Client Information

JOY MILLER & ASSOCIATES
counseling and wellness services

Please fill out to the best of your ability. If the question does not apply ***please write n/a***.
If you have any questions, please ask the receptionist or your therapist for assistance.

Date:_____ Therapist Name:_____

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

May we contact you by phone: ☐ Yes ☐ No If yes, Preferred Phone ☐Home ☐Work ☐Mobile
May we contact you by email: ☐ Yes ☐ No Email: _____

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Date of Birth: _____ Age: _____ Social Security Number: _____

If Minor, Parents/Legal Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

If Married, Partner's Name: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Emergency Contact:_____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Referred By: ☐Self ☐Insurance ☐EAP ☐MD ☐Friend Name of Referent: _____

Employer Name: _____

Person responsible for payment: _____

Do you have authorization prior this appointment (If applicable): ☐Yes ☐No

If authorization is required, authorization/precertification number: _____

PRIMARY INSURANCE INFORMATION: (Please complete information for policy holder)

Insured's Name: _____ DOB:_____ Relationship:_____

Insurance Company: _____

Member/Insured ID: _____ Group Number: _____

Address:_____

Employer Group: _____ Phone Number: _____

Medical History

Medical Doctor: _____ Date of Last Physical: _____

Psychiatrist (If Applicable): _____ Date of Last Appt: _____

Do you have any RELEVANT health concerns: □Yes □No If Yes, Please List Below:

_____

_____

_____

Medications:

NAME	DOSAGE	LENGTH OF USE

Family History

	Self	Immediate Family	Extended Family
Hospitalized for Emotional Problems	□Yes □No	□Yes □No	□Yes □No
Treated for Drug or Alcohol Problems	□Yes □No	□Yes □No	□Yes □No
Previous Counseling	□Yes □No	□Yes □No	□Yes □No
Attempted Suicide	□Yes □No	□Yes □No	□Yes □No
Arrested for DUI	□Yes □No	□Yes □No	□Yes □No

Do you see yourself as suicidal now: □Yes □No

Please identify any children that you have:

Please list child/children below:	Age	Living With You	Do Your Have Any Concerns About Them
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No

Personal History

Do you have any of the following concerns?

		Specify Concern Below:
Support System	☐Yes ☐No	
Legal Concerns	☐Yes ☐No	
Family Concerns	☐Yes ☐No	
Financial Concerns	☐Yes ☐No	
Addictions	☐Yes ☐No	

Do you use any of the following:

		Amount	Frequency	First Use	Last Use
Tobacco	☐Yes ☐No				
Alcohol	☐Yes ☐No				
Cannabis	☐Yes ☐No				
Cocaine	☐Yes ☐No				
Amphetamines	☐Yes ☐No				
Opioids/Narcotics	☐Yes ☐No				
Hallucinogens	☐Yes ☐No				
Other: _____	☐Yes ☐No				

Do you have any of the following concerns?

	Not At All	Mild	Moderate	Severe
Inability to Stay Focused (ADHD)	☐	☐	☐	☐
Bipolar (Previously Diagnosed)	☐	☐	☐	☐
Chronic Depression	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐
Post Trauma	☐	☐	☐	☐
Relationship Problems	☐	☐	☐	☐
Violent Temper	☐	☐	☐	☐
Homeless or Housing Inadequate	☐	☐	☐	☐
Chronic Fatigue	☐	☐	☐	☐
Personal Safety	☐	☐	☐	☐

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

	Not At All	Mild	Moderate	Severe
Little interest in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling asleep, or sleeping too much	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself, or that you are a failure	☐	☐	☐	☐
Trouble concentrating such as reading or watching TV	☐	☐	☐	☐
Moving or speaking so slowly that others have noticed	☐	☐	☐	☐
Thoughts that you would be better off dead	☐	☐	☐	☐
Worried about your health	☐	☐	☐	☐
Concerned about how you look	☐	☐	☐	☐
Little or no sexual desire or pleasure during sex	☐	☐	☐	☐
Difficulties with spouse/parents/friends	☐	☐	☐	☐
The stress of taking care of children/parents/family members	☐	☐	☐	☐
Financial worries	☐	☐	☐	☐
Stress at work or school	☐	☐	☐	☐
Having no one to turn to when you have a problem	☐	☐	☐	☐
Something bad that happened **recently**	☐	☐	☐	☐
Thinking or dreaming about something bad that happened in past	☐	☐	☐	☐

Have you had an anxiety attack (suddenly feeling fear or panic)?	☐Yes ☐No
Do some of these attacks come suddenly where you don't expect to be uncomfortable?	☐Yes ☐No
Do these attacks bother you a lot or are you worried about having another attack?	☐Yes ☐No
During your last attack, did you have shortness of breath, heart racing, dizziness, and numbness?	☐Yes ☐No
Has this happened before?	☐Yes ☐No
Episodes of violence or anger	☐Yes ☐No
History of physical or emotional abuse	☐Yes ☐No
Problems with eating	☐Yes ☐No
Periods of mania	☐Yes ☐No
History of self-mutilation	☐Yes ☐No
Major loss affecting daily living	☐Yes ☐No
Past psychological testing	☐Yes ☐No

What brings you to therapy TODAY? _____

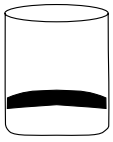
_____

_____

How did you find out about us?

☐Google ☐EAP ☐Friend/Family ☐TV ☐Newspaper ☐Insurance ☐Women's Lifestyle Show ☐Yellow Pages

Alcohol Screen (AUDIT)

Light Beer 425ml 2.9% Alcohol	Full Strength Beer 285ml 4.9% Alcohol	Wine 100ml 12% Alcohol	Fortified Wine 60ml 20% Alcohol	Spirits 30ml 40% Alcohol	Full Strength Can or Stubbie 375ml 4.9% Alcohol
					

*The guide above contains examples of **one standard drink**.* A full strength can or stubbie contains ***one and a half standard drinks***.

Introduction

Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of **'standard drinks'**. Please ask for clarification if required.

AUDIT Questions Please tick the response that best fits your drinking.

						Score	Sub totals
	Never	*Monthly or less*	*2 - 4 times a month*	*2 - 3 times a week*	*4 or more times a week*		
1. How often do you have a drink containing alcohol?	☐ Go to Qs 9 & 10	☐	☐	☐	☐		
	1 or 2	*3 or 4*	*5 or 6*	*7 to 9*	*10 or more*		
2. How many standard drinks do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐		
	Never	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*		
3. How often do you have six or more standard drinks on one occasion ?	☐	☐	☐	☐	☐		
4. How often during the last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐		
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐		
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐		
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐		
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐		
	No		*Yes, but not in the last year*		*Yes, during the last year*		
9. Have you or someone else been injured because of your drinking?	☐		☐		☐		
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	☐		☐		☐		
						TOTAL	

Supplementary Questions

	No	*Probably Not*	*Unsure*	*Possibly*	*Definitely*
Do you think you presently have a problem with drinking?	☐	☐	☐	☐	☐
	Very easy	*Fairly easy*	*Neither difficult nor easy*	*Fairly difficult*	*Very difficult*
In the next 3 months, how difficult would you find it to cut down or stop drinking?	☐	☐	☐	☐	☐

Joy Miller and Associates 7617 N. Villa Wood Lane – Peoria IL 61614 – (309) 693-8200 – www.joymillller.com

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Confidentiality Statement

The confidentiality of your discussions with your therapist is protected by State of Illinois, federal and HIPPA law, as well as professional ethics. Your therapist needs our written permission to release any information about you. Case notes are the sole property of the therapist, but (s)he will provide a summary if you request the release of information about your therapy. There may be a charge for processing your request. There are some exceptions to confidentiality requirements:

• If you are dangerous to yourself or others. Your therapist is not held to confidentiality if (s)he feels you are likely to hurt yourself or someone else.

• When there is reason to believe that children, the elderly and certain other groups have been or may be abused or neglected. All states have laws that mandate the reporting of child abuse; there may also be limits on confidentiality when the abuse affects the elderly or the disabled, and in case of domestic violence.

• When there is a medical emergency.

• When the therapist is acting under a court order. If a judge orders your therapist to reveal information about you, this overrules confidentiality.

• When your therapist is consulting with other professionals. Your therapist can consult with other professionals in the same agency regarding your therapy if (s)he believes the advice will help improve your care.

• When necessary for your therapist to prepare a legal defense.

• When the therapist is trying to collect on a delinquent account.

• All bills submitted to insurance for payment contain information about you, including your name, address, insurance ID number, employer name, dates of service, type of service, and diagnosis. If your insurance is a managed care plan, requiring authorizations and reviews, you may also be consenting to the release of more detailed information. This may include written plans for your treatment within information about the nature of your problems, how it affects your personal and work life, other problems you may have, and the prognosis for your recovery.

• If you decide to use private or managed care insurance services, you may be consenting to: accepting the limitations of your treatment options; accepting limitations on the frequency and duration of your treatment; consenting to access to your information by your employer; permitting your information to be stored in database systems, which can be accessed by third-party individuals.

Your signature on this form is an agreement between you and *Joy Miller & Associates*, acknowledging you have read and understand the privacy practices and that you have had your questions answered.

If you do not sign this form, we cannot treat you. If you are concerned about some of the information, you have the right to ask us to not use or share some of it. Although we try to respect your wishes, we are not required to agree to these limitations. If we do agree, we promise to comply with your wishes.

You have the right to revoke this consent in writing, and we will comply with your wishes from that date forward. However, if we've already released information about you prior to the revocation, we cannot change that.

Signature of client or client's personal representative
_____ *Date*_____

Please print name of client or client's personal representative
_____

*Relationship to client (if needed)*_____

Signature of therapist _____ *Date* _____

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joymiller.com

JOY MILLER & ASSOCIATES
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Financial Policy

Joy Miller & Associates
Counseling & Wellness

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Peoria, Illinois 61614

309.693.8200

joymiller.com

Financial policy with Joy Miller & Associates

I understand that payment is due at the time of service.

I am personally responsible for clearing any outstanding balance at the end of each month.

I understand that if payment is not made, *Joy Miller & Associates* may proceed with necessary legal action and may release information necessary to collect my account.

I understand I may be responsible for attorney fees or related collection costs if legal action is necessary. *Joy Miller & Associates* reserves the right to charge interest on any unpaid balance.

I understand that I may be charged 100 percent of the session fee if I fail to keep an appointment or cancel an appointment with less that 24 hours notice. I understand that Monday cancellations must be made prior to noon on Friday.

I understand that there is a $25 fee for any returned check.

Disclosure of Mental Health Information and Assignment of Benefits

I will be responsible for filing my own insurance claims unless I have made other arrangements **in advance** with *Joy Miller & Associates*.

Insurance benefits are verified as a courtesy and are quoted based on what information is provided by your company. I understand that Joy Miller and Associates is not liable for information that is inaccurate or misrepresented by your insurance company. You are responsible for knowing what services are or are not covered.

I understand it is my responsibility to notify this office immediately if your insurance coverage or company changes. It is my responsibility to understand my coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current. I understand that I am responsible for any charges my insurance does not pay (including my annual deductible and co-payments), and that is my responsibility to resolve any insurance disputes.

I authorize the release of any medical, mental health, or other information necessary to process any and all insurance claims.

I authorize payment of medical benefits to the undersigned provider, Joy Miller and Associates for mental health services provided at 7617 N. Villa Wood Lane.

I understand that I am responsible for payment of the following fees:

- Individual, couples or family session rate _____
- Telephone session (after five minutes) $2 per minute

I have read and agree to the financial policy.

*Client*_____

*Witness*_____

*Date*_____

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ATTENTION MEDICAL OFFICE-THIS IS NOT A REQUEST FOR RECORDS. This is for notification purposes only until otherwise requested.

Coordination of Care Release of Information

Many insurance companies require Coordination of Care between primary care physicians and behavioral health providers. Communication between Joy Miller & Associates (JMA) and your primary care physician is important to ensure that you receive comprehensive and quality health care. This form will allow Joy Miller & Associates to share protected health information with your medical provider.

Patient Rights

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Joy Miller & Associates at, 7617 North Villa Wood Lane, Peoria, IL 61614. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. If you make a request to end this authorization, it will not include information that may have already been used or disclosed base on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices. I further understand that Joy Miller & Associates will not condition my treatment on whether I give authorization for the requested disclosure. It has been explained to me that failure to sign this authorization may result in the inability to coordinate client care, but not affect my right to treatment.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict that HIPAA and provides additional privacy.

Expiration

This authorization expires **one year from the date signed** or as otherwise indicated:_____.

_____ _____ /_____ /_____

Client Name — Date of Birth – MM/DD/YYYY

_____**YES, I AGREE**. You may notify the medical provider the following information:

Description of information to be disclosed: **(Client *must* initial each item to be disclosed)**

____ Demographic Information ____ Assessment & Diagnosis ____ Progress in Treatment

____ Contact with Joy Miller & Assoc. ____ Treatment Plan Summary ____ Discharge/Transfer Summary

____ Other _____

_____**NO, I DO NOT AGREE**. Do not notify the physician.

Primary Care Physician: _____ PCP Phone: _____

PCP Address, City, ST, Zip: _____

_____

_____

Signature of Patient/Client (over the age of 12 years) Date

_____

Signature of Parent, Guardian Date

_____

Signature of Staff Witness Date

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Joy Miller & Associates

Your experience at Joy Miller & Associates is IMPORTANT to us.

Please read carefully:

Joy Miller & Associates is the leader in Counseling and Wellness in the Peoria area. How do we know that? Because we can prove it with statistical data that we have been collecting for over 5 years. We collect data on client satisfaction, on the number of sessions typically attended by clients, presenting concerns of clients, and most importantly on the statistical empirically-based evidence of client improvement & the decrease of symptoms and concerns within therapy.

As Peoria's Premiere private practice, we are constantly striving to improve our value based patient-centered outcome data and are participating in an intensive client outcome study called the Value-Based Client Outcome Study: (VBCO). This new outcome study is very similar to trending national surveys that examine client's presenting concerns and their response to the effectiveness of their therapy, as well as the relationship with their individual therapist.

We are excited to have you be a part of our new study. We hope you will take time and fill out the questionnaire carefully prior to your first session within your therapist's office. Together you will create the first document that will assess your entry score for your initial session.

You will be filling out a similar questionnaire each session prior to meeting with your therapist. Your answers will assist your therapist meet your individual needs, and create a more meaningful & productive outcome within each session.

We thank you for your cooperation and we know these new surveys will enhance what we have already been doing in the field of counseling for the last five years. We hope that you will discuss the findings of your results with your therapist as a means of evaluating your progress and outcomes at Joy Miller & Associates.

Joy Miller & Associates
A Proven Tradition of Excellence in Counseling and Wellness.