Danielle Osier-Tatar, MFT, LADC

2450 Vassar Street, Suite 3-A

Reno, Nevada 89502

# Adult History Form

In order for us to be able to fully evaluate you, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to; do the best you can. Thank you!

**PATIENT IDENTIFICATION**

Name:______________________________ First Appointment Date:__________________
Birth Date:___________________________ Age __________ Sex_____________________
Religion _____________________________ Marital Status___________________________
Race_________________________________ Children______________________________
Address:_____________________________________________________________________
City__________________________________ State ___________ Zip_____________________
Home Phone # ___________________ Work #_________________ Cell #_______________________

**REFERRAL SOURCE**

Referral Source__________________________________________________________________
Referral Address ________________________________Phone #________________________________
Do we have your permission to release information to the referring professional when it is appropriate? Yes ____ No_____

**PURPOSE OF THE CONSULTATION**

(Please give a brief summary of the main problems)

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**PRIOR ATTEMPTS TO CORRECT PROBLEMS / PRIOR PSYCHIATRIC HISTORY**

(Please include contact with other professionals, medications, types of treatment, etc.)

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**WHAT IS YOUR DESIRED OUTCOME FOR THIS SERVICE**

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**MEDICAL HISTORY**

Current medical problems ___________________________________________

___________________________________________

Current medications ___________________________________________

___________________________________________

Other doctors/clinics seen regularly___________________________________________

___________________________________________

Any history of head trauma? (describe) ___________________________________________

___________________________________________

Ever any seizures or seizure like activity?___________________________________________

Any periods of spaciness or confusion?___________________________________________

Prior hospitalizations (place, cause, date, outcome) ___________________________________________

___________________________________________

Prior abnormal lab tests, X-rays, EEG, etc. ___________________________________________

___________________________________________

Allergies/drug intolerances (describe) ___________________________________________

Present Height: _________________ Present Weight:___________________

**CURRENT LIFE STRESSES** (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)

___________________________________________

___________________________________________

___________________________________________

___________________________________________

**FAMILY HISTORY**

Family Structure (who do you currently live with, add other information as necessary)

___________________________________________

___________________________________________

___________________________________________

___________________________________________

**Significant Developmental Events** (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)___________________________________________

___________________________________________

___________________________________________

___________________________________________

**Current Marital or Relational Situation/Satisfaction**

___________________________________________

___________________________________________

___________________________________________

**Life History**:

School: Highest grade completed ______________________________
Learning problems (specify) ______________________________
Behavior problems (specify) ______________________________
Childhood atmosphere (family position, siblings, abuse, neglect, illnesses, trauma, etc.) ________

Did mother or father ever seek psychiatric or mental health treatment? If yes, for what purpose?
Mother______________________________

Father ______________________________

Mother alcohol/drug use history ______________________________

Father alcohol/drug use history

Have any relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) ______________________________

Any Family Medical Problems ______________________________

**Siblings** (names, ages, problems, strengths, relationship to patient)

**Children** (names, ages, problems, strengths)

**EMPLOYMENT HISTORY:** (summarize jobs you've had, list most favorite and least favorite)
Current Employment____________________________________________

____________________________________________

____________________________________________

Previous Employment____________________________________________

____________________________________________

Any work-related problems? ____________________________________________
What would your employers or supervisors have said about you? ____________________

____________________________________________

**MILITARY HISTORY:** ____________________________________________

____________________________________________

**EVER ANY LEGAL PROBLEMS?** ____________________________________________

____________________________________________

____________________________________________

**ALCOHOL AND DRUG HISTORY:** (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.) These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.) cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Ever experience withdrawal symptoms from alcohol or drugs? ____________________
Has anyone told you they thought you had a problem with drugs or alcohol? ____________
Have you ever felt guilty about your drug or alcohol use? ____________________
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? ____

____________________________________________

Have you ever used drugs or alcohol first thing in the morning? ____________________
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) ____________________
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) ______

____________________________________________

____________________________________________

**Cultural/Ethnic Background** ____________________________________________

____________________________________________

____________________________________________

**Describe your relationships with friends** ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Describe yourself** _______________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Anything else important for the therapist to know**_______________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Therapist: ______________________
Appointment Date/Time: ___________

Danielle Osier-Tatar, MFT, LADC
2450 Vassar Street, Suite 3-A
Reno, Nevada 89502

# Application for Services

Name of Client_________________________________ Referred by:____________________________________

__________________________________________________________________________________________
Address City State Zip

Telephone: Home( )_______________ Business ( )_____________ Cell ( ) ________________
May we leave a message? Yes____No____ Yes____No____ Yes____No____

Soc. Sec. or Medical ID #____/____/____ Date of Birth____/____/____ Married ( ) Single ( ) Other ( )

**If Client is a Minor, please list Parent or Guardian and address information:**

Parent or Guardian:_________________________________________________________________________

___________________________________________________________________________________________
Address (if different from Client) City State Zip

Employer:____________________________________Address:_______________________________________

**Primary Care Physician**:________________________Address (City/State is fine):_______________________

Spouse:_____________________________________________________________________________

Soc. Sec or Medical ID #_________/_________/________ Date of Birth: ______ _____ _____

Spouse's Employer:______________________________ Address:_________________________________

**Insured (if not client)**:______________________________ **Insurance Co**.___________________________

Address:_____________________________________________________________________________________

Policy #_______________ Group #________________ Phone: (____)_______________

**FAMILY MEMBERS**

____________________________________________ Date of Birth ________/_________/_________

____________________________________________ Date of Birth ________/_________/_________

I am seeking help because_______________________________________________________________________

_____________________________________________________________________________________________

**I understand that a "per session" charge may be made for non-kept appointments or appointments canceled without 24 hour notice**.

**I agree to pay the per-hour fees or appropriate insurance co-payment for services provided. I understand that I am responsible for the total incurred fee although my insurance may be billed for the service.**
I agree to assign insurance benefits for the above mentioned insurance company.

___________________________________________ ___________________________
Client Signature or Parent/Guardian Date

___________________________________________ ___________________________
Parent/Guardian (if joint custody) Date

## NEW CLIENT INSTRUCTION LIST

Please take a few minutes to fill out the attached forms and bring all items with you for your first session. If you have any questions, please discuss them with your therapist:

1) APPLICATION FOR SERVICES - **Please fill out completely, read responsibility clause and sign and date.**

2) MINDSMATTER OFFICE POLICIES - **Please read, indicate where we may reach you and sign and date.**

3) CONFIDENTIALITY / CLIENT RIGHTS- **Please read, sign and date.** If you would like a copy we would be happy to provide one.

4) HIPPA - PRIVACY PRACTICES NOTICE - **Please check one of the two choices, sign, date and print your name.** Your therapist can provide a copy of the Guidelines if you so choose.

5) 1500 HEALTH INSURANCE CLAIM FORM - **Please sign and date in Box 12 and sign only in Box 13.** Complete top left section ONLY if you did not complete the insurance information on Application for Services.

6) POLICY ON REMINDER PHONE CALLS - **Please indicate your preferred numbers and other options then sign and date.**

7) CHILD and ADOLESCENT CONSENT TO TREAT – (Child Packets only)
**Please read, sign and date.** If you have any questions regarding this policy, please discuss with your therapist at the first session.

8) CHILD or ADULT HISTORY FORM and ADULT SYMPTOM CHECKLIST - **Please fill out the appropriate forms for the client - yourself or your child.**

**FULL PAYMENT OF FEES / CO-PAY IS EXPECTED AT TIME OF SERVICE.**

**For your convenience, we accept check, cash and credit/debit cards.**
**We charge a $25 NSF check fee.**

9) IF USING INSURANCE, please bring your insurance card and co-pay with you.
IF USING MEDICAID - You/your child must be eligible at the time of each service or you will be responsible for the full fee.

10) IF PAYING CASH, Please bring the full fees with you.

MindsMatter Wellness Center

Danielle Osier-Tatar, MFT, LADC
2450 Vassar Street, Suite 3-A
Reno, Nevada 89502
(775) 400-1229

## AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL / PSYCHOTHERAPY RECORDS

**(PLEASE PRINT)**

_______________________________________ _______________________________________
Patient Name at the Time of Treatment Date of Birth

The undersigned hereby authorizes and requests this facility or ___Danielle Osier-Tatar, MFT, LADC_____________, to provide:

☐ Physician ☐ Psychotherapist ☐ Insurance ($1.00 per page) ☐ Attorney ($1.00 per page)

☐ Other Purpose: ______________________________________________

Name of Person, Organization to whom disclosure will be made: ________________________________________

**I understand that the parties in receipt of these records may re-disclose my PHI (Protected Health Information) to persons or entities that are not subject to the HIPAA Privacy Regulations, resulting in my PHI no longer being protected by HIPAA regulations.**

**Signature:** ______________________________________________________________________

I would like the following information released: ☐ Only those items listed below:

______ Intake Information ______ Progress Notes ______ Discharge Summary

______ Record of Appointments ______ Diagnosis ______ Billing Records

______ Psych Assessment Report ______ Summary of Treatment ______ History

______ Other: ____________________________________________

I specifically authorize release of information for the following treatments or procedures that are included in these records. (You must initial those items requested, or they will not be released with the above record.)

____ Drug/Alcohol Abuse Treatment ____ Psychological and Mental Health Treatment ____ Psychotherapy Notes

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it. I understand that the revocation must be made in writing, and addressed to Danielle Osier-Tatar, MFT, LADC, and delivered or mailed to: Mindsmatter Wellness Center 2450 Vassar Street, Suite 3-A, Reno, Nevada 89502.

This consent will automatically expire 90 days from the date signed. Furthermore, this consent will be revoked upon compliance of this request and will not serve any other future request. I reserve the right to withdraw, in writing, this authorization at any time.

_______________________________ _______________________________
Date Signature of Patient

_______________________________ _______________________________
Witness Signature of Legal Representative

_______________________________ _______________________________
Reason Patient Unable to Sign Relationship

*** * DUE TO CONFIDENTIALITY, WE ONLY FAX UNDER HIPAA GUIDELINES * ***

**Danielle Osier-Tatar, MFT, LADC**

**2450 Vassar Street, Suite 3-A**

**Reno, Nevada 89502**

# CLIENT RIGHTS

- The client has the right to considerate and respectful care.

- The client has the right to obtain from the therapist complete, current information concerning his/her diagnosis, treatment, and prognosis in terms the client can be reasonably expected to understand. When it is not clinically advisable to give such information to the client, the information should be made available to an appropriate person on his/her behalf.

- The client has the right to receive from his/her therapist information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation and treatment. When clinically significant alternatives for care or treatment exists, or when the patient requests information concerning treatment alternatives, the client has the right to such information.

- The client has the right to refuse treatment to the extent permitted by law, and to be informed of the clinical consequences of his/her action.

- The client has the right to every consideration of privacy concerning his/her own care. Case discussion, consultations, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his/her care must have the permission of the client to be present.

- The client has the right to expect that all communications and records pertaining to his/her care should be treated as confidential.

- The client has the right to expect reasonable continuity of care. This includes the right to know in advance that appointment times and therapists are available and where.

- The client has the right to examine and receive an explanation of his/her bill regardless of source of payment.

- The client has the right to know the therapists' policies which apply to his/her conduct as a client.

I have read both pages of this document and understand these rights and issues.

Signature_______________________________________________ Date____________________

Danielle Osier-Tatar, MFT, LADC

2450 Vassar Street, Suite 3-A

Reno, Nevada 89502

***<u>On Confidentiality</u>***

Now that you are involved in counseling, we would like to share with you some ideas on a very important issue, that of confidentiality and trust.

Therapy is a very private matter between the counselor and the person being counseled. We respect the personal and private matters that you choose to share in counseling and do not in any way wish to misuse that trust. Our professional ethics and the Nevada Revised Statutes require that information you provide your therapist remains confidential and that it be shared with others only by your written and informed consent.

There are several exceptions to this basic rule when the therapist is required by law or professional ethics to disclose information to specific other persons. These situations include:

- When there is suspected or acknowledged child abuse.
- When there is suspected or acknowledged abuse of an elderly person.
- When there is strong reason to believe that there is significant danger to yourself or to someone else.
- Infrequently, in matters such as child custody disputes or where the Court is otherwise involved, the Court can order records to be released and counselors can be ordered to testify.
- If legal means are required to collect your bill, information on client status and financial agreements may be disclosed to the Court.
- If your records are protected under the Federal Drug and Alcohol statues, there are occasions when we may not be able to release records even with your permission.

We want you to be clear about these expectations but also to assure you that these are the exceptions to the rule rather than the rule. When such exceptions do occur you will be notified.

If the client is a minor, I understand there must be a degree of confidentiality between the therapist and the minor and that not all information will be discussed with the parent. If your child did inform me of any danger (such as drunk driving, suicidal or self-harm behaviors, or severe bullying) the parent would be notified. Other behaviors such as stealing, skipping school, and drug use may not be reported to the parent.

This is not intended to be a legal description of confidentiality but to provide some basic information for your use. We would be happy to discuss any of these matters further with you if you wish. Please let your therapist know if you have further questions about the confidential nature of your discussions.

## Office Policies

Thank you for choosing our practices for your psychological needs. We ask you to read the following information about our procedures and policies. If any questions arise, please discuss them with us.

**Philosophy** We expect to do everything within our professional competencies to be helpful to you. We know that the best gains in counseling and therapy are achieved by a cooperative effort on the part of the therapist and the client. We welcome your active participation in planning your therapy and encourage you to ask questions whenever they arise.

**Location** Our office is located at 2450 Vassar Street, Suite 3-A Reno, Nevada 89502.

**Confidentiality** Law, professional ethics, and our commitment to you require that your therapist not release information about you to anyone, including your spouse/partner or family members, without your written consent or as required by law. If you want your therapist to confer with another professional you will be asked to sign a release of information form. If you disclose child abuse, elder abuse, or the intent to harm yourself or another, your therapist is required to make a report to authorities. If you have any questions about confidentiality, please discuss them with your therapist.

**Fees & Billing** A session is usually 45-50 minutes and fees will be established prior to or at the time of the first session. Payment by check, cash or credit card is due at the **beginning of a session**. We request that you have your payment ready to give to your therapist when you arrive for a session so the entire time for your session can be devoted to your needs.

Phone calls, consultation reports, and correspondence are charged on a pro-rated basis using the basic per hour fee. These fees are not usually covered by insurance. There is no charge for telephone calls under five minutes. A $25.00 fee is charged for returned checks.

Clinical Work connected with Court/other Legal Proceedings:
For Independent Evaluations of children or adolescents, or any other work connected with Court and/or Attorneys, my standard rate is $200.00 per hour, payable in the form of a minimum retainer* of $2500 at initiation of this process.
Services covered under the retainer include:
1) Case consultation with attorneys
2) Research and/or preparation of materials for use in evaluation
3) Intake processes & documentation conducted with parents
4) Time evaluating the child/adolescent/adult
5) Preparation of reports for attorneys
6) Travel & expenses connected with Court appearances
7) Time "lost" from ongoing clinical practice

*This retainer can be divided 50/50 between the parents of a child/children being evaluated, or by the client's attorney(s).
Refunds are sent to Payor(s) (clients/parents/attorneys) for unused funds.

**Insurance** As a service to you, we bill most major insurance companies. However, it is important that you understand:

1. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, not with your insurance company.
2. **All charges are your responsibility** whether your insurance company pays or not. Not all services are a covered benefit in all contracts.
3. You are required to pay unpaid deductibles and co-payments at the beginning of each session.

4. Any balance that accumulates because of a discrepancy between your payment and the insurance company's is your responsibility. If you need to make arrangements for payment on an account, please discuss this with our office staff. An 18% annual interest rate is charged on accounts not paid in a timely fashion. *Delinquent accounts are turned over to Collection Services of Nevada*.
5. If you belong to an HMO or MCO, the company may limit the number of visits they authorize. If you wish to continue in therapy longer than the number of visits authorized, you will be responsible for the full fee.

**Cancellations** If you must cancel an appointment, we require that you leave a message **AT LEAST 24 HOURS IN ADVANCE** on voice mail or by text. You will be expected to pay the full fee, not just the co-pay, for any missed individual or group session which is not canceled 24 hours in advance. Insurance companies rarely pay for missed sessions.

**Office Hours** Office hours are Monday and Wednesday through Friday from 9:00 a.m. to 6:00 p.m. You may leave voice messages or texts during that time or during those hours on Tuesdays, as well.

**Phone Calls** We have voice mail to supplement our regular office hours. We do return calls promptly. However, after-hours it may take up to 24 hours to return a call and up to 48 hours on weekends. If your call is urgent, please indicate that in your message. We do not usually return non-emergency calls Friday through Sunday.

Please hold routine questions about insurance or business matters until your next scheduled session. We give priority to returning urgent calls during breaks between sessions.

We usually make a courtesy reminder call the working day before your appointment. By signing this form you agree to have us call you to remind you of your appointment. Please initial below where we may call or leave a message.

Initial: _______ Please only call me at home.
_______ Please only call me on my cell.
_______ Please only call me at the office.
_______ Please call me at any of my numbers.
_______ **Please do not call me.**

**Please remember this call is a courtesy only and you are still responsible for coming at your appointed time or canceling 24 hours in advance.**

**Emergency** In an emergency, if you need to speak to someone immediately, call the Crisis Call Line at 323-0111, call 911, or go to the emergency room nearest your home.

**Referral** If you were referred to us by a physician, employee assistance program, or other professional, we would like to acknowledge the referral. By signing this form, you are giving us permission to do so. Please let us know if you do not want to acknowledge the referral.

**I have read these policies and I agree to abide by them**.

_______________________________________ _______________
Signature Date

_______________________________________ _______________
Signature Date

**Danielle Osier-Tatar, MFT, LADC**
**2450 Vassar Street, Suite 3-A**
**Reno, Nevada 89502**

# PRIVACY PRACTICES NOTICE

Mindmatter Wellness Center
strictly adheres to the regulations mandated by the

***Health Insurance Portability and Accountability Act***
***(HIPAA, Title II*****)**

Copies of the *INFORMATION PRACTICES NOTICE,*
describing the Privacy Practices and Guidelines
set forth as a result of this legislation,
are available for review or receipt upon request.

## ACKNOWLEDGEMENT

_____ I hereby acknowledge that I have read the above and choose not to receive a copy of the Privacy Practices and Guidelines at this time. I have been made aware that I can request, at any time, to review or to obtain a copy of the *INFORMATION PRACTICES NOTICE* for Mindsmatter Wellness Center.

_____ I requested and have received a copy of the *INFORMATION PRACTICES NOTICE* for Mindsmatter Wellness Center.

Signature: ________________________________ Date:_________________

Print Name: _______________________________

Signature of Therapist:_____________________________________________