

**Mission Statement**

We believe that all individuals possess core strengths that can be utilized to lead meaningful lives. We strive to facilitate the journey through acceptance without reservation, maximizing the inherent strengths in every individual, healing the wounds that have resulted from the hurt/trauma/anger, and to convey the wholeness that is now a part of the individuals' lives.

**Letter of Commitment from CEO of EASLEY & ASSOCIATES, LLC**

Thank you for choosing LLC for your mental EASLEY & ASSOCIATES, LLC health needs. I trust that your involvement with our Clinical Team will be helpful and profitable to you. I take pride in knowing that the staff provides the best all around clinical care in a nonjudgmental, nurturing atmosphere. The office manager will make you feel welcomed when you walk in the door and should be able to answer any questions you may have about the intake process, paying your co-pay and scheduling follow up appointments.

If you have any concerns please see me or contact me immediately so that I can address them in an appropriate manner. I will hear your concerns or compliments without bias. You can be assured that I will personally handle the situation professionally so that care is not compromised and you can be confident that your needs can best be met.

The staff and myself are committed to provide you with an eclectic approach to services that are effective and individualized for you in a safe environment so that you will thrive and maximize your full potential to mental wellness and wholeness.

Sincerely,  
Amy L. Easley, LCSW-C  
CEO and Owner

# Easley & Associates, LLC

## Client Intake

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: H: \_\_\_\_\_ W: \_\_\_\_\_ Cell: \_\_\_\_\_

Age: \_\_\_\_\_ Highest grade of school completed: \_\_\_\_\_ email address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Type of Class:  Reg.  Spec. Ed with  504 Plan or  IEP

Do you have weapons/guns in your home?  Yes  No Are they locked in a safe place?  Yes  No

Are you currently in a pain management or methadone program?  No  Yes, Facility/Years \_\_\_\_\_

### Insurance Information: Please provide us with a copy of your insurance card

Patient's relationship to the insurance policy holder?  self  spouse  child

### POLICY HOLDER INFORMATION IF IT IS NOT THE CLIENT.

Name of policy holder: \_\_\_\_\_ Name of employer: \_\_\_\_\_

DOB of policy holder: \_\_\_\_\_ SS# of policy holder: \_\_\_\_\_

MA/Membership ID # \_\_\_\_\_ Group # \_\_\_\_\_

### Person to Contact in Case of an Emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Primary Care Physician:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ Zip: \_\_\_\_\_

### ONLY COMPLETE FOR CHILD UNDER THE AGE OF 18. MUST HAVE CUSTODY PAPERS, IF APPLICABLE

Does the client live with you?  Yes  No Did you provide copies of the awarded physical custody?  Yes  No

Do you have legal authority to make psychiatric decisions?  Yes  No Do you have joint custody?  Yes

No; with whom: including name and phone number: \_\_\_\_\_

+++++ OFFICE USE ONLY+++++

Client/Parent/Guardian's initials indicate the information above is current or remains the same. **Checked 9/1 or 1/1**

Date \_\_\_\_\_ Date \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

# EASLEY & ASSOCIATES, LLC

Client's Name: \_\_\_\_\_

## ADMISSION PAPERWORK CHECKLIST

My signature indicates I have read, understand, and been given a copy of the following documents. Please indicate by placing your initials after each policy

- A. Office Policies \_\_\_\_\_
  - B. Release of Information \_\_\_\_\_
  - C. Telephone calls \_\_\_\_\_
  - D. Session Length \_\_\_\_\_
  - E. Fees and Payments \_\_\_\_\_
  - F. Insurance \_\_\_\_\_
  - G. Cancellations/Missed Appointments \_\_\_\_\_
  - H. Reasons to be discharged \_\_\_\_\_
  - I. **Privacy Acts (see below)** \_\_\_\_\_
- Please read carefully and sign the attached receipt of Privacy Acts**
- J. Financial policy \_\_\_\_\_
  - K. Insurance Payments \_\_\_\_\_
  - L. Scheduling \_\_\_\_\_
  - M. Consent for Treatment \_\_\_\_\_
  - N. Rights of Clients \_\_\_\_\_
  - O. Confidentiality Statement & exceptions \_\_\_\_\_

### HIPPA PRIVACY NOTICE TO PROTECT YOUR PHI (personal health information)

I wish to be contacted in the following manner; check all that apply:

- Home Telephone \_\_\_\_\_
- Leave message with call back # only.
- OK to leave message with detailed information
- Work Telephone: \_\_\_\_\_
- Leave message with call back # only.
- OK to leave message with detailed information.

I consent that communicate and/or disclose clinical risk information to or answer questions from:

- spouse/partner \_\_\_\_\_
- child: \_\_\_\_\_
- None
- Parent: \_\_\_\_\_
- Other: \_\_\_\_\_

#### Written Communication

- Mail to: \_\_\_\_\_
- Genbook Email Reminders:  Yes  No  Please call: \_\_\_\_\_
- Emails will be returned for appointments only.
- Therapists are not able to return emails sent containing any information except about the appointment day and time.
- Texting between client and therapist/office staff may only be about appointments or to notify if running late, traffic, etc.

Client/Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\* Office Use Only \*\*\*\*\*

- refused to sign
- emergency circumstances
- communication barrier prohibited / acknowledgement
- other: \_\_\_\_\_

8109 Harford Rd Unit #6, Parkville, MD 21234 / 123 Heritage Lane, Sykesville, MD 21784  
Phone: 410-665-2900 Fax: 410-665-2933 or 410-549-0600 [www.easleytherapy.com](http://www.easleytherapy.com)

### A. OFFICE POLICIES AND PROCEDURES

Welcome to EASLEY & ASSOCIATES, LLC. We are pleased that you have chosen our agency as your mental health provider. We value you as our client and are committed to provide you with a comprehensive and optimum treatment that is both effective and meets your individual identified needs. Please read and complete all documents thoroughly, so that you are prepared to discuss any questions with your therapist during your first session.

### B. RELEASE OF INFORMATION FORM – Clinician Communication Form

All information obtained/derived during the course of your treatment are strictly confidential; disclosures you or your child share with the therapist are strictly confidential. The client or client's parent/guardian may SIGN a consent form indicating to release part or all of the information to a designated agency. This consent is in effect for one year or until the client or client's parent/guardian rescind the consent at any time. .

**Your insurance carrier requests that there is collaboration of care between your/your child's PCP and/or health care providers.** This collaboration can be a phone call stating you are in therapy or to discuss treatment recommendations or prognosis. You have the right to disclose this information yourself, sign consent for your therapist to share any information or to decline to have any information disclosed. Therefore, to either release or obtain information from a specific individual or agency, a **Consent for Disclosure** must be obtained, with signatures and date; and you will need to indicate on the form what if any disclosures are made.

**Exceptions to this guideline include instances when:**

- The client is in clear and eminent danger to him/herself or others.
- **When the minor client (under the age of 18) reports** that he/she has been a victim of physical, psychological or sexual abuse and/or neglect by anyone; the law requires that a report be completed to Child Protective Services.
- **If the therapist suspects** that abuse/neglect are occurring to a vulnerable child or adult client; the law requires that a report be completed to Child or Adult Protective Services.
- In addition, cases may be discussed within the agency's clinical staff or for the purpose of supervision to provide feedback, additional resources, alternative treatment models, and for the continuity of care.
- **Please note that at all time your confidentiality or your child's confidentiality will be respected and discussed without the use of any identifying personal information.**

### C. TELEPHONE CALLS

Occasionally the need to talk to your therapist may arise between normally scheduled sessions. **Psychotherapy cannot occur over the phone.** When leaving a confidential message in your therapist's mail box; leave a detailed message is that when the call is returned, your therapist has been able to locate the information needed or a resource to assist you further. Your therapist will respond to your call during his or her normal business hours. **If you need more than a few minutes to discuss a concern with your therapist, you should call to schedule an urgent care appointment.** **If it is a psychiatric emergency, you will need to call 911 or go immediately to your nearest Emergency Room.**

#### D. SESSION LENGTH

Psychotherapy sessions are **45 minutes in length beginning at the appointed time and concluding 45 minutes thereafter**. Therefore, it is to your benefit to arrive a few minutes in advance of your scheduled appointment time. Since your therapist has sessions scheduled immediately after your session, the session must end 45 minutes after the appointment time regardless of your arrival time. The full fee for the session will be charged. By arriving early, you will be able to pay your co-pay and schedule your next appointments with the office staff, so that your session time is not used for these business transactions.

**There may be times when your therapist is running late due to an unexpected emergency, please be aware that on these rare occasions, you will be given your entire 45 minutes and that there may be a time when you too will need that same courtesy extended to you. So please be patient, knowing that it is this office's policy to always provide the utmost in quality and optimum care.**

#### E. CO-PAYS, FEES AND PAYMENTS

**All co-pays are due at the time of service. We accept checks, cash, and debit/credit card payments. Personal checks should be made payable to EASLEY & ASSOCIATES, LLC .**

- A \$35.00 service charge will be levied on all checks or ATM payments returned or denied by your bank for insufficient funds. If you have 2 returned checks or ATM rejections; all payments thereafter will only be accepted in cash.
- Our current fee per session is \$250.00 for an intake evaluation and \$190.00 per individual or family session.
- **A monthly interest fee of 2.9% will be charged on outstanding balances until they are paid in full.**
- **Therapeutic services may be discontinued if the balance is over \$40.00 and you have not made arrangements with your therapist to bring your account up to date.**
- **We have contracted with ADVANCED MEDICAL SERVICES, INC. at 410-663-4036 to manage all of our billing and collection of fees.**
- **If you received a bill it is your responsibility to contact ADVANCED BILLING SERVICES at 410-663-4035 to discuss payment due or to reconcile any discrepancies.**
- Please be advised that it is required by law that each client is responsible for meeting any deductible required by your insurance plan and the co-payments/co-insurance payments per your insurance carrier.
- **Your co-pay fee will be charged for any session that is a no show or was not cancelled 24 hours prior to the appointment date and time.**

#### F. INSURANCE

We will gladly file insurance claims for you for services rendered; however, you are responsible for any amount not covered by your insurance for whatever reason.

- **We cannot accept responsibility for negotiating a settlement on a disputed claim.**
- You are responsible to notify the office if your insurance had been terminated or changed: failure to notify the office manager immediately may result in your being charged the full fee for the session.
- All new insurance coverage will need to be verified to obtain your coverage, benefits and co-pay information prior to any appointments being attended to avoid being charged the full rate for the session not covered by your new plan.

- **Please note that you are responsible for the entire fee if the insurance changes and you have failed to notify and provide the office manager with all pertinent information as this will result in the claim being denied by the insurance company.**

### **G. CANCELLATIONS AND MISSED APPOINTMENTS**

When an appointment is scheduled, that time is reserved for you. If the appointment is **missed or cancelled** without sufficient notice, the therapist is unable to make use of that time. Therefore, sessions must be canceled 24 hours in advance or a cancellation fee equal to your co-pay will be charged to you. **Your insurance will not cover this fee and so the responsibility of this payment is solely that of the client.** No further appointments will be scheduled until the fee is paid. Your therapist reserves the right to discharge you if there are more than two missed appointments.

### **H. REASONS TO BE DISCHARGED FROM TREATMENT**

You understand that you may be discharged from EASLEY & ASSOCIATES, LLC under the following conditions:

- No show for intake appointment or more than 2 no show appointments.
- Successful completion of treatment goals.
- Failure to keep regular appointments.
- Decision regarding different choice of treatment.
- Refusal to follow agreed-upon goals.
- Persistent AWOL behavior.
- Disrespectful behavior.
- Violent and/or criminal activities.

### **I. NOTICE OF PRIVACY PRACTICES**

**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**

EASLEY & ASSOCIATES, LLC is dedicated to maintaining the privacy of your personal health information, referred to as PHI, as part of providing professional care. We are required by law to keep your information confidential. These laws are complicated; as of 03/09, our Privacy Officer, Amy Easley, is available to speak with you about any concerns or question you may have about your PHI.

#### **How we use and disclose your PHI with your consent:**

We will use the information collected about you to provide you with treatment, to arrange for payment of our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice, we will ask you to sign a consent form to let us use and share your information as indicted above. If you do not consent and sign the form, we cannot treat you.

#### **Disclosing your health information without your consent**

There are occasions when the laws require us to use or share your PHI. They are as follows:

- When there is a serious threat to your health, another's health and safety, or to the public.
- We will only share your PHI with persons who are able to help prevent or reduce the threat.
- When we are required by lawsuits, and other legal/court proceedings.
- If a law enforcement official requires us to do so.

- Workers' compensation and similar benefit programs; such as FML, short/long term disability, etc.
- There are some other rare situations.

### **Your rights regarding your PHI:**

- You will identify how we are to communicate with you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment.
- You identify others whom you want involved in your care or the payment for your care, such as family members or you may decide that no PHI is to be shared with anyone.
- You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting room, and you can always get a copy of it from the privacy officer.
- You may request to see the PHI that we have about you. Your therapist or the Privacy Officer will arrange for a time for you to sit with him/her to review your PHI.
- You may request a copy of your PHI by contacting the privacy officer, Amy Easley, for PHI consent.
- If a determination is made by our professional team deeming that it is harmful or not in your best interest to have access to these notes, this will be discussed with you as to the team's rationale.
- All requests for a copy of the record must be submitted in writing to the privacy officer by mail or hand delivered. You may obtain a copy at the front desk or from the Privacy Officer, Amy Easley.
- An original signature is required; faxed copies will not be accepted on requests for PHI information.
- There will be a fee of \$0.34 per page and it will be the responsibility of the party requesting the PHI to pay for all charges in cash; prior to receiving the information.
- EASLEY & ASSOCIATES, LLC will respond as promptly as we are able to your request for your PHI.
- We will notify you of the total charges due when the copy of the PHI is ready.
- All outstanding balances for services rendered must be paid in full prior to the release of any PHI.
- If you believe that the information in your records is incorrect, you can ask the privacy officer to make corrections to your PHI to amend the situation. This request will need to be in writing to our privacy officer; explaining reasons you want to make the changes, and a copy of the changes you would like to be added to your PHI. Your amendments will be added to your PHI as an addendum identifying the date of services in which you would like to amend. A copy of this form can be obtained from our privacy officer, Amy Easley.
- You have the right to file a complaint if you believe your privacy rights have been violated.
- You can file a complaint with our privacy officer, Amy Easley, or the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing.
- **Filing a complaint will not change the quality of care provided to you in any way.**
- Our privacy officer, Amy Easley, will be happy to discuss any concerns or situations with you now or as they arise.
- If you have any questions regarding this notice or your PHI, please contact our privacy officer, Amy Easley at 410-665-2900.
- The Privacy Policies have been in effect since April 14, 2003.

### J. Financial Policy

#### **ALL CO-PAYMENTS ARE TO BE PAID AT TIME SERVICE IS RENDERED.**

- Payment is to be by cash, check made payable to EASLEY & ASSOCIATES, LLC or debit/credit card payment. **We accept checks, cash, and debit/credit card payments.**
- Personal checks are accepted and should be made payable to EASLEY & ASSOCIATES, LLC. **A \$35 .00 service charge will be levied on all checks or ATM payments returned or denied by your bank for insufficient funds.** If you have 2 returned checks or ATM rejections; all payments thereafter **will only be accepted in cash.**
- Our current fee per session is \$250.00 for an intake evaluation and \$190.00 per session.
- **Also, a monthly interest fee of 2.9% will be charged for outstanding balances until they are paid in full.**
- EASLEY & ASSOCIATES, LLC has contracted with **Advanced Medical Services, Inc.** to manage all of our billing and collection of fees.
- If you receive a bill in the mail from. Advanced Medical Services, Inc, it is your responsibility to reconcile any discrepancies by **contacting Advanced Medical Services, Inc, at 410-663-4036.**
- Please be advised that it is required by law that each client is responsible for meeting any deductible required by your insurance plan and the co-payments/co-insurance payments per your insurance carrier.

### K. INSURANCE PAYMENTS

- I/ we understand that even though EASLEY & ASSOCIATES, LLC is billing my/our insurance that **I/we** are responsible for any balance that the insurance does not cover, according to each individual plan.
- All unpaid balances on accounts will be collected from the client 90 days after the insurance has been billed and EASLEY & ASSOCIATES, LLC has not received payment. This provides your insurance company with 90 days to pay the claim. The law states that it must be processed within 30 days of receipt.
- After 90 days, **you** are responsible to pay EASLEY & ASSOCIATES, LLC directly. You will be provided with a receipt to use when obtaining reimbursement from your insurance company for the services rendered.
- I/we understand that it is my/our responsibility to inform the office of any insurance changes and to understand the benefits of my/our plan by contacting my/our insurance carrier.
- I/we understand that by signing this form, I /we agree to pay any unpaid balance on my/our account in a prompt manner (30 days)

### L. SCHEDULING

- The office manager can schedule client's appointments into a time slot that is available in the therapist's schedule, usually on a weekly or bi-weekly schedule.
- **It is EASLEY & ASSOCIATES, LLC's policy to bill a fee that is equal to your co pay if there is late cancellation/no show fee;** as the therapist has made her/himself available to you/your child at this time, and there are other clients who would have been able to be seen at that time.
- If you opt not to pay the late cancellation/no show fee; this agency will consider that you/your child no longer wish to continue in therapy with EASLEY & ASSOCIATES, LLC; and you will be discharged.
- If you choose to pay the cancellation fee, you will be able to reschedule another appointment, after the payment has been received by this office.

- **If you cancel with less than 24 hours' notice, the cancellation fee always applies. Your co-pay fee will be charged for any session that is a no show or was not cancelled 24 hours prior to the appointment date and time. Your insurance will not cover this fee and so the responsibility of this payment is solely that of the client.** No further appointments will be scheduled until the fee is paid.

Your therapist reserves the right to discharge you if there are more than two missed appointments. When an appointment is scheduled, that time is reserved for you. If the appointment is **missed or cancelled** without sufficient notice, the therapist is unable to make use of that time.

#### **M. CONSENT FOR TREATMENT**

EASLEY & ASSOCIATES, LLC have my/our permission to provide mental health treatment to me or my child. I agree to the delivery of such identified services which are deemed appropriate by me or my child and the treatment team. I agree that EASLEY & ASSOCIATES, LLC may administer first aid or authorize treatment to me or my child in case of an emergency that requires immediate or urgent attention.

#### **N. RIGHTS OF CLIENTS**

You will be receiving appropriate care and treatment this restricts your personal liberty only to the extent necessary to your treatment and/or rehabilitation needs and applicable with relevant Federal and State laws and regulations.

You do have the right to be protected from harm and to be free from mental, physical and sexual abuse in the program. Therefore all allegations of client abuse by staff members will be reported to the local law enforcement agency or to the program director that must report them to the local law enforcement agency.

You have the right to participate in a manner appropriate to your condition, in the development and periodic review of your treatment and/or rehabilitation plan at any time during your visits.

You have the right to be informed in appropriate terms and language of:

- The content and objectives of your treatment and/or rehabilitation plan.
- The nature and significant possible negative effects of your treatment and/or rehabilitation.
- The name, title and role of staff members who are directly responsible for implementing your individual treatment and/or rehabilitation plan.
- When appropriate, you may be referred to other treatment services or mental health providers.

You have the right to refuse medication

EASLEY & ASSOCIATES, LLC is responsible to have the individual's right and office policies posted in prominent place in the facility or given to the client at the point of admission.

You have the right to file a grievance if the individual is not satisfied with treatment and/or rehabilitation plan that he/ she receives.

**O. CONFIDENTIALITY STATEMENT & EXCEPTIONS**

I understand that my child's right to confidentiality is protected by the Privacy Rights Act. I understand that the therapist/agency will not violate my child's rights.

**EXCEPTIONS:**

**For the Parent/Guardian:**

Your confidentiality rights are protected and will be maintained by the Privacy Act. The two exceptions to your confidential rights being maintained by your therapist/agency are:

1. The therapist has reason to believe that you will harm yourself.
2. The therapist has reason to believe that you are at risk of harming others.

**For the minor child:**

You child's confidential rights are protected and will be maintained at all times by your therapist/agency.

The 3 exceptions to your child's rights not being maintained by your therapist/agency are:

1. The therapist has reason to believe that your child will harm his/herself.
2. The therapist has reason to believe that you child will harm others.
3. The therapist has reason to believe that someone or something is harming you child.

**Your parent/guardian will immediately be notified of any such disclosure.**

# Easley& Associates, LLC

## HIPPA – Privacy Act

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### **Notice of Privacy Practices**

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 are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer, Amy Easley, about any questions or problems.

#### **How we use and disclose your protected health information with your consent**

We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

#### **Disclosing your health information without your consent**

There are some times when the laws require us to use or share your information.

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. Workers' compensation and similar benefit programs.

There are some other rare situations.

#### **Your rights regarding your health information**

1. You can ask us to communicate with you in a particular way or at a certain place that 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.

## Easley& Associates, LLC

### HIPPA – Privacy Act

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2. You can 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 medical and billing records. You can get a copy of these records, but you will be charged for it or your professional team may decide it is not in your best interest to have access to these notes. Contact our privacy officer, Amy Easley, to arrange how to review your records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also 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 notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. 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 that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, Amy Easley, at 410-665-2900.

The effective date of this notice is April 14, 2003

**Notice of Privacy Practices**

**Receipt and Acknowledgment of Notice**

**Client Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Easley & Associates, LLC's Notice of Privacy Practices; **Letter "I" within Office Policies**. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Amy Easley, the Privacy Officer for EASLEY & ASSOCIATES, LLC..

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent/ Guardian/Personal Representative \***

\_\_\_\_\_  
**Date**

\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

**Patient/Client Refuses to Acknowledge Receipt:**

\_\_\_\_\_  
**Signature of Staff Member**

\_\_\_\_\_  
**Date**

**\*\*\*\*\*For office use only\*\*\*\*\***

Yearly: Client/Parent/Guardian initials indicate that he/she was advised and offered a copy of the Privacy Act.

Int/Date: \_\_\_\_\_ Int/Date: \_\_\_\_\_ Int/Date: \_\_\_\_\_ Int/Date: \_\_\_\_\_ I

All insurance carries require contracted behavioral health practitioners/providers to coordinate treatment with other providers, especially the PCP, and any appropriate medical practitioners involved in this members care. Please complete this form and fax it to the PCP and/or other appropriate medical providers involved in the member's treatment of care.

**Consent for PCP Disclosure**

Client name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Section A**

Treating Therapist's name: _____	Telephone # <b>410-665-2900</b>	Cell/other # _____
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**Section B**

PCP/Medical or MH Practitioner Name: _____ Telephone: _____ FAX: _____	Address: _____ _____ _____
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**Section C**

1. The client is being treated for the following behavioral health diagnosis: _____ _____	
2. The client is prescribed the following psychotropic medication(s): _____ _____	
3. Expected prognosis and length of treatment: _____	
4. Coordination of care Issues/Other significant information impacting medical and/or behavioral health: _____ _____ _____ _____	

**Date mailed or faxed to PCP or other health care provider: \_\_\_\_\_ retain copy for client's record**

I hereby freely, voluntarily and without coercion, authorize my treating behavior health practitioner list above in Section A to release the information contained on this form in section C to the provider identified in Section B. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent is effective for 90 days from the date signed. I hereby understand that I may revoke my consent at any time.

<input type="checkbox"/> I do not wish to have information shared with <input type="checkbox"/> My PCP or other medical practitioner <input type="checkbox"/> My other behavioral health practitioner	<input type="checkbox"/> I am not currently receiving services from: <input type="checkbox"/> Any PCP/medical practitioner <input type="checkbox"/> Any behavioral health provider
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\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Behavioral Health Practitioner Signature

\_\_\_\_\_  
Date

Client's Name: \_\_\_\_\_

**Consent for the Treatment**

I, \_\_\_\_\_, give Easley & Associates, LLC, permission to provide  
Client/Parent/Guardian

mental health treatment to me or my child and agree to the delivery of such identified services which are deemed appropriate by myself or my child and the treatment team. I agree that Easley & Associates, LLC:

- May administer first aid or authorize treatment to me or my child in case of an emergency that requires immediate or urgent attention.

**I am giving my permission for Easley and Associates and their agents to contact the person below in case of an emergency.**

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Name	Phone #s	Relationship
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**EASLEY & ASSOCIATES, LLC**

Client's Name: \_\_\_\_\_

**SELF REPORTED CONFIDENTIAL INFORMATION**

If you are the parent/guardian please complete the form according to your child's history.

**GENERAL HISTORY**

Client's Name : \_\_\_\_\_ Sex: M F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

SSN: \_\_\_\_\_ if applicable: Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Home#: \_\_\_\_\_ Work#: \_\_\_\_\_

Cell Phone : \_\_\_\_\_ email: \_\_\_\_\_

Do you have sole custody of this child?  Yes  No If no, shared with whom and relationship to the child?

Is this person aware that this child is in treatment?  Yes  No If no, explain: \_\_\_\_\_

Have you given copies of custody papers to the office manager?  No  Yes Copies have to be on file.

Do you understand that under NO circumstances will the information disclosed in therapy be disclosed in any legal proceedings pertaining to custody, divorce, or other legal dispute .  No  Yes

Do you have weapons/guns in your home?  Yes  No Are locked in a safe place?  Yes  No

**EMERGENCY CONTACTS: (must be completed)**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell # \_\_\_\_\_

**PRESENTING PROBLEM:** What is the presenting problem that brought you here?

- anger management     eating disorder     mood swings     anxiety     insomnia/sleep hygiene
- depression     grief/loss     fear/phobias     work issues     parent child conflicts
- parenting issues     drugs/alcohol     trauma     financial     relationship problems
- mental confusion     sexual problems     divorce     abuse     school related issues

Other: \_\_\_\_\_

Is this a **mandatory referral** or an **ultimatum**?  Yes  No Explain: \_\_\_\_\_

**RELATIONSHIP HISTORY**

Marital Status:  single  engaged  married  remarried  separated  divorced  widowed

If engaged, married, separated, divorced, or widowed for how long? \_\_\_\_\_ # previous marriages" \_\_\_\_\_

If married, spouse's name: \_\_\_\_\_ Age: \_\_\_\_\_

**EMPLOYMENT HISTORY**

What is your current occupation/employer? \_\_\_\_\_ Years: \_\_\_\_\_

What is your level of satisfaction with your occupation?

- Highly Satisfied     Satisfied     Neutral     Dissatisfied     Highly Dissatisfied

# EASLEY & ASSOCIATES, LLC

Client's Name: \_\_\_\_\_

## EDUCATION HISTORY

What is the highest grade you completed? \_\_\_\_\_ High School/Date graduated: \_\_\_\_\_

College(s) attended and degree \_\_\_\_\_

School: \_\_\_\_\_ Current Grade: \_\_\_\_\_ Describe grades: \_\_\_\_\_

Type of Class:  Reg.  Spec. Ed with O 504 Plan or O IEP Extra Curriculum Activities/sports: \_\_\_\_\_

Describe any behavioral problems you had at school. \_\_\_\_\_

Did you repeat or fail any grade?  No  Yes If yes, which grade \_\_\_\_\_

## FAMILY HISTORY

Please list your children (including biological, step, half, adopted, foster) below:

Name	Sex	Age or Year & cause of death	Relationship to you	Living with whom?

Who else lives with you? Please list names and ages and relationship: \_\_\_\_\_

## COUNSELING HISTORY

If you have had any previous counseling, psychiatric, substance abuse or residential/in-patient treatment, please list the therapist's names or programs starting with the most recent treatment:

Therapist's Name or Program	Major Issue	Dates of Treatment	Reason for Stopping

Has anyone in your life been treated or hospitalized for substance abuse?  Yes  No

If yes, describe how you were affected \_\_\_\_\_

Mental health issues, even if never formally diagnosed?  No  Yes; If yes, describe how you were affected \_\_\_\_\_

Have any of your family members ever attempted or committed suicide?  Yes  No

If yes, who and how you were you affected: \_\_\_\_\_



**EASLEY & ASSOCIATES, LLC**

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Client's Name: \_\_\_\_\_

Are you **currently** experiencing any suicidal thoughts?  Yes  No  Yes, but passive thoughts

If yes, do you have a plan?  No  Yes What is your plan: \_\_\_\_\_

What would prevent you from following through on your plan? \_\_\_\_\_

Can you contract for safety?  No  Yes  **Contract completed with therapist, attached**

Have you experienced suicidal thoughts in the **past**?  Yes  No

Have you attempted suicide in the **past**?  No  Yes If yes, were you hospitalized, where, when and for how long?

\_\_\_\_\_

Are you **currently** experiencing any violent or homicidal thoughts?  No  Yes

If yes, what are your thoughts and toward whom are they directed? \_\_\_\_\_

Are you able to contract for safety?  No  Yes  **contract attached**

**What I need:**

What do you hope to gain from this counseling experience?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How have you attempted to deal with this problem thus far (please be brief and specific)?

\_\_\_\_\_  
\_\_\_\_\_

What have you tried in the past in therapy that was not helpful?

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Client

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Signature

\_\_\_\_\_  
Date reviewed by therapist

**THIS INFORMATION WILL NOT BE READ OR SHARED WITH ANYONE BUT YOUR THERAPIST.**

**EASLEY & ASSOCIATES, LLC 123 Heritage Lane Sykesville, MD 21784**

Circle one: Visa    Mastercard    Discover    Medical Expense Account

Client: \_\_\_\_\_ Card Holder's Name: \_\_\_\_\_

Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Card Holder's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Phone number: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Phone number: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_