Donna Brooks Therapy
Client Demographic Form

OFFICE USE ONLY
Account No. _____
Staff Code _____
Situation _____
Program Code _____

PERSONAL INFORMATION: Date: _____

Name: _____
Mr./Mrs./Ms. First Name Last Name MI

Address: _____

_____
City State Zip Code

Home Telephone: (___) _____ Work Telephone: (___) _____

Employer: _____ Occupation: _____ Marital Status _____

SS# _____ Date of Birth: ___/___/___ Age: ____ Sex: M ☐ F ☐ Referred by: _____

Emergency Contact Person: _____ Emergency Telephone: _____

FAMILY INFORMATION:

***Refer to legend below for codes. We would appreciate your providing the following information as it is helpful in understanding the people we serve. You have the option of declining.**

Total Number in Household: _____ Total Household/Family Income: _____

Household Members Names (include self)	Relationship	Date of Birth	Sex	*Racial/ Ethnic	*Religion	*Yrs of Education	*Employment	*Primary Language	*Handicap
	SELF								

Racial/Ethnic	Religion	Education	Employment	Primary Language	Handicap
White - W	Protestant - P	0 - 12 yrs - PS	Full-time - FT	English - E	Unimpaired - U
Black - B	Catholic - C	13 - 16 yrs - SC	Part-time - PT	Spanish - S	Blind - B
Asian - A	Jewish - J	17 - + yrs - GS	Unemployed - UE	French - F	Deaf - D
Am Indian - N	Other - O		Not in labor force - NLF	Creole - C	Learning - L
Latino - L	No pref. - N			Other - O	Physical - P
Haitian - H					Emotional - M
Other - O					Other - O

INSURANCE INFORMATION:

Primary Carrier: _____

Company Name: _____

Company Address: _____

Secondary Carrier: _____

Company Name: _____

Company Address: _____

PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST TO MAKE A COPY.

DONNA BROOKS THERAPY

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, the undersigned, _____, DOB _____, authorize Donna Brooks Therapy to:

☐ Release Information to:

Check only one box per release

☐ Receive Information from:

_____ _____

Name/ Title of Person or Organization Telephone

_____

Address

_____

City State Zip

This information will be released for the purpose of:

[ ] Treatment planning and continuing care

[ ] Other

Extent or Nature of Information to be disclosed:

Specification of the date, event or condition upon which this consent expires on _____

I understand that the information from my record is confidential and protected from redisclosure without additional written authorization from me. I understand that this information may contain confidential psychiatric, psychological drug and /or alcohol abuse treatment and may contain confidential HIV (AIDS) related information.

In treatment related to alcohol and/or drug abuse, I understand that my records are also protected under title 42 of the code of federal regulations for alcohol and drug abuse. I also understand that I may revoke this consent at any time, and unless specified above, my consent will expire 180 days from this date if not acted upon prior to that time. This release was fully explained and consent was given of my own free will.

_____ _____

Client Signature **Date**

_____ _____

Parent / Legal Guardian **Date**

_____ _____

Witness Signature **Date**

Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by Donna Brooks Therapy to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. I understand that further information regarding how Donna Brooks Therapy will use and disclose my information can be found in the Notice of Privacy Practices.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received Donna Brooks Therapy's Notice of Privacy Practices currently in effect.

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

Unable to obtain written consent and acknowledgment because:

- ☐ Individual refused
- ☐ Emergency treatment situation
- ☐ Individual not able to sign due to incompetence or other medical reason
- ☐ Other: _____

Donna Brooks Therapy
Intake Wellness Client Self Report Measure

Name:_____

Date:_____

For each item, CIRCLE the answer that matches your view:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Appropriate
I deal well with my daily problems.	5	4	3	2	1	0
I deal well with crisis.	5	4	3	2	1	0
I get along well with my family.	5	4	3	2	1	0
I do well in social situations.	5	4	3	2	1	0
I do well in school and/or work.	5	4	3	2	1	0
I feel calm.	5	4	3	2	1	0
I feel hopeful.	5	4	3	2	1	0
I feel energy for daily activities and life events.	5	4	3	2	1	0
I have an interest in things.	5	4	3	2	1	0
I sleep well.	5	4	3	2	1	0
My drinking does not cause problems in my life.	5	4	3	2	1	0

In general, would you say your health is Excellent Very Good Good Fair Poor

Please indicate if you have a serious or chronic medical condition.

Asthma Diabetes Heart Disease Back Pain or other Chronic Pain Other Condition

In the past 6 months, how many times did you visit a medical doctor? None 1 2-3 4-5 6+

In the past month, how many days were you unable to work because of your physical or mental health? (answer only if employed) _____

In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? (answer only if employed) _____

In the past month have you ever felt you ought to cut down on your drinking or drug use? Yes No

In the past month have you ever felt annoyed by people criticizing your drinking or drug use? Yes No

In the past month, have you felt bad or guilty about your drinking or drug use? Yes No

In the past week how many drinks did you consume?_____

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, Donna Brooks, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 718-664-8289 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

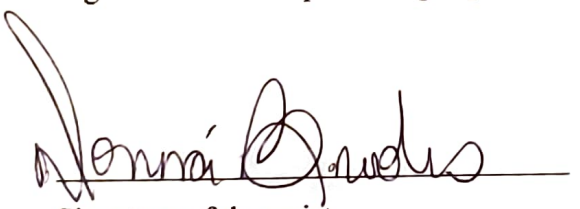
and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date



Signature of therapist

4/1/20

Date

SUMMARY NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS A SUMMARY OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A complete explanation of the privacy practices of Donna Brooks Therapy can be found in the attached Notice of Privacy Practices (the "Notice"). We are required by law to provide you with a copy of the Notice and comply with its terms. The attached Notice is meant to inform you more fully of the uses and disclosures of protected health information that we may make and your rights regarding your protected health information.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

- We will use and disclose your protected health information to provide you with medical treatment, to bill and receive payment for your medical treatment, for certain administrative purposes and to evaluate the quality of your care.
- We will make reasonable efforts to limit access to your protected health information to those persons who need access to carry out their duties.
- We may use or disclose your protected health information without your specific permission to enable third parties to perform a job for us or for other reasons permitted by law.

YOUR PRIVACY RIGHTS

- You may have the right to request certain restrictions or limitations on the protected health information we use or disclose.
- You may have the right to specify how you receive communications of protected health information.
- You may have the right to access and amend your protected health information for as long as it is maintained by Donna Brooks Therapy
- You may have a right to request an accounting of disclosures of protected health information made by Donna Brooks Therapy.

QUESTIONS OR COMPLAINTS

If you have any questions or complaints about our privacy practices, please contact:
Hipaa Privacy Officer
180 South Broadway, Suite 409
White Plains, NY 10605

PLEASE SIGN THE ATTACHED CONSENT AND ACKNOWLEDGEMENT FORM TO ENABLE DONNA BROOKS THERAPY TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH DONNA BROOKS THERAPY'S NOTICE OF PRIVACY PRACTICES.