

Welcome to my practice. I am pleased to have the opportunity to work with you. This document contains important information about my professional services and procedures. Please read it carefully and discuss any questions you have with me. When you sign this document, it will represent your informed consent for psychotherapy services.

Consent to Treatment: I understand that the services I and/or my dependent(s) will receive are based on currently accepted practices in the field of mental health. Psychotherapy has both benefits and risks: while it is empirically demonstrated to have beneficial effects on emotions, behaviors and relationships, at times it can also arouse distressing thoughts, feelings and behaviors. There are no guarantees as to the results of treatment or of any procedures. It is important to let me know of any concerns you have about your response to our sessions.

Professional Fees and Insurance Coverage: My fee is \$140 for a 50-55 minute therapy session. Your health insurance may cover my services (excluding co-pays and deductibles). If I am a participating provider for your plan I will accept their approved fee and will bill them electronically. Your co-pay is due at each session by check, cash, credit, debit or flex savings card. You're responsible for the full cost of each session until you meet your deductible. If I am a non-participating provider for your insurance, payment in full is expected at each session unless otherwise arranged. Please verify details of your coverage before we meet. The returned check fee is \$30.

Cancellations: I understand that the full fee is charged for appointments missed and for appointments cancelled less than 24 hours in advance. Insurance will not cover missed appointments.

Availability: I routinely check my voicemail, email and text messages and will get back to you within 24 hours. Phone calls lasting more than 5 minutes will be billed at the agreed-upon hourly rate. In case of emergency, contact UM Psychiatric Emergency Services at 734-996-4747, go to the nearest hospital emergency room or call 911.

Informed Consents:

My signature below shows that I understand the information provided in this document and that I consent to treatment. It also serves as acknowledgement that you have reviewed or received a copy of the HIPAA Notice posted on my website.

Printed Name

Signature

Date

Payment agreement:

I authorize the release of any protected health information necessary to process insurance claims for payment. I hereby authorize payment of insurance benefits to be made directly to Karen Hague, LMSW. I understand that I am financially responsible to Karen Hague, LMSW for services not covered or payable by my insurance carrier.

Signature

Date

Information about you:

Last Name _____ First Name _____

Birth Date _____ Age _____ Sexual Orientation (circle) Heterosexual Gay Lesbian Bi Transgender

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email (if you want) _____

Emergency Contact: _____ Phone: _____

Spouse/Partner Name: _____ Children? (ages): _____

Employer _____

Insurance Carrier _____

Other Information:

Why are you seeking treatment at this time?

Referred by: _____

History of previous therapy (please list all previous contact with mental health professionals, including hospitalization and medications, using back of sheet as necessary)

Name	Dates	Reason(s)
_____	_____	_____
_____	_____	_____

History of psychiatric medications. Please list all, including dosages, dates of usage, and general response.

Drug	Dates of use/current?	Response/reason for discontinuing
_____	_____	_____
_____	_____	_____

Any current health problems? _____

Do you drink two or more alcoholic beverages per day? _____

Do you use any drugs? (what? frequency?) _____

Do you have any thoughts/behaviors of harming yourself or others? _____

Family history of addiction, mental illness, suicide or hospitalization? (specify)

Any history of/or current physical/sexual abuse? (specify) _____

Any recent changes in sleeping or eating patterns? (specify) _____

ADULT SYMPTOM CHECKLIST

NAME: _____ AGE: _____ DATE: _____

Please circle the symptoms that apply to you now in the past few weeks:

	Never	Rarely	Sometimes	Always		0	1	2	3	4	5		
Depression	0	1	2	3	4	5	On the go, hard to relax	0	1	2	3	4	5
Crying spells	0	1	2	3	4	5	Periodic overspending	0	1	2	3	4	5
Hopelessness	0	1	2	3	4	5	Gambling problem	0	1	2	3	4	5
Worthlessness	0	1	2	3	4	5	Alcohol problem (in the last year)	0	1	2	3	4	5
Sleep disturbance	0	1	2	3	4	5	Drug problem (in the last year)	0	1	2	3	4	5
Trouble falling asleep	0	1	2	3	4	5	Blackouts, shakes, tremors	0	1	2	3	4	5
Interrupted sleep	0	1	2	3	4	5	Anxiety/panic attacks	0	1	2	3	4	5
Early morning wakening	0	1	2	3	4	5	Heart beating fast	0	1	2	3	4	5
Oversleeping	0	1	2	3	4	5	Chest pains/tightness	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5	Lightheadedness	0	1	2	3	4	5
Overeating	0	1	2	3	4	5	Stomach upset	0	1	2	3	4	5
Weight loss or gain	0	1	2	3	4	5	Sexual difficulties	0	1	2	3	4	5
If so, how much in the last 3-6 months:							Relationship problems	0	1	2	3	4	5
Gained: _____ Lost: _____							Work problems	0	1	2	3	4	5
Lack of interest in usual things	0	1	2	3	4	5	Eating disorder	0	1	2	3	4	5
Suicidal thoughts, present	0	1	2	3	4	5	Suspiciousness/paranoia	0	1	2	3	4	5
Suicidal thoughts, past	Yes _____ No _____						Feeling controlled	0	1	2	3	4	5
Suicide attempt, gesture	Yes _____ No _____						Hitting/domestic violence	0	1	2	3	4	5
Homicidal thoughts	0	1	2	3	4	5	Hearing voices (that others don't)	0	1	2	3	4	5
Anxiety, nervousness	0	1	2	3	4	5	Seeing things (that others don't)	0	1	2	3	4	5
Irritability, edginess	0	1	2	3	4	5	Need for cleanliness	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5	Need for organization	0	1	2	3	4	5
Racing thoughts	0	1	2	3	4	5	Counting behavior/thoughts	0	1	2	3	4	5
Hard to concentrate/ stay focused on task	0	1	2	3	4	5	Rituals that you must do/ need to check and recheck	0	1	2	3	4	5
Fatigue/tiredness	0	1	2	3	4	5	Unexplained physical symptoms	0	1	2	3	4	5
Bursts of energy	0	1	2	3	4	5	Trauma, other abuse	0	1	2	3	4	5
Worry	0	1	2	3	4	5							
Fears of ordinary things (for example, crowds, germs, doctors, flying, closed spaces)	0	1	2	3	4	5							
Yelling/screaming	0	1	2	3	4	5							