Client Information (Please Print) Provider Name: _____

Client Name: _____
(Last) (First) (Middle Initial)

Home Address: _____ **Apt #** _____

_____
(City) (State) (Zip Code)

Home Phone: - - **Other Phone:** - - **Sex:** ☐ **Male** ☐ **Female**

Date of Birth: / /
Month Day Year

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner
Occupation: ☐ Full-Time ☐ Part Time ☐ Unemployed ☐ Full-Time Student ☐ Part-Time Student

Name of Employer/School: _____

Previous Mental Health Treatment (Within 2 years: ☐ Psychiatrist ☐ Psychologist ☐ LCSW-C ☐ Other

Mental Health Provider Name: _____

Insurance Information

Primary Insurance Company: _____ ID Policy # _____ Group # _____

Claims Address: _____ Phone: - -

Policy Holder's Employer: _____

Client's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Person Responsible for Account: ☐ Client ☐ Parent ☐ Other

_____ Date of Birth: / / Phone # - -
Name (if different from client)

Effective Date of Insurance: / / Social Security Number: _____

Policy Holder Name: _____ Date of Birth: / /
Month Day Year

Authorization to Bill Insurance:

Patient or Authorized person's signature: I authorize John Genardo, LCMHC to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed: _____ Date: _____

Mental Health Questionnaire

Date:_____ **Name**_____ **DOB**_____ ☐ **Male** ☐ **Female**

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced

Presenting concerns: _____
_____
_____
_____
_____

History of mental health treatment (Inpatient & Outpatient): _____
_____
_____
_____
_____

Substance abuse history: _____
_____
_____
_____

Who lives in your household: _____
_____
_____
_____
_____

Do you have children that do not live with you? (names and age): _____
_____
_____
_____

Legal issues/history: _____
_____
_____
_____

Were you clinically diagnosed with a learning disability during your childhood? (If yes, describe):
_____
_____
_____

Mental Health Questionnaire

Stressors (check all that apply)**:**

___ Relationship problems ___ Verbal or emotional abuse ___ Sexual abuse

___ Physical abuse ___ Financial problems ___ Health concerns

___ Legal issues ___ Employment concerns ___ Moving a lot

___ Difficulty with children ___ Difficulty with teachers ___ Schoolwork problems

___ Difficulty getting along with other children ___ Difficulty getting along with other people

What are your life stressors like: _____
_____
_____
_____

What do you do for fun: _____
_____
_____

Do you identify with any religion or spiritual beliefs: _____
_____

Who can you turn to for support: _____
_____

Have you been the victim or perpetrator of physical or sexual abuse _____
_____
_____

Have you been the victim or perpetrator of domestic violence? _____
_____
_____
_____

Please list all prescribed mental health medications: _____
_____
_____
_____

Is there anything else you feel we should know about? _____
_____
_____
_____

Medical Questionnaire

Name: _____ **Male / Female** **Date of Birth** _____

Height: _____ **Weight:** _____ **Date of last physical exam:** _____

Primary Care Physician: _____

Address: **Phone:** _____

_____
_____
_____

Allergies:	

List All Current Prescription Medications			
Medication	**Dosage**	**When Taken**	**Prescribed By**

List Any Medical and/or Psychiatric Diagnosis

Medical Questionnaire

Check if you have had any of the following:

- ____ **Head injury**
- ____ **Migraines or blurred vision**
- ____ **Allergies to medications**
- ____ **Surgery**
- ____ **Cancer/tumor**
- ____ **Asthma**
- ____ **Chronic pain issues**
- ___ **Lung infection**
- ___ **Light headedness, dizziness**
- ___ **Allergies**
- ___ **Diabetes**
- ___ **High blood pressure, rapid heartbeat**
- ___ **Thyroid problem or goiter**

Are you pregnant: _____

Do you have regular periods: _____

Communicable Diseases			
	Last year tested	**Results**	**Comments**
Tuberculosis			
Hepatitis			
Ringworm			
Meningitis			
MMR			

Sexually Transmitted Diseases			
	Last year tested	**Results**	**Comments**
HIV			
Gonorrhea			
Venereal warts (HPV)			
Herpes			
Chlamydia			

Please list any other information that you feel may be necessary for us to know

_____

_____

_____

_____

_____

John Genardo, LCMHC
41 Juliand Street
Bainbridge, NY 13733
(607) 287-0058

Billing and Payment

Payment is expected at time of visit unless it is agreed on beforehand. My rates are $125 per hour; however, I charge on a sliding scale, meaning rates may vary but will not exceed my normal rate. There will be a $35 charge for all returned checks.

Forensics and Litigation

It is the stated philosophy of this practice that I do not participate in lawsuits of any type unless compelled to do so by a subpoena or court order. If you become involved in legal proceedings that require my involvement, you will be expected to pay for all my professional time, including preparation, dispositions, telephone time, transportation costs, court appearance, report writing, consultation and supervision, even if I am called to testify for another party. Because of the complexity of legal involvement, I charge $250 per hour for all preparation and attendance at any legal proceeding.

Emergencies

In the event of a psychiatric emergency, please call 911 or go to your nearest emergency room and ask to be evaluated by a psychologist or psychiatrist on call. The National Suicide Prevention Lifeline is also available 24 hours a day, 7 days a week: 1-800-273-TALK (1-800-273-8255).

Acknowledgement of Receipt of Client's Rights, Exemptions to Confidentiality and Privacy Practices

As mental health clinicians, we have an ethical and legal responsibility to maintain and protect your confidentiality as a client. We take this responsibility seriously and work hard to ensure the privacy of all clients is kept confidential. Although we strive for confidentiality, there may be exceptions in which we might have to break confidentiality:

Exceptions:

If the clinician believes that you may be a serious threat to yourself or someone else.
If the clinician learns of possible child abuse.
If the clinician is subpoenaed to testify in a court case.
The clinician believes there is custodial abuse, neglect, threats to harm yourself, threats to harm someone else, suicide gestures, as well as certain criminal offenses.

I have been supplied with a copy of the Patient's HIPPA Rights and Confidentiality. I have read and understand the information in the document. If I did not understand, I asked the clinician for clarification. By signing this document, I agree that I received and understand the Patient's HIPPA Rights and Confidentiality.

Client Signature: _____ Print Name: _____

Parent/Guardian Signature for Minor: _____ Date: _____

41 JULIAND STREET ⁂ BAINBRIDGE, NEW YORK 13733 ⁂ JOHN GENARDO, LCMHC 607-287-0058 ⁂ genardocounseling@charter.com

1) A person has a right to continuous, ongoing treatment with an individualized treatment plan and the right to participate to the fullest extent consistent with the patient's capacity, in his/her own treatment planning.
2) A person has the right to a full explanation of services rendered in accordance with his treatment plan.
3) Participation in an outpatient treatment program is voluntary and a person has a right to refuse treatment unless he/she is found to be legally incompetent and/or a danger to him/herself or others.
4) While a patient's full participation in his treatment is the central goal, objection to his/her treatment plan or disagreement with any portion of the plan shall not result in the patient's termination from treatment unless such objection renders the patient's continued participation in the treatment clinically inappropriate or would endanger the safety of him/herself or others.
5) The patient's clinical record shall be a confidential document maintained in accordance with Section 33.13 of the Mental Hygiene Law.
6) The patient shall be assured access to his clinical records in accordance with Section 33.13 of the Mental Hygiene Law.
7) The patient has the right to receive clinical care and treatment which is appropriately suited to his/her needs, skillfully, safely and humanely administered and with full respect for dignity and personal integrity.
8) A patient has a right to receive treatment in a manner that is non-discriminatory.
9) A patient has the right to be treated in a way which acknowledges and respects his/her cultural environment.
10) A patient has the right to privacy consistent with the effective delivery of treatment.
11) A patient has the right to freedom from abuse and mistreatment by an employee.
12) A patient has the right to request a change of therapist.
13) A patient has the right to terminate treatment, unless determined to be a danger to him/herself or others.
14) A patient has the right to be informed of the provider's grievance policy and procedure and to initiate any question, complaint or objection, in accordance to the policy.