VANESSA C. SELBY, PH.D.

Licensed Psychologist

ADULT BEHAVIORAL MEDICINE • ANXIETY/PANIC • PAIN MANAGEMENT • WELLNESS MANAGEMENT

NEW CLIENT REGISTRATION

Please Print

Name_____ Date of Birth_____

Address_____ Email_____

City_____State_____Zip_____

Home Phone (____)_____ May we leave a message? Yes No

Cell/Other Phone (____)_____May we leave a message? Yes No

Emergency Contact_____Relationship_____

Home Phone (____)_____Cell Phone (____)_____

Referring Physician_____Phone_____

Address_____

Marital status (please circle) Single Partnered Married Separated Divorced Widowed

Preferred Method of Contact (please circle) Phone call Text Email

INSURANCE INFORMATION (please provide all information)

Primary Insurance Company_____

ID#_____Group #_____

Name of Subscriber_____Relationship to client_____

Subscriber's Date of Birth_____Employer_____

Secondary Insurance Company_____

ID#_____Group #_____

Name of Subscriber_____Relationship to client_____

Subscriber's Date of Birth_____Employer_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize my mental health practitioner to release only medical information necessary to process my claims or for Quality Assurance purposes. I permit a copy of this authorization to be used in place of the original. I authorize this office to apply for benefits on my behalf for covered services rendered and request that payment from any and all insurance companies be made directly to them. **I understand that I am responsible for my account.**

Signature of Client_____Date_____

Parent/Guardian (if under 18) _____Date_____

Witness_____Date_____

MENTAL HEALTH BACKGROUND

List any psychotropic medications (medicines for your nerves) that you are taking:

Medication	Dose/Frequency	When started	For what symptom(s)?

List any previous mental health or substance abuse treatment (include any inpatient or hospital treatment for a mental health or substance abuse disorder) that you have had.

Date of treatment (approximately)	Provider/agency name?	What was your issue?	Were your goals met?

Was anything in your previous treatment particularly helpful? Not helpful?_____

_____

_____

_____

At this time do you ever have thoughts of harming yourself? YES _____ NO _____

Have you ever attempted suicide? YES _____ NO _____

At this time do you ever have thoughts of harming others? YES _____ NO _____

SOCIAL HISTORY

Education (please circle): Did Not Finish High School High School Some College
College Degree Graduate or Professional School

Occupation_____

Current Employer (or School)_____

How long have you worked there?_____

What other jobs have you held?_____

_____

List the people currently living with you:

Name	Age	Relationship to you	Occupation

Describe your religious or spiritual orientation? _____

If you have a religion, how often do you attend religious services? (Circle one)

At least weekly monthly several times a year once a year or less

Which of the following statements best describe you (check all that apply)

_____ I have a lot of friends with whom I can confide in or count on
_____ I have many close family members with whom I can confide in or count on
_____ I have a few close friends with whom I can confide in or count on
_____ I have a few close family members with whom I can confide in or count on
_____ I have a lot of friends, but I can't confide in them or count on them
_____ I have few friends and none whom I can confide in or count on

Would you say that you are lonely?

_____ frequently _____ occasionally _____ sometimes _____ rarely

Does your family have a history of mental illness or substance abuse? If so, please explain the nature of the problem, treatment they received and indicate if any particular medication was helpful.

_____

_____

_____

_____

LEGAL HISTORY

Legal Event		If Yes, please describe briefly
Have you ever been arrested?	Yes No	
Have you ever been arrested for a DUI (driving under the influence?)	Yes No	
Have you ever been in prison?	Yes No	
Are you currently involved in any litigation?	Yes No	

MEDICAL INFORMATION

Name of primary care physician or provider _____

Address_____Phone_____

Do I have your permission to send basic information (presenting problem, summary of treatment, relevant health information, etc.) to your primary care provider? _____YES _____NO

If yes, you will need to sign a specific "authorization" or "release of information form" in order for me to contact your primary care provider.

How would you describe your physical health?

___ excellent ___ good ___ average ___ poor ___ very poor

Briefly describe your efforts to remain healthy _____

_____

_____

_____

_____

List any medical conditions that you have:

Medical condition or symptoms	Treatment(s)

List any prescription medications that you take:

Medication	Dose/Frequency	When started?	For what symptoms?

List any non prescription (over-the-counter) medications that you take:

Medication	Dose/Frequency	When started?	For what symptoms?

Do you have any allergies or sensitivities to drugs, foods, or other substances? _____YES _____NO

If yes, please indicate the substances that you are allergic to or have sensitivities to:

_____

_____

Do you smoke or use other tobacco products? _____YES _____NO

If yes, please indicate what you smoke (or chew) and how much in an average day.

_____

_____

Do you drink alcohol? _____YES _____NO

If yes, please indicate what you drink and how much you drink in an average day.

_____

_____

Do you use recreational drugs such as marijuana, cocaine, or other drugs? _____YES _____ NO

If yes, please indicate what you use how much you use in an **average week**.

_____

_____

CAGE Questionnaire:

1. Have you ever felt you should cut down on your drinking? _____Yes _____No
2. Have people annoyed you by criticizing your drinking? _____Yes _____No
3. Have you ever felt guilty about your drinking? _____Yes _____No
4. Have you ever had an "eye-opener" - a drink first thing in the morning to help you feel better? _____Yes _____No

Is there any other information that would be useful to know about you?

_____

_____

_____

_____

_____

_____

_____

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HIPAA Notice of Privacy and Health Information Practices

My Commitment to Your Privacy

Our office is dedicated to maintaining the privacy of your Personal Health Information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA). I have prepared this explanation (Notice) of how I am required to maintain the privacy of and how I may use and disclose your personal health information and how you can gain access to this information. Please read it carefully.

I. Consent

With your consent (as documented on the attached service agreement) I may "*use*" your protected health information (PHI) within my practice, for treatment, payment, and health care operation purposes. In all cases, I will share only the minimum amount of information necessary to conduct the activity. To help clarify terms, see definitions below:

Treatment involves providing, coordinating, or planning your health care, for example, when I consult with another health care provider, e.g., family physician or another psychologist regarding the most effective plan of treatment.

Payment refers to when I obtain reimbursement for your health care. Examples would include disclosure of PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice, such as measures of treatment effectiveness, patient satisfaction and appointment reminders.

Use refers to activities within the office such as employing, applying, utilizing, examining and analyzing information that identifies you.

Disclosure refers to activities outside of the office such as release, transferring, or providing access to information about you to other parties.

II. Use and Disclosure Requiring Authorization

I will only "*disclose*" the minimum necessary PHI for purposes other than treatment, payment, and health care operations noted above when you have provided appropriate prior written authorization. This authorization will identify the specific information you wish to disclose, the specific identity of the person(s) to whom the information is to be disclosed, and the purpose. Our psychotherapy notes, which may describe some of the content of your sessions, will only be disclosed with your specific authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization or the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures Without Authorization

I may be required to disclose PHI without your authorization to preserve life, protect persons from immediate harm, or to refer you to a more appropriate level of care when there is:

Suspected Child Abuse: I am required by law to report any suspected abuse on the basis of my professional judgment to the Pennsylvania Department of Public Welfare.

Older Adult and Domestic Abuse: If I believe that an adult is in need of protective services (regarding abuse or neglect) I may need to report such to the local agency which provides protective services.

Serious Threat to Health or Safety: If you express a serious threat to kill or seriously injure a readily identifiable person, including yourself or others, and I determine that you are likely to carry out the threat, I am mandated to take reasonable measures to prevent harm to you or others. This may include directly advising the potential victim of the threat or referring you to a higher level of care.

Judicial or Administrative Proceedings: I may also be required to disclose PHI without your consent or authorization for the following specific legal reasons. If you are involved in a court proceeding and a request is made about the professional services I have provided you or the record thereof, such information is privileged under state law and will not be released without your written consent or court order. This privilege does not apply when you are being evaluated for a third party or a court ordered evaluation is involved. You will be informed in advance if this is the case.

Worker's Compensation: If you file a worker's compensation claim, I will be required to file periodic reports with your employer, which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

IV. Patient's Rights and Psychologist Duties

PATIENT RIGHTS:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request. Your request should be made in writing, stating the specific restriction requested and to whom you want the restriction to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are seeing me. Upon request, we will send your bills to another address.

Right to Inspect and Copy: You have the right to inspect or obtain a copy of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On request, I will discuss with you the details of the request and denial process.

Right to Amend: You have the right to request and amendment to PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to An Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section II of this Notice). On request, we will discuss the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive this notice electronically.

PSYCHOLOGIST DUTIES:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of these changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will notify you in writing if the revision applies to you.

V. Questions & Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have any other concerns about your privacy rights, you may contact my office at 1200 Camp Hill Bypass, Suite 300, Camp Hill, PA 17011. You may also contact the U.S. Department of Health and Human Services, Office of Civil Rights, if you feel that your privacy protections have been violated.

VI. Effective Dates, Restrictions and Changes to Privacy Policy: This notice will go into effect September 7, 2012.

I acknowledge that I have read and understood this Notice of Privacy Practices.

_____ Date_____

Signature of Client

_____ Date_____

Parent/Guardian (if under 18)

_____ Date_____

Witness

I have been offered a copy of the Notice Form: _____ accepted or _____ declined

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CLIENT INFORMED CONSENT

I have chosen to receive assessment/treatment services from Vanessa C. Selby, Ph.D. My choice has been voluntary and I understand I may terminate therapy at any time.

I understand there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults, or in cases where there is a danger to self or others. I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand my basic rights including:
The right to be informed of the various steps and activities involved in receiving services.
The right to confidentiality under federal and state laws relating to receiving services.
The right to humane care and protection from harm, abuses, or neglect.
The right to make an informed decision whether to accept or refuse treatment.
The right to review information in my file with my therapist when appropriate.
The right to contact/consult with counsel at my expense.
The right to select practitioners of my choice at my expense.

I understand that my therapist may exchange information regarding my therapy with my insurance carrier or health plan to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I also understand that with my written permission, my therapist may exchange information with my primary care physician or other involved health care providers for the purpose of coordination of care. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after the end of treatment or after all claims for treatment have been paid according to provisions of my insurance or health care program.

I have read and understand the above.

_____ Date_____
Signature of Client

_____ Date_____
Parent/Guardian (if under 18)

_____ Date_____
Witness