FACE SHEET

DATE:

Please Complete ALL Information

1. Client Demographics						
Client Last Name:			First:		Middle:	
Sex:	DOB:	Age:	Marital Status:	Ethnic Origin:		Religion:
Address:		City:	State/Zip:	Race:		
Home Phone:	**Cell Phone:**		Social Security #:	Driver's License/ State (if applicable):		
Employer Name:	Occupation:		Length of Employment:	Employer Phone:		
Highest Level of Education (current grade level):			Degree Obtained:			
Primary Care Physician Name:	Address/City		Phone #/Fax#:	Preferred Pharmacy/Phone:		

2. Guarantor/Legal Guardian/Parent of Minor:				
Last Name:	First:	Sex:	DOB:	Relation:
Cell Phone:	Social Security#:	Occupation:		
Address:	Apt #:	City:	State/Zip:	
Employer Name:	Length of Employment:	Employer Phone:		

3. Primary Insurance Information:					
Name of Insurance:		Insurance Phone:			
Policy/Hic#:	Social Security #:	Group Name:	Group#:		
Insured's Last Name:	First:	Middle Initial:	Sex:	Relation:	DOB:
Employer Name:	Occupation:	Length of Employment:	Employer Phone:		
Employer Address:	Suite#:	City:	State/Zip:		

4. Secondary Insurance: **None-Go to Section 5** **Yes - Complete Section 4**					
Name of Insurance:		Insurance Phone:			
Policy/Hic#:	Social Security #:	Group Name:	Group#:		
Insured's Last Name:	First:	Middle Initial:	Sex:	Relation:	DOB:

5. Please describe briefly the problem that brought you here today.

6. Emergency Contact Information:	
Emergency Contact:	Relationship:
Address:: City, State/Zip:	Best Contact Number:
For minors, if parents are not together and patient has contact with non-custodial parent, please provide parent's name and include status of custody arrangement.	Relationship to Patient:
2nd Parent Name:	Status of Custody Arrangement:
Address: City, State/Zip:	Best Contact Number:

7. Previous Mental Health or Chemical Dependency Hospitalizations:	
Last 12 months: Yes No	Last 6 months: Yes No
Where:	Where:
When:	When:
Why:	Why:
How long:	How long:

8. How did you hear of Mind Above Matter?
Mental Health Professional Legal/Judicial Psychiatrist Clergy/Church Family/Friend Internet Insurance Company A Previous Client Advertisement Organization Other (Please Specify below)

9. Specific names of individuals/organizations who referred you:	
Name:	Relationship to Client/Title:
Address:	City:
State:	Zip:
Telephone:	**Permission to contact: Yes No**

10. If client is a minor, provide information on client's school.	**Homeroom/Primary Teacher Name**:
School Name/District:	City:
Address:	State/Zip:
Telephone:	**Permission to contact: Yes No**

Purpose of disclosure: To identify persons supporting and using services; notification of admission, discharge, and aftercare plans.
All requested information must be completed for insurance claims to be correctly processed. Exclusion of insurance policy information may result in an insurance denial in which you will be totally responsible for your bill. The person who signs consent is the Guarantor/responsible party for this bill.
I authorize the release of any medical or other information necessary to process this claim to my insurance company. This may also include case managers with your insurance company. I also authorize payment of medical benefits to Mind Above Matter, LLC, for services rendered to me.

_____ _____
Signature Date

MIND ABOVE MATTER

CURRENT PROBLEMS AND CONCERNS:

Please mark below, the symptoms which you have experienced in the past 3 months. Rate the intensity from 1 to 3, with 3 being the most severe.

 1= Absent/Low  2=Moderate  3=Severe

Depression	Perfectionism
Feeling Hopeless	Feeling guilty
Obsessions/Compulsions	Problems getting along with family
Extreme sadness	Problems with anger
Trouble concentrating	Feeling Fearful
Changes in sleep habits	Trouble doing your job/schoolwork
Memory problems	Feeling anxious
Lack of energy	Acting violently
Changes in eating habits	Lack of enjoyment/no motivation
Weight changes	Feeling tearful
Feeling stressed	Muscle tension
Feeling extremely happy	Sudden feelings of panic
Self-esteem problems	Physical complaints
Easily irritated	Change in sexual function
Thoughts of harming/killing yourself	Thoughts of harming/killing others

Other concerns or symptoms:_____

MIND ABOVE MATTER

MEDICAL INFORMATION:

Prescription/Non-Prescription medication(s) you are currently taking:			
Name of Medication	Dosage	Directions (ex. How many times a day, route)	Date of Initial Rx

Medication Allergies:	Other Allergies:

Past/Current Medical Problems, including head injuries, concussions, seizures, surgeries, etc:

Life Style Questionnaire	
Frequency/quantity of alcohol consumption	Amount of caffeine consumption (incl. soda pop)
Frequency/quantity of drug consumption	Frequency/type of physical exercise
Quantity of cigarette smoking	Amount/quality of sleep

Please list the individuals with whom you reside.			
Name	Age	Relationship to Patient	Quality of Relationship
If patient is a minor, status of patient's parents (ex. Legally married, remarried, divorced, etc):			

MIND ABOVE MATTER

PREVIOUS MENTAL HEALTH TREATMENT:

Have you ever been in therapy before? Yes No

If yes, please describe below:

Name of therapist	Dates of Service
Type/effectiveness of treatment	
Name of therapist	Dates of Service
Type/effectiveness of treatment	

OTHER IMPORTANT INFORMATION:

Any history of abuse (physical, emotional, or sexual)	Yes No Unsure
Any custody issues or other legal issues (Probation, pending charges, etc.)	

Please use this space to provide additional information:

Mind Above Matter

Assessment Service Disclosure Statement and Consent to Assessment

Mind Above Matter lawfully and ethically operates an assessment service by a licensed mental health professional. The clinician may refer appropriate patients for outpatient treatment or to a physician for further evaluation or recommend admission to the facility. Before referring and/or assessing a person, the following disclosures must be made to each person seeking treatment or assessment:

- Mind Above Matter is not obligated to provide an assessment by a physician unless deemed necessary by the assessment clinician. Physician assessments are billable services.
- This assessment is voluntary and the client is free to choose whether they want to pursue further treatment.
- The assessment clinician is an employee of Mind Above Matter.
- The assessment is confidential unless the client gives permission in writing to release information.
- Specific mental health professionals the client may be referred to are licensed and meet clinical and ethical standards of the hospital.
- Financial reimbursements are never given or received by Mind Above Matter based on referrals.

I certify that I have read and fully understand the above consent for assessment. I agree to absolve Mind Above Matter and its staff rending the treatment(s) from any liability.

I certify that I am: Client Biological parent with authority to consent
Adoptive Parent Foster Parent Legal Guardian (papers are required)

IN CASES INVOLVING DIVORCE/ADOPTION OR FOSTER PARENT ARRANGEMENT PAPERS MUST BE PRESENTED PRIOR TO CONSENT FOR ASSESSMENT.

I Consent to Assessment I Refuse Assessment

_____ _____
Individual Consenting or Refusing Assessment or Medical Screening Date

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness/Clinician Date

Consent to Treat

I, _____ have fully discussed with the staff of MAM (hereby known as "clinician") the various aspects of the psychotherapy contract.

I have voluntarily chosen to receive treatment services. I understand I may withdraw from treatment at any time but if I decide to do this I will discuss my plan with Clinician before acting on it. 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 I am required to attend as scheduled. If I am absent for three consecutive days and have not notified the team in advance I may be discharged for noncompliance. Should I readmit a new assessment must be scheduled and completed prior to re-admission.

The Clinician has further discussed with me scheduling policies, fees to be charged, and policies regarding payment, missed appointments, matters relating to insurance, and if applicable, preauthorization and utilization review issues. I fully understand my rights and responsibilities as a client.

In general, the confidentiality of all communications between a patient and psychotherapist is protected by law, and information can only be released to others with my written permission. There are a few exceptions, however.

From MAM staff to client:
In most judicial proceedings you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part or all of your treatment or evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. Testimony may also be ordered in (a) legal proceeding relating to psychiatric hospitalization; (b) in malpractice and disciplinary proceedings brought against a psychologist; (c) court-ordered psychological evaluations; and (d) certain legal cases where the client has died.

In addition, there are some circumstances when I am required to breach confidentiality without a patient's permission. This occurs if I suspect the neglect or abuse of a minor, in which case I must file a report with the appropriate State agency. If, in my professional judgment, I believe that a patient is threatening serious harm to another, I am required to take protective action which may include notifying the police, warning the intended victim, or seeking the client's hospitalization. If a client threatens to harm him/herself, I may be required to seek hospitalization.

The clear intent of these requirements is that a psychotherapist has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such danger exists. Fortunately, these situations rarely arise in my practice.

There are several other matters concerning confidentiality:
1. I may occasionally find it helpful or necessary to consult about a case with another professional. In these consultations I make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If I feel that it would be helpful to refer you to another professional for consultation then, of course, with your authorization, I will discuss your case with her or him.
2. I am required to maintain complete treatment records. Patients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the patient's appropriate designee. Patients will be charged an appropriate fee for preparation.
3. If you use third party reimbursement, I am required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. If you request it, I will provide you with a copy of any report which I submit.
4. If you are under eighteen years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of the treatment.
5. Under current TEXAS law, in group and family therapy and in marital therapy all participants are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, you should be aware that the laws governing these issues are often complex and I am not an attorney. I encourage our active discussion of these issues. However, if you need more specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions or summaries of the applicable State laws governing these issues.

I am aware that MAM is a teaching facility. This means that my treatment could be provided by a Master's level student intern, who is consulting with a supervisor regarding my care on a regular basis. If I have any questions or concerns about these informed consent procedures, or about the therapeutic or consultative services that you are receiving, I may contact the Site Supervisor.

I have read the above; fully understand the diagnosis, the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached. I fully understand my rights and responsibilities as a client as well as expectations of the program. I acknowledge that I have been given the handbook, which includes all of this information.

_____	_____
Client or Guardian Signature	Date
_____	_____
Name of Minor Child/Adolescent (print)	Date
_____	_____
Witness	Date