Sean Burns, MA, LLP, CAADC
Psychotherapist
3300 Burton St SE
Grand Rapids, MI 49546
P: (616) 706-9741
F: (616) 285-6880

Client (Adult) Information Form

Date:___________________________

Primary Insured DOB:___________
Address:___________________________
____

Identification

Client name:___________________________Date of Birth:________________Age:____
Social Security#:________________________
Home street address:____Apt.:__________
City:____State:________Zip:_____________
Primary phone:________________________Secondary phone:_____________________
E-mail:____

Referral Source: [ ] Internet [ ] Friend [ ] Professional [ ] Insurance Company
[ ] Other:_______________May I thank this person for the referral? [ ] Yes [ ] No

Your Medical Care:

Doctor's name/Clinic:______________________________Phone:____________________
Address:____
If you enter counseling with Sean Burns, may he tell your medical doctor so that he or she can be fully informed and can coordinate your treatment? [ ] Yes [ ] No

Religious and racial/ethnic identification: Current religious denomination/affiliation
[ ] Buddhist [ ] Catholic [ ] Christian [ ] Hindu [ ] Jewish [ ] Muslim [ ] Protestant
[ ] Other (specify):____
Involvement: [ ] None [ ] Some/irregular [ ] Active
How important are spiritual concerns in your life?
____

Employer

Employer Name:_____________________________Phone:__________________________
Address:____

School

School Name:________________________________Phone:__________________________
Address:____
Grade/year in college:_________________________College Major:__________________

Emergency information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?
Name:_______________________Phone:_______________Relationship:______________
Address:____

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Appointment, Fee & Consent for Treatment Information

Therapy Appointments: I often schedule several appointments in advance so that you can plan to make therapy sessions a priority in your busy schedule.

Cancelled Appointments: Cancelled appointments delay therapy work. The time we have reserved for you is very important for your care. Please try not to miss sessions if you can possibly help it. When you must cancel, please give at least 48 hours notice.
Late Fee: Cancellations made less than 24 hours of a business day in advance of your appointment will be billed as follows: 1/2 session charge for the first late cancel and a full session charge for the second and thereafter. Your insurance will not cover this charge.

Payment is expected at time of service. I accept cash, checks, credit, and debit cards.

Psychotherapy Service Fees:

Initial Evaluation	$180.00
Therapy Session (45-50 minutes)	$130.00
Therapy Session (60 minutes)	$150.00
Family Session (45-50 minutes)	$150.00
DOT/SAP Evaluation	$600.00
Substance Use Evaluation	$200.00
Driver's License Evaluation	$200.00

Please balance your account by the end of each month.

_______Please initial here when you have read this section

Health Insurance Coverage: Because I am a licensed mental health provider, many insurance plans will help pay for my services. Every insurance plan is different. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth.

If you have no health insurance coverage, or do not intend to use it, please check here [ ], Skip this section.
If you will be using insurance, please complete the following:
Primary Insurance Company:____
Name of subscriber (if not the patient):____
ID/Policy #:______________________Group or enrollment #:_______________________
Address to send claims:______________________________Phone:__________________
Does your insurance require authorization for my services? [ ] Yes [ ] No
Did you call to get authorization? [ ] Ye [ ] No, Authorization#:______________________
What is your deductible?:$_____________[ ] per person or [ ] per family [ ] per fiscal year [ ] per calendar year or [ ] per policy year?
How much of this deductible has been used so far? $ __________
Number of visits:___ Copayment per session: $_____

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Insurance Release: I give Sean Burns permission to release any information obtained during treatment this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

Financial Responsibility: I understand that I am responsible for all charges, regardless of insurance coverage.

Assignment of benefits: I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Sean Burns. A photocopy of this assignment is to be considered as good as the original.

____

Signature of Client, **Printed Name** **Date**
Indicating agreement to all of the statements above

Therapy Agreement/Consent for Treatment: I,______________________(or his/her guardian), understand I have the right not to sign this form. My signature below indicates I have read this agreement and had any questions answered; it does not indicate that I am waiving any of my rights. I understand that any of the points mentioned in this document can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this brochure, I can talk with my therapist about them, and he will do his best to answer them. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. How've, I will make every effort to discuss my concerns about my progress with my therapist before ending therapy.

- I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.
- I have read, or have had read to me, the issues and points in this brochure. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this brochure. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

____

Signature of client (or person acting for client) Printed Name Date
Relationship to client: [ ] Self [ ] Legal guardian

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Adult Checklist of Concerns and History

Please mark all of the items below that apply. Add notes or details in the space next to the concerns checked.

[ ] Abuse: Physical, sexual, emotional, neglect,
[ ] Aggression, violence
[ ] Alcohol use
[ ] Anger, hostility, arguing, irritability
[ ] Anxiety, nervousness
[ ] Attention, concentration, distractibility
[ ] Career concerns, goals, and choices
[ ] Childhood issues (your own childhood)
[ ] Codependence
[ ] Confusion
[ ] Compulsions
[ ] Custody of children
[ ] Decision making, indecision, putting off decisions
[ ] Delusions (false ideas)
[ ] Dependence
[ ] Depression, low mood, sadness, crying
[ ] Divorce, separation
[ ] Drug use
[ ] Eating problems-over, underrating, vomiting, appetite
[ ] Emptiness
[ ] Failure
[ ] Fatigue, tiredness, low energy
[ ] Fears, phobias
[ ] Financial or money troubles
[ ] Friendships
[ ] Gambling
[ ] Grieving, mourning, deaths, losses, divorce
[ ] Guilt
[ ] Headaches, other kinds of pain
[ ] Health, illness, medical concerns, physical problems
[ ] Housework/chores-quality, schedules, sharing duties
[ ] Inferiority feelings
[ ] Interpersonal conflicts
[ ] Impulsiveness, loss of control, outbursts
[ ] Irresponsibility
[ ] Threats, violence
[ ] Trauma Experience
[ ] Withdrawal, isolating
[ ] Judgement problems, risk taking
[ ] Legal Matters, charges, suits
[ ] Loneliness
[ ] Marital problems
[ ] Memory problems
[ ] Menstrual problems, PMS
[ ] Menopause
[ ] Mood swings
[ ] Motivation, laziness
[ ] Nervousness, tension
[ ] Obsessions, compulsions
[ ] Oversensitivity to rejection
[ ] Pain, chronic
[ ] Panic or anxiety attacks
[ ] Parenting issues
[ ] Perfectionism
[ ] Pessimism
[ ] Procrastination, laziness
[ ] Relationship problems
[ ] School problems
[ ] Self-centeredness
[ ] Self-esteem
[ ] Self-neglect, poor self-care
[ ] Sexual issues
[ ] Shyness
[ ] Oversensitivity to criticism
[ ] Sleep problems
[ ] Smoking and tobacco use
[ ] Spiritual, religious, moral,
[ ] Ethical issues
[ ] Stress
[ ] Suspiciousness, distrust
[ ] Suicidal thoughts
[ ] Temper problems
[ ] Thought disorganization
[ ] Confusion
[ ] Weight and diet issues
[ ] Work problems
[ ] Other Concerns or issues:____

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

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<u>Presenting Issues:</u> What are the main reasons you came in for treatment?

Please give a brief history of these problems (when they began, attempted solutions, etc.)

<u>Abuse History:</u> [ ] I was not abused in any way. [ ] I was abused.
Please describe:

<u>Legal History:</u>
Are you presently suing anyone or thinking of suing anyone? [ ] No [ ] Yes
If yes, please explain: ____
Is your reason for coming to see me related to an accident or injury? [ ] No [ ] Yes
If yes, please explain: ____
Are you required by a court, the police, or a probation/parole officer to have this appointment?
[ ] No [ ] Yes If yes, please describe:

<u>Military Experience:</u>
Do you have military experience (describe)?

<u>Is there any other information you would like your therapist to know?</u>

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Notice of Privacy Practices (Brief Version)

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.

My commitment to your privacy. Sean Burns PLLC, is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. This is a shorter version of the full, legally required notice of privacy practices.

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

Disclosing your health information without your consent. There are some times when the laws require me to use or share your information. For example:

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

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I try my best to do as you ask. 2. You can ask me to limit what I tell people involved in your care or payment for your care, such as family and friends.
3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but I may charge you for it. 4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. You must tell me 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 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 I 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. I will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or my health information privacy policies, please contact me at (616) 706-9741.

The effective date of this notice is 06/01/2015

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Consent to Use and Disclose Your Health Information

This form is an agreement between you and me. When I use the words “you” and “your” below, this can mean you, your child, a relative, or other person as follows:__________.

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls “protected health information”(PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information.
If you do not sign this form agreeing to my privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change my notice of privacy practices.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to me. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

_______________________________________ ______________
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

____
Signature of authorized representative of this office or practice

Date of NPP:____________________________

❑Copy given to the client/parent/personal representative

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