Kathy Green, MA LCPC
4696 W. Overland Rd. Suite 214. Boise, ID 83705
Phone: (208) 342-8347
Fax: (866) 639-2595
www.kathygreen.org

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- **I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.**
- **Co-payments are due at time of service.**
- **If my plan requires a referral/authorization, I must obtain it prior to my visit.**
- **If I have any EAP's, I am responsible for bringing in the necessary paperwork to bill authorization. My health insurance will be billed if no paperwork is presented.**
- **In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.**
- **If I am uninsured, I agree to pay for the medical services rendered to me at time of service.**
- **I understand that I will be charged for missed appointments unless I give 24-hour notice.**

_____(Initials)

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- **I hereby authorize and direct payment of my medical benefits to Kathy Green on my behalf for any services furnished to me by the providers. _____(Initials)**

3. AUTHORIZATION TO RELEASE RECORDS

- **I hereby authorize Kathy Green to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider._____(Initials)**

4. TELEHEALTH CONSENT

- **I authorize consent to engaging in telehealth sessions with Kathy Green, LCPC whenever she deems necessary or there is an agreement between both parties. My telehealth sessions will occur through interactive audio and video and I have the right to withdraw consent at any time._____(Initials)**

Signature of Patient, Authorized Representative or Responsible Party:
_____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient:
_____

Date:_____

INFORMED CONSENT FOR TELEHEALTH SERVICES

I, _____(Name of Client) hereby consent to engaging in telehealth sessions with Kathy Green, LCPC.

I understand the following with respect to telehealth.

My telehealth sessions will occur through interactive audio and video.

The conditions in this Informed Consent for telehealth are in addition to the conditions in the general Informed Consent for treatment.

I have the right to withdraw consent at any time.

The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed to my therapist during the course of my sessions is confidential. However, all the mandatory reporting exceptions outlined in the general Informed Consent at Kathy Green, LCPC also apply to telehealth.

There are potential risks and consequences with telehealth, including but not limited to the possibility that the transmission of my personal information could be disrupted or distorted by technical failures or be interrupted by unauthorized persona.

My clinician will conduct my telehealth sessions in a private room. In order to protect my privacy, I should find a quiet and private place for my session.

No permanent voice or video recording is kept of my telehealth sessions.

Telehealth services and care may not be as complete or as effective as face to face services, especially if there is a poor audio or video connection.

If my Clinician believes that I would be better served by another form of intervention (face to face services). I will be referred to a mental health professional who can provide such services in my area.

INFORMED CONSENT FOR TELEHEALTH SERVICE

Name of client's emergency contact:

_____

Telephone number of client's emergency contact:

_____

Local area crisis services name(s) and number(s):

_____

Telephone number my clinician should call to talk to me in the case of a disrupted telehealth session:

_____

Client Signature_____

Client name (printed)_____

Date_____

Clinician Signature_____

Clinician name (Printed)_____

Date_____

Acknowledgement and Consent for Electronic Delivery and Signatures

Electronic Signature or Acknowledgement. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original as against any party whose signature appears thereon, and all of which together shall constitute one and the same instrument. The provision of photographic or facsimile copies, or electronic signature, confirmation or acknowledgement of or by a party, shall constitute an effective original signature of a party for all purposes under this Agreement, and may be used with the same effect as manually signed originals of this Agreement for any purpose. (Initials)

Consent to Electronic Delivery; Electronic Signature. In lieu of receiving documents in paper format, Participant agrees, to the fullest extent permitted by law, to accept electronic delivery of any documents that the Company may be required to deliver (including, but not limited to,intake forms, agreements, account statements, and all other forms of communications) in connection with this Company. Electronic delivery may be via a Company electronic mail system or by reference to a location on a Company intranet to which Participant has access. Participant hereby consents to any and all procedures the Company has established or may establish for an electronic signature system for delivery and acceptance of any such documents that the Company may be required to deliver, and agrees that his or her electronic signature is the same as, and shall have the same force and effect as, his or her manual signature. (Initials)

Signature of Patient, Authorized Representative or Responsible Party:

_____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient:

_____

Date:_____

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

_____

Phone Number: _____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (usually last 3 digits located on the back of the credit card)

Amount to Charge will vary depending on patient's coinsurance or copay agreement with their insurance.

_____ ok to email statements

Email Address: _____

I authorize **Kathy Green** to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

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PERSONAL INFORMATION

PATIENT INFORMATION		FINANCIALLY RESPONSIBLE PERSON
Name:		**Name:**
Address:		**Address:**
City/State/Zip:		**City/State/Zip:**
Marital Status:	**DOB:**	**Relation to Patient:**
Gender:	**SSN:**	**Home Phone:**
Name of Spouse:	**Yrs Together:**	**Referred By:**
Home Phone:		**SSN:**
Employer:		**Employer:**
Address:		**Address:**
Occupation:		**Occupation:**
Business Phone:		**Business Phone:**
Cell Phone:		**Cell Phone:**
Email:		**Email:**

INSURANCE

This care will be paid for by: **Blue Cross_____** **Blue Shield_____** **HP_____** **Self Paid_____** **Other_____**

Name of Insurance Company:_____Address:_____

City/State/Zip:_____Phone:_____

Group Number:_____ Subscriber's Name:_____

Insurance ID Number _____ Date of Birth_____

PAYMENT AND PROMISORY INFORMATION

All charges for professional services rendered by Kathy Green, MA LCPC, are the responsibility of the patient or financially responsible person listed on page one of this document. The patient or financially responsible person listed above is fully responsible for all fees. Payment for our services is due and payable at the time they are rendered.

The patient or financially responsible person understands that he or she is personally financially responsible for payment for services rendered to the above named patient and that a service charge of $15 per month will be added to the unpaid balance (excluding amount billed to insurance.)

COLLECTION NOTE: **I also understand that if the account becomes delinquent, efforts to collect may include assignment to collection agencies and/or Small Claims Court, making my name public record.**

MISSED APPOINTMENT NOTE**:** ***I understand that I will be charged for missed appointments unless I give 24-hour notice.***

Signature of Patient or Financially Responsible Person **Date Signed:**

_____ _____

Name:_____

REASON FOR SEEKING ASSISTANCE

YOUR FAMILY'S MEDICAL/PYSCHOLOGICAL HISTORY

- ☐ **Abuse**
- ☐ **AIDS**
- ☐ **Alcoholism**
- ☐ **Arthritis**
- ☐ **Allergies**
- ☐ **Asthma**
- ☐ **Bronchitis**
- ☐ **Cancer**
- ☐ **Chronic Fatigue Syndrome**
- ☐ **Chronic Lung Disease**
- ☐ **Diabetes**
- ☐ **Drugs**
- ☐ **Heart Disease**
- ☐ **Hepatitis**
- ☐ **Hernia**
- ☐ **Kidney Disease**
- ☐ **High Blood Pressure**
- ☐ **Pneumonia**
- ☐ **Rheumatic Fever**
- ☐ **Seizures/Epilepsy**
- ☐ **Stroke**
- ☐ **Thyroid Disease**
- ☐ **Tuberculosis**
- ☐ **Ulcers**
- ☐ **Vaccine Reaction**
- ☐ **Whooping Cough**
- ☐ **Sexually Transmitted Diseases**
- ☐ **Any and all other conditions:**
- ☐ **Alzheimer's**
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐

Other Medical Conditions in Your Family's Past

_____

YOUR CURRENT MEDICAL CONDITIONS

Are you pregnant? _____ **Birth Control Methods**_____ **Do you have a pacemaker?**_____

Do you have AIDS?_____ **Do you have hepatitis in any of its forms?**_____

Do you have any other current medical condition?_____

YOUR PAST MEDICAL CONDITIONS

- ☐ **Abuse**
- ☐ **AIDS**
- ☐ **Alcoholism**
- ☐ **Allergies**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bronchitis**
- ☐ **Cancer**
- ☐ **Chronic Fatigue Syndrome**
- ☐ **Chronic Lung Disease**
- ☐ **Diabetes**
- ☐ **Drugs**
- ☐ **Heart Disease**
- ☐ **Hepatitis**
- ☐ **Hernia**
- ☐ **Kidney Disease**
- ☐ **High Blood Pressure**
- ☐ **Pneumonia**
- ☐ **Rheumatic Fever**
- ☐ **Seizures/Epilepsy**
- ☐ **Stroke**
- ☐ **Thyroid Disease**
- ☐ **Tuberculosis**
- ☐ **Ulcers**
- ☐ **Vaccine Reaction**
- ☐ **Whooping Cough**
- ☐ **Sexually Transmitted Diseases**
- ☐ **Any and all other conditions:**
- ☐ **Alzheimer's**
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Other Medical Conditions in Past

_____

For children clients: mom, how was the pregnancy and delivery? Stress, strep, throat, gestational diabetes, etc.

_____

_____

_____

Name:_____

GENERAL MEDICAL INFORMATION

- ☐ Poor Appetite
- ☐ Change In Appetite
- ☐ Large Appetite
- ☐ Cravings
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fevers
- ☐ Chills
- ☐ Sweating
- ☐ Night Sweats

- ☐ Sweat Easily
- ☐ Insomnia
- ☐ Hours of Sleep _____
- ☐ Fall Asleep Easily
- ☐ Heavy Sleeper
- ☐ Light Sleeper
- ☐ Dream Disturbances
- ☐ Hard To Fall Back To Sleep
- ☐ Tremors/Shaking
- ☐ Dizziness

- ☐ Poor Coordination
- ☐ Headache
- ☐ Vertigo
- ☐ Edema
- ☐ Bleeds Easily
- ☐ Bruises Easily
- ☐ Fatigue/Tired
- ☐ Sudden Drop In Energy
- ☐ When?_____
  _____

GENERAL MEDICAL INFORMATION

Energy Level: 0_____10
Low High

Sexual Desire Level: 0_____10
Never Think About Always Think About

Thirsty: 0_____10 Desires: Hot_____Cold_____Room Temperature_____No Desire_____
(water temperature)

Appetite: 0_____10 *Desires:* _____ *Aversions:*_____
Never Hungry Always Hungry (Food) (food)

Coldness Hands_____ Feet_____ Back_____

Heat: Hand_____ Feet_____ Solar Plexus_____ Abdomen_____ Whole Body_____

Stiffness: Joints_____ Back_____ Limbs_____

Intolerance To: Heat_____ Cold_____ Wind_____ Fan_____ Air Conditioning_____

Pain: Upper Back_____ Lower Back_____ Upper Limbs_____ Lower Limbs_____
Entire Body_____

Please Rate Your Pain On A Scale From 1 to 10, 10 Being the Worst. _____

SKIN AND HAIR

- ☐ Rashes
- ☐ Eczema
- ☐ Dry Skin
- ☐ Moist Skin
- ☐ Sores
- ☐ Ulcers
- ☐ Herpes
- ☐ Psoriasis
- ☐ Eruptions
- ☐ Discharge

- ☐ Acne/Pimples
- ☐ Bruises
- ☐ Hives
- ☐ Itching
- ☐ Sweating
- ☐ Change in Skin Texture
- ☐ Dandruff
- ☐ Loss of Hair
- ☐ Balding
- ☐ Thinning of Hair

- ☐ Change in Hair
- ☐ Other Hair Problems
- ☐ Birth Marks
- ☐ Other Skin Problems

RESPIRATORY

- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Coughing Blood
- ☐ Wheezing
- ☐ Tightness in Chest

- ☐ Shortness of Breath
- ☐ Fullness in Chest
- ☐ Difficulty Breathing When Sitting Down
- ☐ Difficulty Breathing When Lying Down
- ☐ Other Chest Discomfort

Cough:
Dry_____ Croup_____
Other:_____
Phlegm:
Thin_____ Thick_____
White_____ Yellow_____
Green_____
How Long Coughing? _____

Name:_____

HEAD/EYES/EAR/NOSE/MOUTH/THROAT

Head

- ☐ Dizziness
- ☐ Migraine
- ☐ Frontal Headaches
- ☐ Temporal Headaches
- ☐ Vertex Headaches
- ☐ Occipital Headaches
- ☐ Head Injury
- ☐ Facial Pain
- ☐ Facial Paralysis
- ☐ Sinus Problems
- ☐ Other_____ _____

Eyes

- ☐ Cataract/Glaucoma
- ☐ Eye Pain
- ☐ Twitching
- ☐ Floaters/Spots
- ☐ Poor Vision
- ☐ Blurry Vision
- ☐ Night Blindness
- ☐ Itchiness
- ☐ Glasses/Contacts
- ☐ Red Eyes
- ☐ Dry eyes
- ☐ Thick matter in corner
- ☐ other_____ _____

Ears

- ☐ Loss of Hearing
- ☐ Discharge
- ☐ Earaches
- ☐ Poor Hearing
- ☐ Itchiness
- ☐ Loud Ringing In Ears
- ☐ Soft Ringing in Ears
- ☐ High Pitched Ringing
- ☐ Low Pitched Ringing
- ☐ Inflammation/Tenderness
- ☐ Other_____ _____

Nose

- ☐ Loss of Smell
- ☐ Increased Sense of Smell
- ☐ Nose Bleeds
- ☐ Allergies
- ☐ Nasal Discharge
- ☐ Color of Discharge
- ☐ Amount of Discharge
- ☐ Other_____ _____

Mouth

- ☐ Grinding Teeth
- ☐ Drooling
- ☐ Excess Saliva
- ☐ Dry Mouth
- ☐ Pyorrhea
- ☐ Bad Breath
- ☐ Gum Bleeding
- ☐ Gum Swelling

Mouth

- ☐ Taste In Mouth
- ☐ Ulcers
- ☐ Sores
- ☐ Silver fillings
- ☐ Fever blisters
- ☐ Coating on tongue
- ☐ Other_____

Throat

- ☐ Dry Throat
- ☐ Hoarseness
- ☐ Recurrent Sore Throat
- ☐ Loss of Voice
- ☐ Difficulty in Swallowing
- ☐ Lump in throat

Throat

- ☐ Frequent Tonsilitis
- ☐ Other_____ _____

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Dizziness
- ☐ Fainting
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Cold Hands/Feet
- ☐ Swelling Hands/Feet
- ☐ Irregular Heart Beat
- ☐ Insomnia
- ☐ Difficulty In Breathing
- ☐ Shortness of Breath
- ☐ Dream Disturbance
- ☐ Poor Memory
- ☐ Mania/Delirium
- ☐ Coma
- ☐ Loss of Consciousness
- ☐ Other _____ _____

MENTAL EMOTIONAL TRAUMAS

- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Emotional Abuse
- ☐ Depression Self
- ☐ Depression Family

- ☐ Parents Divorced (Your Age At Divorce)_____
- ☐ Ages In Your Life For Which You Don't Have Memories: _____
- ☐ Mental Hospitalization (Reason):_____
- ☐ Death of Friend or Relative (Date): _____
- ☐ Other_____

SURGERIES

Type of Surgery	Date of Surgery	Doctor Performing Surgery

Name:_____

TRAUMATIC INJURIES

Car Accident	**Date**
Car Accident	**Date**
Falls	**Date(s)**
Head Trauma(s)/Concussion(s)	**Date**

ALLERGIES

Foods_____

Drugs/Chemicals_____

Other_____

CURRENT MEDICATIONS

1)_____ **2)**_____

3)_____ **4)**_____

OCCUPATIONAL/ENVIROMENTAL EXPOSURES OR HAZARDS

Chemical_____ **Acid/Alkaloids**_____

Heavy Metals_____ **Physical Labor**_____

Electrical_____ **Psychological**_____

HABITS/EXESSIVE USAGE

☐ **Alcohol**	☐ **Drugs**	☐ **Sugar**
☐ **Chocolate**	☐ **Exercise**	☐ **Tea**
☐ **Cigarettes**	☐ **Food**	☐ **Other**
☐ **Coffee**	☐ **Salt**	_____
☐ **Cola/Diet Cola**	☐ **Sex**	

PROFESSIONAL HISTORY

Have you had any psychological treatment/therapy in the past?_____ **Name of Therapist**_____

In the past 5 years, have you seen any physicians?_____ **Name of Physician(s)**_____

Chiropractors:_____ **Attorneys:**_____

Other Health or Legal Practitioners: _____

_____

Name:_____

EMERGENCY CONTACT INFORMATION

Name:_____ **Address:**_____ **City/State/Zip:**_____

Relationship:_____**Phone:** _____

Name:_____ **Address:**_____ **City/State/Zip:**_____

Relationship:_____**Phone:** _____

FAMILY HISTORY

Your Parents

Patient's Mother:_____**Alive Age:**_____**Died of:** _____**Age at Death:**_____

State of Health:_____

Patient's Father:_____**Alive Age:**_____**Died of:** _____**Age at Death:**_____

State of Health:_____

Your Age at the Time of Your Mother's Death:_____**Father's Death:**_____

Your Children **Please include names, ages, if from present or prior marriage and the name and age of former spouse.**

Name:_____ **Age:**_____ **Present/Prior Name of Former Spouse:** _____

Name:_____ **Age:**_____ **Present/Prior Name of Former Spouse:** _____

Name:_____ **Age:**_____ **Present/Prior Name of Former Spouse:** _____

Name:_____ **Age:**_____ **Present/Prior Name of Former Spouse:** _____

Name:_____ **Age:**_____ **Present/Prior Name of Former Spouse:** _____

Your Siblings **Please include ages, from oldest to youngest and health problems past and present.**

Brother/Sister: **Alive Age:**_____ **Age at Death:**_____**Cause:**_____

Health Problems:_____

Brother/Sister: **Alive Age:**_____ **Age at Death:**_____**Cause:**_____

Health Problems:_____

Brother/Sister: **Alive Age:**_____ **Age at Death:**_____**Cause:**_____

Health Problems:_____

Brother/Sister: **Alive Age:**_____ **Age at Death:**_____**Cause:**_____

Health Problems:_____

Brother/Sister: **Alive Age:**_____ **Age at Death:**_____**Cause:**_____

Health Problems:_____

Brother/Sister: **Alive Age:**_____ **Age at Death:**_____**Cause:**_____

Health Problems:_____

Have you had miscarriages?____**Abortions?**____**Stillborn Babies?**_____**# of Children Who Have Died**_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACE PRACTICES

***THIS PAGE MUST BE COMPLETELY FILLED OUT**

By my signature below I,_____, acknowledge that I received a copy of the Notice of Privacy Practices for Kathy Green LCPC.

_____ _____
Signature of Client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____
Relationship to Client: _____

The HIPPA Privacy rule gives individuals the right to request confidential communications or that a communication of the private health information is made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

Preferred Method of Communication-Select all that apply

Home Phone

- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with a call-back number only

Work Phone (check one):

- ☐ Okay to lave a message with detailed information
- ☐ Leave a message with a call-back number only

Cell Phone (check one if applicable):

- ☐ Leave a message with a call-back number only
- ☐ Leave a message with a call-back number only
- ☐ Okay to send a text message

Written Communication (check all that apply):

- ☐ Okay to mail to my home address
- ☐ Okay to mail to my work/office address
- ☐ Okay to fax to this number _____

E-Mail Communication:

- ☐ Okay to email to the listed email address

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **Other (Please Specify)**

_____

_____

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Name: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

Two-Way Health Care Information Release:

Name and Organization: _____ or/and
(example: name of physician or spouse)
Insurance Company: _____

Address: _____

State: _____ Zip Code: _____ Phone Number: _____

Fax Number: _____
*Required if this is to a Physician
Release the following information:

_X_ Health care information relating to the following treatment condition:
MENTAL HEALTH_____

_____ Health care information for the date(s) below:
_____

_____ All health care information:
_____

_____ Other:
_____

This authorization ends: _X_ in 90 Days; or end of therapy/billing process:
_____ When the following occurs (but no longer than 90 days:)

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from Kathy Green, MA LCPC; or
2) Write, sign and date a letter to Kathy Green, MA LCPC to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form.

Once Kathy Green, MA LCPC gives out the information, then she no longer has control over it. The recipient might re-disclose it. Privacy laws may no longer protect it. I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for: HIV (AIDS virus), Sexually transmitted diseases, Psychiatric disorders/mental health, or Drug and/or alcohol use.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.