**Office of Maureen Lansat, LMHC**

**CLIENT INFORMATION**

Name:_____
First Middle Last

Address:_____
Street City State ZIP

Phone:_____ Marital Status: _____ Birth Date:_____

Email:_____

Gender_____

Preferred method of contact:_____-_____

How did you hear about us?_____

**RESPONSIBLE PARTY** (If other than client)

Name:_____ SS#:_____
First Middle Last

Address:_____
Street City State ZIP

Relationship to Client:_____Phone:_____

Payment type: credit card/ check/ cash

Credit card _____ Exp. Date _____

**Office of Maureen Lansat, LMHC**

**INSURANCE INFORMATION**

Primary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Provider Telephone: _____

Secondary Insurance Carrier: _____

Please call The Member Services Phone number for Behavioral Health on your Insurance Card and ask the Customer Service representative the following questions:

Is Individual Psychotherapy (CPT 90834) covered? _____

Is Family Psychotherapy (CPT 90847) covered? _____

How many visits are covered? _____

Do I have a co-pay? (And how much is it?) _____

Do I have a deductible? (And how much is it?) _____

For new clients: Is Diagnostic Interview (CPT 90791) covered? _____

## Office of Maureen Lansat, LMHC

## Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and me/us, The Healing and Creative Arts Center. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here_____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

**If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.**

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Web Site, www.healingandcreativearts.org or by calling us at 561-373-4697, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Client Date of Birth

_____

Date of NPP Copy give to the client/parent/personal representative.

**Office of Maureen Lansat, LMHC**

## Authorization to Use and Disclose Protected Health Information

1. I am completing this form to allow the use and sharing of protected health information about

Printed name: _____ Date of Birth: _____

2. I authorize this person or organization: The Healing and Creative Arts Center of the Palm Beaches

3a. To use or disclose the following information:

- Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness or drug and/ or alcohol abuse.
- Admission and discharge summaries
- Psychological or psychiatric evaluation(s),reports, assessments treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- Social family, educational and vocational histories
- Progress, nursing, case or similar notes.
- Evaluations and reports of consultants
- Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
- Vocational evaluations and reports
- Billing records
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here Do not release these.
- Complete copy of the medical record.
- Other:_____

3b. Dates of care included: From_____ to _____ and
From_____ to_____ and
From_____ to_____

4. To this person or organization:

_____

_____

5. The information will be used/ disclosed for the following purposes:
_____therapeutic purposes_____

6. I understand and agree that this Authorization will be valid and in effect until _____ [Enter a date or event upon which this Authorization expires.] I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the "professional or facility listed at number 4 above, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy the health information described in this authorization.

10.I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

11. I understand that this professional or facility will receive compensation for the use or disclosure of my health information The arrangement has been explained to me and understand and accept it. Does not apply

12. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it as indicated by my signature below.

13. _____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

14. I acknowledge that I received a copy of this completed form

15. I, a mental health professional, have discussed the issues above with the client and/ or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ _____
Signature of professional Printed name of professional Date

**Office of Maureen Lansat, LMHC**

## Payment Agreement

I hereby authorize Maureen Lansat, LMHC at The Healing and Creative Arts Center of the Palm Beaches, Inc to release to my insurance company or its representatives any information regarding my treatment, including diagnosis, necessary to process my insurance claim.

I hereby assign all my rights to benefits payable by my insurance company to Maureen Lansat at The Healing and Creative Arts Center of the Palm Beaches, Inc. and thereby authorize and request my insurance company to pay my benefits directly to Maureen Lansat at The Healing and Creative Arts Center of the Palm Beaches, Inc.

All insurance information has been listed correctly. I understand that if I have any other health insurance coverage, including an HMO that is not listed above, any charges not covered by the listed insurance will be my responsibility.

I accept responsibility for payment of any charges that are not covered by insurance.

_____ _____

Signature Date

_____

PRINT NAME

**Office of Maureen Lansat, LMHC**

## ADULT PERSONAL HISTORY (18 AND OLDER)

CLIENT NAME: _____DATE: _____
CLIENT PHONE NUMBER_____
CLIENT EMAIL_____
CLIENT ADDRESS:_____
_____
Person completing form for client: _____

Please take your time and complete entire form. The information will help your therapist understand you better.

Emergency Contact Name:_____

Address:_____

Relationship to Client:_____

Phone:_____

Primary Care Physician:_____ Phone:_____

Address_:_____

Current Health Problems:_____

Medications Prescribed:_____

Date of Last visit:_____

What RECENTLY HAPPENED to make you decide to seek help now? _____
_____
_____

What are your goals for therapy? _____
_____
_____

Use back of last sheet of this form if necessary.

CLIENT NAME: _____DATE: _____

| **FULL NAME** | Age | Living with? | If Deceased, Year/cause |
|---|---|---|---|
| Parents _____ | | | |
| _____ | | | |
| Spouse/Partner: _____ | | | |
| Children and _____ | | | |
| Step-children: _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |

MARITAL STATUS:

Unmarried _____

Live together _____ How many years? _____

Married _____ How many years? _____

Separated _____ How many years? _____

Divorced _____ How many years? _____

Widowed _____ How many years? _____

Number of times married: _____

Who lives in your home? _____

You were raised by: _____

Number of brothers/sisters: _____ # living: _____ # older than you: _____

Family members you are close to now: _____

MENTAL HEALTH HISTORY:

Have you ever attempted to commit SUICIDE or seriously harm yourself? _____

When? _____ How? _____

Has anyone in your family attempted suicide? _____ Committed suicide? _____ Who?_____

Explain: _____

Have you ever attempted to kill or seriously harm someone else? _____ Who? _____

Explain: _____

Have you ever hit, slapped or choked any of your loved ones? _____

During arguments/fights do you threaten, throw or break things, punch the walls or slam doors, yell or scream at your partner or children?_____

Describe: _____

Is your partner afraid of you sometimes? _____ Are your children? _____

CLIENT NAME: _____DATE: _____

Do you feel guilty about your behavior afterward? _____
Have you ever been the victim of physical, sexual or verbal abuse?_____
Describe: _____
Describe any sexual concerns that you might have: _____
_____

CIRCLE or CHECK any of the following that apply to you now or within the past month (feel free to explain):

| | | |
|---|---|---|
| Depression | Increased alcohol use | Nervous/Anxious |
| Crying spells | Increased drug usage | Panic attacks |
| Hopelessness | Blackouts/memory loss | Can't concentrate |
| Relationship breakup | Withdrawal symptoms | Confusion |
| Loneliness | Financial worries | Mood swings |
| Emptiness | Loss of control in: | Racing thoughts |
| Loss of appetite | - alcohol/drug use | Fear of dying |
| Sleep disturbance | - overeating/bingeing | Job stress |
| Nightmares | - purging | Decreased activity |
| Thoughts of harming self | - yelling/breaking | Not seeing friends |
| Thoughts of harming others | - hitting people | Feel controlled |
| Suicide attempts/injuries | - endangering self | Feel talked about |
| Hearing voices | - endangering others | Guilt/shame |
| Seeing things others don't | - spending | Sexual problems |
| Unusual thoughts | - gambling | School problems |

Please explain circled items: _____
_____
_____
_____

PREVIOUS MENTAL HEALTH TREATMENT:
Were you ever HOSPITALIZED for depression, hearing voices or other mental or emotional problems?_____
How many times? _____ Any involuntary? _____ Year of first admission:_____ Where: _____
Reason: _____
Year of last admission: _____ Where: _____
Reason: _____
Have you received any OUTPATIENT Mental Health counseling? _____
Where/when: _____
Reason: _____
Have you ever been involved in any support groups (Emotions Anonymous, Recovery, Weight-Watcher, Incest Survivors, ACOA, Alanon, etc.)? _____When? _____Type of Group: _____
Reason: _____ Was it helpful? _____
Has anyone in your FAMILY ever been hospitalized for depression or any other mental or emotional problems?
Please explain who, when and reason: _____
_____
_____
_____

ETHNIC Background: _____
Any ethnic problems/concerns? _____
RELIGIOUS/SPIRITUAL Background: _____
Current religious/spiritual activity: _____
Do you have any spiritual concerns now? _____
EDUCATION: Last grade completed: _____ Degree: _____ In school now? _____

CLIENT NAME: _____DATE: _____

Special training or skills: _____
Hope/plan to go to school? _____
Have a learning difficulty? _____
EMPLOYMENT: What do you do for a living? _____
Employer: _____ Years on job: _____ Pay rate: _____
If no job, when did you last work? _____ Looking for work now? _____ Any job problems now? _____
Ever been fired? _____ How many times: _____ Why? _____
FINANCIAL: Do you have any financial problems? _____
What financial aid do you receive? _____ Amount: _____
What aid does rest of family get?_____ Amount: _____

LEGAL HISTORY:

| Arrest Date | Charge | Convicted? | Sentence |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are you currently on Probation? _____ Parole? _____ Ending Date: _____
Are you involved in any lawsuits?_____
Any upcoming Court dates?_____
MILITARY SERVICE: Type: _____ When: _____
Honorable discharge? _____ If not, why? _____
Describe any combat experience:_____
Are you troubled now by your experience in the military? _____
INTERESTS/ACTIVITIES (Circle or check):

| | | | |
|---|---|---|---|
| Television | Be with friends | Shopping | Fix/repair things |
| Movies/videos/DVDs | Be with family | School | Sew/knit/crochet |
| Music listening | Be alone | Get high | Build/decorate |
| Play instrument | Cooking/eating | Exercise | Gardening |
| Singing | Go to museums | Play sports | Photography |
| Dancing | Volunteer work | Watch sports | Video games |
| Reading | Travel/sight-see | Hiking | Care for elderly |
| Writing | Prayer/Church | Gambling | Child-care |
| Drawing | Camping | Sex | Nothing |

Other interests/activities: _____
Have you recently lost interest in activities you normally enjoy? _____
Do you feel you spend enough time on your interests or non-work activity? _____
PHYSICAL HEALTH:
CIRCLE THE NUMBER FOR EACH ITEM THAT APPLIED TO YOU IN THE PAST OR NOW, AND THEN EXPLAIN BELOW:

1. Allergies
2. Asthma
3. Ulcers
4. Cancer
5. Stomach problems
6. Pancreatitis
7. Chronic pain
8. Heart disease
9. Bacterial endocarditis
10. Seizures
23. Sever headaches/migraines
24. Frequent neck/shoulder pain
25. Head injuries
26. Physical Abuse
27. Sexual abuse
28. Premenstrual syndrome
29. Sexually transmitted diseases
30. Positive HIV
31. AIDS
32. Tuberculosis

CLIENT NAME: _____DATE: _____

11. High Blood Pressure
12. Low Blood Pressure
13. Diabetes
14. Hypoglycemia (Low blood sugar)
15. Thyroid Problems
16. Liver Disease
17. Vision problems
18. Hearing problems
19. Speech problems
20. Dental problems
21. Weight loss
22. Weight gain
33. Hepatitis
34. Major surgeries
35. Chronic fatigue syndrome
36. Impotence
37. Prolapsed mitral valve
38. Circulation problems
39. High Cholesterol
40. Irritable bowel
41. Broken bones
42. Accidents
43. _____
44. _____

| # | At what ages? | Describe problem and treatment (include medications): |
|---|---|---|
| ___ | _____ | _____ |
| ___ | _____ | _____ |
| ___ | _____ | _____ |
| ___ | _____ | _____ |
| ___ | _____ | _____ |
| ___ | _____ | _____ |

Date of last physical: _____ Results: _____
Do you eat a regular balanced diet? _____ Do you skip meals? _____
Any poor eating/junk-food habits? _____
Do you exercise regularly? _____ How often? _____
FOR WOMEN: Number of pregnancies? _____ Live births: _____ Adoptions: _____
Normal menstrual cycle? _____ Are you pregnant?_____
Premenstrual syndrome? _____ Menopause? _____ Hormone therapy? _____

ALCOHOL AND DRUG HISTORY:
How many days a month do you drink _____ or use non-prescribed drugs?_____
On the days that you drink or use drugs, about how much do you drink in ounces (including beer) or use in drugs?_____
How many times a month do you drink more than you planned to? _____
Do you ever experience blackouts (memory lapses) when drinking? _____
Have you ever overdosed _____ or experienced withdrawal symptoms? _____
Explain:_____
How much alcohol and drugs have you used in the last 48 hours?
Alcohol: _____ Drugs: _____
What's the longest period you remained totally alcohol/drug-free? _____
What helped you to stay clean? _____
Did you ever receive HOSPITAL or RESIDENTIAL treatment for an alcohol or drug-related problem? _____
How many times? _____
Where/When: _____
Have you ever received any OUTPATIENT alcohol/drug treatment? _____
Where/When: _____
Ever involved in alcohol/drug Support groups (AA, NA, etc.)? _____
Where/When: _____ Helpful?_____
Has any family member/loved one ever had a drinking or drug problem? _____
Who? _____ Please describe:_____
_____
IF YOU ANSWER YES TO EITHER OF THE NEXT TWO QUESTIONS PLEASE COMPLETE THE FOLLOWING PAGE.

CLIENT NAME: _____DATE: _____

Has drinking or drugs ever caused problems in any of the following areas:

family _____ employment _____ legal _____ emotional _____
social _____ financial _____ behavior _____ physical _____

Does a relative, loved one, friend, court or employer think so? _____

| TYPE OF DRUG | AGE OF 1ST USE | WHAT AGE WERE YOU USING IT REGULARLY | AVERAGE NUMBER OF DAYS USED EACH WEEK | ABOUT HOW MUCH WOULD YOU USE EACH DAY | # DAYS USED IN PAST 30 DAYS | LAST DATE YOU USED |
|---|---|---|---|---|---|---|
| Coffee, Cola<br>Caffeine pills | | | | | | |
| Cigarettes | | | | | | |
| Beer<br>Wine<br>Liquor | | | | | | |
| Marijuana | | | | | | |
| Crack cocaine<br>51's<br>Cocaine powder | | | | | | |
| Heroin: Snort<br>Snoot | | | | | | |
| Methadone | | | | | | |
| Pain Medication<br>Type: | | | | | | |
| Tylenol #3 or 4 | | | | | | |
| Muscle Relaxers<br>Soma, Flexeril<br>Other: _____ | | | | | | |
| Valium, Librium<br>Other: _____ | | | | | | |
| Glue<br>Poppers<br>Aerosols | | | | | | |
| PCP<br>LSD<br>Mescaline | | | | | | |
| Meth-amphetamine | | | | | | |
| Phenobarbital<br>Sleeping pills | | | | | | |
| Steroids | | | | | | |
| Other: | | | | | | |