative locations. For example, I can send your bill to another address if requested for privacy purposes.

Right to Inspect and Copy: You have the right to inspect or obtain a copy, or both, of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the

record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may be denied access to Psychotherapy Notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. I shall notify you or your representative if I do not grant complete access. ON your request, I will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to Accounting: You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

**Psychologist's Duties:**

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

In the psychologist intends to revise his/her policies and procedures, he/she must describe in the notice to patients how the psychologist will provide patients with a revised notice of privacy policies and procedures.

**Questions and Complaints:**

If you have any questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Carrie Holl PsyD Clinical Psychologist and Owner at (202) 332-0113.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to 1755 S Street NW, Suite 6B, Washington DC 20009.

You may also send a written complaint to the Secretary of the US Department of Health and Human Services. The person listed about can provide you with the appropriate address upon your request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

**Effective Date, Restrictions and Changes to Privacy Policy:**

This notice will go into effect on September 1, 2013.

**Receipt of Acknowledgement of HIPAA:**

**I hereby acknowledge that I have received and have been given an opportunity to read a copy of Carrie Holl PsyD's (1755 S Street NW, Suite 6B Washington DC 20009) Notice of Privacy Practices. I understand that if I have any questions, I can contact Carrie Holl at 202-332-0113:**

_____ _____

Patient Name and Date of Birth Date

_____

Signature