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355 North 21st Street, Suite 200
Camp Hill, PA 17011
Phone: (717) 745-7463
Fax: (717) 545-2699

Client Information

Client's Name: _____
(First) (Initial) (Last)

Date of Birth: _____ Age: _____ SS#: _____

Address: _____

_____

Email Address: _____

Phone: (W) _____ (H) _____

(C) _____ ok to leave message? Y N

Emergency Contact Name: _____

Emergency Contact Phone: _____

Who referred you for treatment? Name: _____

What is their contact information? Address: _____

Phone #: _____

Who is your treating Primary Care Physician? _____

Address: _____ Phone # _____

Who else lives in your home?

Name	DOB	Relationship to client

Marital Status

___Single ___Married (Length of time: ___) ___Unmarried, living together (Length of time: ___)

___Separated (Length of time: ___) ___Divorced (Length of time: ___) ___Widowed (Length of time: ___)

Total Number of Marriages: _____

Assessment of current relationship (if applicable): __Good __Fair __Poor

What are some of your chief concerns for your life right now?

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Client Information

Client name: _____ DOB: _____

Physician's Name: _____ Date of last visit: _____

Physician's Address: _____ Physician's phone number: _____

_____

_____

Are you currently under medical treatment?

Describe:

Indicate any medications you are ***CURRENTLY*** taking:

Medication	Dose/Frequency	Physician / When Started	Reason

Indicate any medications you have taken in the past ***FEW YEARS:***

Medication	Dose/Frequency	Physician / When Started	Reason

Personal Physical Health History (Allergies, Traumas, Extended Treatments)

Personal Psychological / Psychiatric History:

History of Family Psychological / Psychiatric Treatment:

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Treatment Consent

Client name: _____ DOB: _____

By my signature below, I am providing consent to treatment for myself, or for my child and I am expressing an understanding and an agreement of the details of this document.

I consent to treatment for myself, or for my child. I understand that psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the patient, and the particular problems I bring forward. I understand that there are many different methods that each therapist may use to deal with the problems that I wish to address. Psychotherapy is not like a medical doctor visit. Instead it calls for a very active effort on my part. In order for my therapy to be most successful, I will have to work on things we talk about both during sessions and at home.

I understand that psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, I understand that there are no guarantees of what I will experience.

Contact: I understand that Up*turn* clinicians are available by email and telephone. However, I understand that phone and email are not appropriate ways to gain "treatment" and will use these means of contact only for scheduling purposes and / or brief check ins when needed. I understand that telephone and email are not entirely secure and confidential. I understand that the clinician office hours vary, and while they may be in the office, they probably will not answer the phone when they are with patients. When they are unavailable, their telephone is answered by voice-mail. I realize that they will make every effort to return my phone call on the same day that I place it, with the exceptions of weekends and holidays. If I am difficult to reach, I will provide some times when I am most available. I understand that if I am in emergency and an Up*turn* clinician is unable to be reached and I feel I cannot wait for a returned phone call I will contact my family physician or the nearest emergency room and ask for the psychologist on call, or I will call 911. If Up*turn* clinicians will be unavailable for an extended period of time they will provide me with the name of a colleague to contact if necessary.

Emergencies: In an emergency situation in which one's physical safety is in danger or there is a need for hospitalization, I will contact Crisis Intervention for my specific county. These numbers are listed below:

Cumberland County:	717-763-2222	Carlisle Area:	717-243-6005
Dauphin County:	717-232-7511	Lebanon County:	717-274-3363
Lancaster County:	717-394-2631	York County:	1-800-673-2496

Professional Records: I understand that the law and standards of the profession require Up*turn* to keep treatment records. I am entitled to receive a copy of my records, or a summary of these records. Because these are professional records, they have the potential to be misinterpreted and / or upsetting to untrained readers. If I wish to see my records, I can review them in an Up*turn* clinician's presence so that we can discuss their contents. I understand that I will be charged an appropriate fee for any professional time spent responding to information requests.

Minors: I understand that for clients who are under the age of 14, the law may provide parents the right to examine treatment records. It is Up*turn's* policy to request agreement from parents that they agree to give up access to my records. If my parents agree, Up*turn* will provide them only with general information about our work together, unless the clinician feels there is a high risk that I will harm myself or someone else. In this case, she will notify my parents of her concern. They will provide them with a summary of the treatment plan when it is complete. Prior to giving them any information, we will discuss the matter together, if possible, and do our best to handle any objections I might have with what we are prepared to discuss.

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Treatment Consent

Confidentiality: In general, the privacy of all communications between a client and a psychologist is protected by law, and my clinician can only release information about our work to others with my written permission. But there are a few exceptions.

In most legal proceedings, I have the right to prevent Up*turn* from providing any information about my treatment. In some proceedings involving child custody and those in which my emotional condition is an important issue, a judge may order Up*turn's* testimony if s/he determines the issues demand it.

There are some situations in which Up*turn* is legally obligated to take action to protect others from harm, even if she has to reveal some information about a patient's treatment. For example, if she believes a child is being abused, she must file a report with the appropriate state agency.

If she believes that a patient is threatening serious bodily harm to another, she is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm herself/himself, she may be obligated to seek hospitalization for her/him or to contact family members or others who can help provide protection.

These situations rarely occur in Up*turn's* practice. If a similar situation occurs, she will make every effort to fully discuss it with you before taking any action.

Consultation and Coordination: Up*turn* clinicians will occasionally find it helpful to consult with other professional about a case. During a consultation, your Up*turn* clinician makes every effort to avoid revealing the identity of her patients. The consultant is also legally bound to keep the information confidential. My clinician will not be required to tell me about these consultations unless she feels it is important in our work together.

I understand that, with my consent, Up*turn* will likely provide brief summary updates periodically to my Primary Care Physician.

If there are other concerns that come up for me, I agree to speak with Diana Brown, owner, about them directly. She will be happy to discuss them with me if I need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and she is not an attorney.

☐ I have read the two pages of this document and understand the above information.

_____ _____

Patient Signature (age 14 and over) Date

_____ _____

Parent / Legal Guardian Signature (for patients under age 18) Date

Consent to Use and Disclose Protected Health Information

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This form is an agreement between you, _____, and Up*turn*, LLC. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his/her name here _____.

When we evaluate, diagnose, treat, or refer you to another provider, we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to determine what treatment is best for you and to provide any 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 healthcare operations allowable under HIPAA privacy laws.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read the NPP 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 we may change the Notice of Privacy Practices. If we do change it, you can get a copy from Dr. Diana Brown, or from our website www.UpturnToday.com.

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 do as you asked.

After you have signed this consent, you have the right to revoke it by writing a letter to the Privacy Officer, Diana Coulson-Brown, Psy. D.,and telling her that you no longer consent. We will comply with your wishes about using or sharing your information from that time on but we may have already used or shared some of your information and cannot change that.

_____ _____

Signature of client/guardian Date

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Symptom Checklist

Client name: _____ DOB: _____

CHECK ALL of the symptoms that apply to you:

Physiological Symptoms: ☐ Headaches ☐ Dizziness ☐ Fainting Spells ☐ Racing Heart ☐ Shortness of Breath ☐ Chest Pain ☐ Nausea ☐ Feeling of Choking ☐ Stomach Trouble ☐ No Appetite ☐ Increased appetite ☐ Weight Gain in the last month☐ Weight loss in the last month☐ Fatigue ☐ Tremors ☐ Sweating ☐ Low energy

Thought Symptoms: ☐ Nightmares ☐ Unwanted repetitive thoughts ☐ Suicidal ideas☐ Difficulty with decision making ☐ Lack of interest in doing things ☐ Memory or concentration difficulty ☐ Difficulty paying attention ☐ Easily distracted☐ Feel as if thoughts are racing ☐ Suspecting that your partner is unfaithful

Behavioral symptoms: ☐ Avoidance of crowded places ☐ Seeking alcohol ☐ Unwanted repetitive habits ☐ Difficulty falling asleep ☐ Difficulty remaining asleep ☐ Awakening earlier than intended; ☐ Difficulty waking up ☐ Sleeping for long periods ☐ Past suicide attempts ☐ Sexual problems ☐ Crying spells ☐ Unable to control anger ☐ Money problems ☐ Can't keep a job ☐ Difficulty keeping friends ☐ Difficulty with romantic relationships ☐ Bad home conditions ☐ Food binging ☐ Food purging ☐ Legal problems ☐ Constantly on guard for anything dangerous that could happen ☐ Hear voices ☐ Disorganized ☐ Losing items ☐ Often making careless mistakes ☐ Caffeine having little impact ☐ Difficulty waiting in lines ☐ Starting projects and not finishing ☐ Reading several books at the same time ☐ Difficulty remaining still ☐ Have been told by others that you don't listen well ☐ Difficult to not interrupt others ☐ Tendency to be very talkative ☐ Often "on the go" ☐ Act as if "driven by a motor" ☐ Unrestrained buying sprees, ☐ Periods where car is driven at high speeds ☐A history of purposely cutting or physically hurting your body ☐ Need a lot of reassurance from others ☐Always needing to be in a relationship ☐ Like to be the center of attention ☐Perfectionism

Emotional symptoms: ☐Feel tense ☐Anger ☐Irritability ☐ Panicky ☐ Fear of losing control ☐ Fear of going crazy ☐ Fear of dying ☐ Anxious ☐ Trembling ☐ Feel in a "daze" ☐ Depressed ☐ Feeling detached from others ☐ Feeling void of emotions ☐ Drug use ☐ Unable to relax ☐ Less interest in pleasant activities ☐ Unable to enjoy self ☐ Not like weekends or vacations ☐ Inferiority feelings ☐ Feeling helpless ☐ Feel hopeless ☐ Feel like there is no future for you ☐ Guilt ☐ Over ambitious ☐ Shy ☐ Feel lonely ☐ Work stress ☐ Paranoia ☐ Impatient ☐ Periods where you feel "on top of the world" and can accomplish anything ☐ Feeling empty ☐ Feeling life has no meaning ☐ Feel as if people will abandon you ☐ Mood swings

Situational happenings: ☐ Experienced or witnessed a life threatening event or serious injury ☐ Experienced fear, hopelessness or horror during the event ☐ Distressing recollections of the event ☐ Distressing dreams of the event ☐ Acting or feeling as if the event is recurring ☐ Difficulty talking about the event ☐ Difficulty seeing anything that reminds you about the event

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Authorization for Insurance Release

Client name: _____ DOB: _____

Primary Insurance Company: ☐ Highmark/BCBS ☐Capital Blue Cross ☐Tricare ☐Medicare
Subscriber Name: _____ Subscriber DOB: _____
Policy Number: _____
Group Number: _____
Employer of Subscriber: _____
Plan Type: ☐PPO ☐POS ☐HMO ☐Other

Secondary Insurance Company: ☐ Highmark/BCBS ☐Capital Blue Cross ☐Tricare ☐Medicare
Subscriber Name: _____ Subscriber DOB: _____
Policy Number: _____
Group Number: _____
Employer of Subscriber: _____
Plan Type: ☐PPO ☐POS ☐HMO ☐Other

☐ I authorize the release of any information necessary to process claims with my insurance company.
This information could include a diagnosis, presenting problems, current symptoms, and treatment dates.
☐ I authorize my insurance company to make payments for my treatment directly to Up*turn*, LLC.
☐ I understand that I am responsible for paying my deductible and / or co-payments.
☐ I understand that it is my responsibility for payment of services if my insurance company does not provide reimbursement.

Client Signature: _____ Date: _____

Guardian Signature*: _____ Date: _____
*(If Client is under 14 years of age)

I authorize Up*turn,* LLC to release information to Office Ally, LLC for the purposes of billing.

Client Signature: _____ Date: _____

Guardian Signature*: _____ Date: _____
*(If Client is under 14 years of age)

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Treatment Fees & Financial Responsibility

Client name: _____ DOB: _____

By my signature below, I agree to the following financial conditions of treatment:

It is very important that you understand basic information about benefits for outpatient mental health services covered through your health insurance.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, you (not your insurance company) are responsible for the full payment of fees for services rendered. It is very important that you find out exactly what mental health services your insurance policy covers.

Your insurance company has set your co-payments and deductible amounts and these fees are not subject to negotiation with your therapist. If you would like additional information on these fees, please call your health insurance company or consult your member handbook for additional information on exactly what mental health services your insurance policy covers. I would be happy to assist you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, Up*turn* will be willing to call the company on my behalf.

Co-payments for your treatment may change without notice by your insurance company. You will be held responsible for any co-payments due. You are responsible for informing me about changes to your policy that may affect your mental health treatment coverage. Insurance companies do not allow us to retroactively bill for services rendered beyond certain time frames.

I understand that I am obligated to pay co-payments and deductibles as required by my health insurance company's policy. I also understand that I will be financially responsible for all treatment fees incurred by myself or by my child. I understand that payments are due at the time of service. I understand that any outstanding balance for services rendered will be turned over to collections if not paid promptly.

I understand that most insurance companies will require me to authorize Up*turn* to provide them with a clinical diagnosis. Sometimes Up*turn*, LLC will have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, Up*turn* has no control over what they do with it once it is in their hands. In some cases, they may share this information with a national medical information database. Up*turn* will provide me a copy of any report she submits, if I request it.

☐ I do understand that I always have the right to pay for Up*turn*'s services myself to avoid the problems described above.

☐ I authorize my insurance benefits be paid directly to Up*turn*, LLC. I authorize the release of pertinent medical information to insurance carriers.

_____ _____

Signature of client/guardian Date

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Non-covered services

I accept responsibility for payment for all non-covered services. Non-covered services include, but are not limited to telephone conversations lasting longer than 10 minutes, writing letters, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250 per hour for preparation and attendance of any legal proceeding. Payment for these services will be agreed to when they are requested.

I give permission for Up*turn* to send periodic financial account summaries and billing statements to my email address and / or my home. I understand that the information sent to my email address will require a password for retrieval.

I understand that I will be charged for appointments which are not canceled at least 24 hours prior to the appointment time. I understand that I will be billed for that session at the rate of $50 for the first offense, $100 for the second offense, and $160 for the third offense, barring emergency situations, or severely inclement weather. I also understand that my insurance company will not cover such a claim, and I agree to be responsible for payment of that session. Non-payment after 30 days will be considered late. I understand and agree to a $5 or 1.5% monthly interest rate and / or collection procedures and necessary costs if payment is greater than 30 days late. If my account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Up*turn*, LLC has the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If legal action is necessary, those costs will be included in the claim. In most collection situations, the only information released regarding a patient's treatment is his / her name, the nature of the service provided, and the amount due.

I will be assumed to withdraw from treatment if I fail to keep my account up to date. Should my account be deemed delinquent, all future appointments will be cancelled. Should my account be deemed delinquent, all future appointments will be cancelled. I understand that treatment with Up*turn* clinicians will be terminated if regular appointments with a therapist are not maintained.

I give permission for all persons acting on behalf of Up*turn,* LLC to contact me and leave a message at the following address, email account, and phone numbers. To change this permission, I must contact my Up*turn* clinician in writing.

Mailing Address: _____

_____

Email Address: _____

Home telephone number: _____

Cell phone number: _____

If you have additional questions and / or concerns, you may contact the company that manages your mental health care benefits directly. The health insurance number is usually on the back of your insurance card.

We accept personal checks made payable to **Upturn, LLC** or exact cash. At this time we are unable to accept credit cards or debit cards.

☐ I have read both pages of this document and understand the above information

_____ _____

Patient Signature (age 14 and over) Date

_____ _____

Parent / Legal Guardian Signature (for patients under age 18) Date

Authorization for Release of Protected Health Information (PHI)

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Client Name: _____ DOB: _____

Address: _____ Phone: _____
_____

I _____, authorize Up*turn,* LLC to send / receive the following records to / from:

Provider: _____
Address: _____
Phone: _____
Fax: _____

(*A separate authorization, as defined by HIPAA, is required for psychotherapy notes.)

____ Service Plans ____Summary Reports _____Therapy Notes

____ Psychological Reports ____ entire record, except therapy notes

The above information will be used for the following purposes:

____ Planning appropriate treatment or program
____ Continuing appropriate treatment or program
____ Determining eligibility for benefits or program
____ Case Review
____ Updating files
____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus application state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually one year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have the right to receive a copy of this authorization. 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 Up*turn*, nor will it affect my eligibility for benefits.

☐ I understand that I may inspect and have a copy of the information described in this authorization. There may be a cost for this copy or for other services.

☐ I have read this form or had it explained to me and I understand its contents.

_____ _____ _____
Client or Guardian signature Relationship Date