START & ASSOCIATES
PSYCHOLOGICAL SUPPORT

Consent for Treatment

The following outlines a concise description of our much longer information form which is available at the office. Your signature indicates you agree to the following terms:

Psychological Support:
Our intent is to offer a calm place where you will feel accepted and understood. Thus, the relationship between you and your therapist is of upmost importance and if the fit does not seem right, please discuss with your therapist or Amy Goodman at 616.607.4476 or amy@startandassociates.com. We want you to feel settled and comfortable.

Contacting Your Therapist:
Your therapist can be contacted via his/her phone or email for scheduling and other matters. For all instances, we will attempt to respond within 24 hours. If your therapist is unable to respond and it is an emergency, please phone your physician or 911.

HIPAA/Confidentiality:
We adhere to ethical and legal guidelines regarding HIPPA and confidentiality. Most everything is confidential under these guidelines, though we must report the following to family member(s), hospital, and/or authorities: any abuse or neglect, or threat of abuse or neglect, to another person or animal; threat to harm or kill another person or animal; or threat to harm or kill oneself. We also have release of information forms if you would like us to communicate to others, such as your physician or family members.

Sessions and Fees:
Most sessions are approximately 45-60 minutes unless otherwise planned and will be scheduled directly with your therapist. We accept private pay and are in-network with most insurance companies. Private pay will be determined between you and your therapist before your first appointment. If you opt to use your health insurance, **it is your responsibility to understand your specific benefits, such as what costs you will accrue for deductibles and co-pays, as well as how many sessions are covered.** Your fees will be paid at session time or in some situations, we will bill you. If your balance exceeds your ability to pay at session time, a payment plan could be considered. **We may charge a late cancellation or no-show fee up to $125.00 per incident or the allowed amount per insurance reimbursement rates.** Please note insurance companies do not provide reimbursement for these incidents.

Your signature below indicates you have read, understood, and agreed to these terms:

Client Signature Date

Parent/Guardian's Signature if Client is a minor Date

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Adult Intake Form: Please be aware of any thoughts and feelings you might experience while completing this paperwork. Keep in mind that writing about yourself might be sensitive, therefore, only complete the portions of your choosing.

Name: _____ Date of Birth: _____
Full Address: _____
Home Phone: _____ Cell Phone: _____
Business Phone: _____ Other Numbers: _____
Email Address: _____
How would you prefer to be contacted? _____
May your therapist contact you on the other numbers? _____
Emergency contact and phone number: _____
What is your profession? _____
How did you hear about us? _____
May we send you a satisfaction survey via email? _____

Primary Insurance Company: _____
Effective Date: _____ Contract #: _____ Group #: _____
Name of subscriber: _____ Relationship: _____
Subscriber's DOB: _____ Subscriber's place of employment: _____

Secondary Insurance Company: _____
Effective Date: _____ Contract #: _____ Group #: _____
Name of subscriber: _____ Relationship: _____
Subscriber's DOB: _____ Subscriber's place of employment: _____

Your Family of Origin
Names of parents/caregivers: _____

Please share pertinent information about your parents/caregivers (such as, their professions, locations, health, etc):

Siblings' names and ages: _____

Please describe your relationships with your family members:

Hometown: _____

Your Current Family

Partner's name : _____
Partner's address: _____
Partner's phone number: _____
Partner's profession: _____
Partner's health: _____
Children's names and ages: _____

Please provide a description of what brings you here and issues you would like to address:

When did these problems/issues begin? _____

Are you seeing any other therapists? If so, please list their names, reasons for seeing them, and whether your therapist has permission to contact them if needed:

Please circle any that apply to you in the past or presently:

Anxiety	Social withdrawal	Distractibility
Depression	Irritability	Procrastination
Restless sleep	Food addiction	Nervousness
Suicidal thoughts	Sex addiction	Dislike self
Suicide attempts	Gambling/spending addiction	Chronic guilt
Illegal drug use	Relationship issues	Blackouts
Substance abuse	Communication issues	Memory loss
Anger	Having many fears	Low sex drive
Workaholic	Impulsivity	Feeling overwhelmed
Perfectionism	Brain Fog	

Please circle any of the following words that would describe yourself:

Happy	Confident	Useless
Lonely	Helpless	Trustworthy
Worthwhile	In control	Worthless
Healthy	Hopeless	Intelligent
Confused	Loveable	Unlovable
Attractive	Feeling trapped	Open-minded
Overwhelmed	Hardworking	Successful
Spiritual	Religious	A seeker
Grounded	Settled	Not in control
Guarded	Free Spirit	Hopeful

Health Data

Physician's Name: _____ Phone Number: _____

Are you being treated for any medical problems: _____

What prescriptions medications are you taking? Please include name, amount, when you began taking the medication, and reason(s) prescribed:

How often do you exercise? _____

Do you eat balanced meals? _____

Do you smoke? If so, how much? _____

How much tea, coffee, or caffeinated soft drinks do you consume daily? _____

Please list any injuries, surgeries, or other medical concerns you have experienced in the past:

Have you received outpatient psychological support in the past? If so, with whom, when, and reasons why:

Have you ever received inpatient psychological support in the past? If so, please provide places, dates, and circumstances:

Additional Information

Please provide any other information about yourself:

Thank you for your disclosure. Please sign below.

Signature Date

Name: _____ Date: _____

Instructions: Read each statement carefully. Reflecting on the past week, including today, please indicate how you have been feeling. Mark the answer that best describes your current situation. For this questionnaire, "work" is defined as employment, school, housework, volunteer work, etc.

1. I have trouble falling asleep or staying asleep.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

2. I feel no interest in things.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

3. I feel stressed at work, school, or other daily activities.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

4. I blame myself for things.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

5. I am satisfied with my life.
O 4 Never/almost never O 3 Rarely O 2 Sometimes O 1 Frequently O 0 Almost Always

6. I feel irritated.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

7. I have thoughts of ending my life.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

8. I feel weak.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

9. I find my work, school, or other activities satisfying.
O 4 Never/almost never O 3 Rarely O 2 Sometimes O 1 Frequently O 0 Almost Always

10. I feel fearful.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

11. I use alcohol or drugs to get going in the morning.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

12. I feel worthless.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

13. I am concerned about family troubles.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

14. I feel lonely.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

15. I have frequent arguments.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

16. I have difficulty concentrating.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

17. I feel hopeless about the future.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

18. I am a happy person.
O 4 Never/almost never O 3 Rarely O 2 Sometimes O 1 Frequently O 0 Almost Always

19. Disturbing thoughts come into my mind that I cannot get rid of.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

20. People criticize my drinking or drug use.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

21. I have an upset stomach.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

22. I am not working or studying as well as I used to.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

23. I have trouble getting along with friends and close acquaintances.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

24. I have trouble at work/school because of drinking or drug use.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

25. I feel that something bad is going to happen.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

26. I feel nervous.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

27. I feel that I am not doing well at work/school.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

28. I feel something wrong with my mind.
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

29. I feel “blue.”
O Never/almost never O Rarely O Sometimes O Frequently O Almost Always

30. I am satisfied with my relationships with others.
O 4 Never/almost never O 3 Rarely O 2 Sometimes O 1 Frequently O 0 Almost Always

Please list reasons why seeking treatment: _____
_____

Regarding these reasons, rate your level of distress at this time:
No distress 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 A lot of distress

START & ASSOCIATES
PSYCHOLOGICAL SUPPORT

AUTHORIZATION TO RELEASE AND/OR OBTAIN HEALTHCARE INFORMATION

Client Name: _____ Date of Birth: _____
Previous Name(s): _____
I request and authorize Start and Associates Psychological Support to release and/or obtain healthcare information of the person named above to:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other _____

_____
Signature Date

_____
Parent/Guardian's Signature Date

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS REVOKED IN WRITING.