IN Psych CENTER
A Licensed Clinical Social Worker Corporation

127 EAST THIRD AVE., STE 201
ESCONDIDO, CA 92025
T: 760/489-1092 F: 760/738-8128
INPSYCHCENTER.COM

ADULT ASSESSMENT

Last Name:			First Name:		Date:	
Date of Birth:		Age:	M / F			
Status:	Single	Married	Partnered	Widowed	Divorced	Separated

Address:	Apt#:	City/State:	Zip:
Cell Phone: ( )	Alternate Phone (Home / Work): ( )		
Name of Emergency Contact:		Phone: ( )	
Relationship to you:			

Who referred you, or how did you hear about us?	***May we acknowledge the referral and thank them? Yes____ No ____***
Probation officer, if applicable:	Phone: ( )
CSB caseworker, if applicable:	Phone: ( )
Attorney, if applicable:	Phone: ( )

PERSONAL HISTORY

Living with: _____
Name(s) Relationship(s)

List Children's Names:	Age	M / F	Child lives with:
1.			
2.			
3.			
4.			

Visitation/Legal issues, if applicable:_____

Currently employed by: _____Position: _____
How long: _____Education: Highest grade completed: ___ GED: ___ Degrees: _____
Special Education/Skills Training:_____

PSYCHO-SOCIAL HISTORY

Current problems: _____

_____

_____

_____

Symptoms: _____

_____

_____

_____

Family History: _____

_____

_____

_____

_____

IMMIGRATION HISTORY (if applicable) / Cultural Variables:

_____

PSYCHO-SOCIAL

Stressors/Limitations: _____

Strengths: _____

HISTORY OF PSYCHOLOGICAL/PSYCHIATRIC TREATMENT (Check if applicable)

☐ In-Patient: Number of times: ____ Last In-Patient Date: _____
Reason: _____

☐ Out-Patient: Number of previous therapists: _____
Reason: _____
Outcome: _____

_____

Most recent therapist/physician: _____

How long: _____ Last visit: _____ Diagnosis: _____

Other current treatment: _____

FAMILY HISTORY OF PSYCHOLOGICAL TREATMENT (if applicable)

1. _____ (relationship) Dx: _____

2. _____ (relationship) Dx: _____

MEDICAL HISTORY (if applicable)

Current Medications:

1. _____ Dosage: _____ Duration of use: _____ For: _____

2. _____ Dosage: _____ Duration of use: _____ For: _____

3. _____ Dosage: _____ Duration of use: _____ For: _____

Prescribing Physician: _____

Medical problems over last five years: _____

History of Suicidal Ideation / Attempts	
History of Violent Behavior:	
History of Substance Use Alcohol:	
Other Drugs:	

Previous Treatment for Chemical Abuse: _____ How many times: _____

Where: _____When: _____ Completion: _____

Currently attending "12-Step Group": AA NA CA SA

Currently in treatment: _____ Where: _____

ARREST RECORD (if applicable)

_____

_____

_____

HISTORY OF ABUSE (if applicable)

Were you physically, sexually or emotionally abused or neglected as a child? ____

1. Abused by whom?_____ Your age:____ Their age:_____

Reported? _____ If yes, to whom? _____ When? _____

Circumstances? _____

_____

2. Abused by whom?_____ Your age:____ Their age:_____

Reported? _____ If yes, to whom? _____ When? _____

Circumstances? _____

_____

3. Abused by whom?_____ Your age:____ Their age:_____

Reported? _____ If yes, to whom? _____ When? _____

Circumstances? _____

RELATIONSHIP/SEXUAL HISTORY

How many times married? _____

How many times partnered? _____

Currently in a relationship: Yes ____ No ____

If yes, how long? _____

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English

Acknowledgment of "HIPAA Notice of Privacy Practices" and "Office Policies & General Information: Agreement for Psychotherapy, Psychoeducational, Consulting, and Assessment Services"

Please sign below to indicate that you have been given the opportunity to read the "HIPAA Notice of Privacy Practices" (Revised 1/19/2019) and the "Office Policies & General Information: Agreement for Psychotherapy Services" (Revised 1/19/2019) either in the form of hard copy or electronically. By signing, you also indicate that you understand the information provided in the documents, have had any questions or concerns addressed and have been given a hard copy of either as desired.

_____ _____
Signature of Client or Guardian Printed Name

Date:_____

Español

Reconocimiento de "Notificacion de Practicas de Privacidad de HIPAA" y "Procedimientos de la Oficina E Informacion General: Acuerdo Para Servicios de Psicoterapia, Psicoeducacion, Consultas, y Evaluacion"

Favor de firmar abajo para indicar que se le ha dado la oportunidad de leer la "Notificacion de Practicas de Privacidad de HIPAA" (Revisado 1/19/2019) y los "Procedimientos de la Oficina E Informacion General: Acuerdo Para Servicios de Psicoterapia" (Revisado 1/19/2019) o en la forma de copia en papel o electronica. En firmar tambien indica ud. que entiende la informacion dado en los documentos, se le ha contestado cualquier pregunta o preocupacion y se la ha dado una copia de cualquier de los dos como deseado.

_____ _____
Firma del Cliente o Guardian Nombre Imprimido

Fecha:_____

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
(TPO)

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, we will inform you. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above. I understand that I am responsible for any amount not covered by insurance or other payment entity.

Client Name: _____ Date: _____ Signature: _____

Or
Legal
Representative: _____ Date: _____ Signature: _____

CONSENTIMIENTO A UTILIZAR O A DIVULGAR INFORMACIÓN PARA EL TRATAMIENTO, EL PAGO, Y LAS OPERACIONES DEL CUIDADO MÉDICO (TPO)

Regulaciones federales (HIPAA) permiten que utilice o que divulgue la Información Protegida de Salud (IPS) de su expediente para proporcionarle tratamiento, para obtener pago por los servicios previstos, y para otras actividades profesionales (conocidas como "operaciones del cuidado médico"). Sin embargo, pido su consentimiento para hacer este permiso explícito. La Notificación de las Prácticas de Privacidad describe éstas divulgaciones más detalladamente. Usted tiene el derecho a repasar la Notificación de las Prácticas de Privacidad antes de firmar este consentimiento. Nos reservamos el derecho de revisar nuestra Notificación de las Prácticas de Privacidad en cualquier momento.

Si así lo hacemos, se le notificará del cambio. Usted puede pedir una copia impresa de nuestra notificación en cualquier momento. Usted puede pedir que restrinjamos el uso y la divulgación de cierta información en su expediente que de otra manera sería divulgado en el proceso de su tratamiento, el pago, u operaciones del cuidado médico; sin embargo, no tenemos que consentir con estas restricciones. Si consentimos con una restricción, ese acuerdo es obligatorio. Usted puede revocar este consentimiento en cualquier momento dando notificación por escrito. Tal revocación no afectará ninguna acción tomada basada en el consentimiento antes de la revocación.

Este consentimiento es voluntario; usted puede rechazar firmarlo. Sin embargo, se nos permite negarle servicios de cuidado médico si este consentimiento no es otorgado, o si el consentimiento se revoca más adelante. Yo por la presente doy consentimiento al uso o divulgación de mi Información Protegida de Salud como especificado arriba.

Yo entiendo que soy responsible de cualquier cantidad que no este cubierta por la aseguran o otra entidad de pago.

Nombre del paciente: _____ Fecha: _____ Firma: _____

O representante legal: _____ Fecha: _____ Firma: _____

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Patient's Right for Confidential Communications

In order to protect the privacy and confidentiality of your financial, clinical, or scheduling information, please complete the following which tells me how you would like to be contacted.

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

Phone Communications (check all that apply):

____ Home Phone Number (On Assessment Form) ____ Work Phone Number (On Assessment Form)
____ Cell Phone Number (On Assessment Form)

Types of Messages (check all that apply):

____ Leave message with your name and our call-back # only
____ Leave message with clinical, scheduling, or financial information
____ List anyone with whom you give permission to share information:

_____ _____
Name Relationship

_____ _____
Name Relationship

E-mail Communications

____ E-mail address _____

* Please read the following notice on consent to use unencrypted e-mail or text:

Consent To Use Unencrypted E-Mail Or Text

It is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on InPsych Center's computers are encrypted, e-mails, e-faxes, and texts are not. It is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address, number, or computers. E-mail messages on your computer, your laptop, IPad, phone or other devices have inherent privacy risks – especially when your e-mail access is provided through your employer or when access to your e-mail messages is not password protected.

InPsych Center's computers are equipped with a firewall, a virus protection and a password, and all confidential information from the computer is backed up on a regular basis onto an encrypted drive. Please, note that e-mails, faxes, and texts are all part of your clinical records. Also, be aware that phone messages may be transcribed and sent to your therapist via unencrypted e-mails.

Please notify your therapist if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts, e-fax, or phone messages, it will be assumed that you have evaluated the risks and agree to take that risk. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

Your therapist will continue to communicate with you according to your above response(s) until you change your preferences. You may do so my completing a new form.

By your signature below, you agree to communication in the above manner.

Patient Signature _____

Patient Name _____ Date _____

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Electronic Payment Authorization

Please indicate the card you wish to use for any services (including "no shows") rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC, and Discover.

Payments are processed by Therapy Partner.
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Client Information:

Client Name: ____ Date of Birth: _____________________

Address: ___________________________ City: __________________ State: ___________ Zip: __________

Home Number: ________________________ Mobile Number: ________________________

Please provide your email if you would like to receive statements or "superbills" via email.
Email: ____

Billing Information:

Please indicate the information associated with the debit or credit card you wish to use if it is different from above.

Name: ____

Address: ___________________________ City: __________________ State: ___________ Zip: __________

I authorize all service fees to be deducted from the card ending in ________ (last four digits of the card)

Please enter the CVV code __________ (last three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Client's Full Name(s) ____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

____ _______________________

Cardholder Signature **Date**

- -

Debit/Credit Card Information:

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: ____ Expiration Date: _____________________