1810 Ward Drive
Suite 103
Murfreesboro, TN 37129
615-809-2090 (fax)

Laura L. Tucker-Huggins, LPC/MHSP
931-212-7227
Deborah A. Driggs, LPC/MHSP
931-581-0524

Initial Client Intake

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.

Name: ____
(First) (Middle Initial) (Last)

Parent/guardian (if treating a minor): ______________________________
(First) (Last)

Birth Date: ______ /______ /______ Age: ________ Social Security Number:______________________

Gender: Male Female Marital Status: Never Married Partnered Married Separated Divorced Widowed No of Children: __________

Address: ____
(Street and Number) (City) (State) (Zip)

Home Phone: ______________________________ May we leave a msg? Yes No
Cell/Work/Other Phone:______________________________ May we leave a msg? Yes No
Cell Phone Carrier: ______________________________ May we use text msg? Yes No

E-mail: ______________________________ May we email you? Yes No
*Please be aware that email might not be confidential.

Please indicate the primary reason for your visit today: ______________________________

____

Emergency Information In case of emergency, contact:

Name______________________ Relationship______________ Phone______________

Address______________________ City______________________ State________ Zip_________

INSURANCE INFORMATION *** This MUST be completed even though we have a copy of your card.***

Primary Insurance______________________ Contract/ID#______________________

Subscriber Name_______________________ Group/Acct#______________________

Subscriber Date of Birth__________________ Client's relationship to Subscriber: __Self __Spouse __Child __Other

OCCUPATIONAL INFORMATION:
Are you currently employed? Yes or No If yes, who is your current employer? ______________________

Current position? ______________________ Please list any work-related stressors:______________________

Are you a veteran or currently active in the US Military? Yes or No

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? ____________ If yes, what is your faith? ______________________

If no, do you consider yourself to be spiritual? ______________________________

Do you wish for your counseling experience to include a Christian perspective?______________________

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MEDICAL INFORMATION

Physician______________________________ Phone________________City___________________________ State_____ Zip______

Psychiatrist____________________________ Phone________________City___________________________ State_____ Zip______

List any major medical problems, surgeries, hospitalizations and/or allergies.	
(1)	(3)
(2)	(4)

Current Medications:____________________________________ **Dosage:**____

____ ____

____ ____

Mental Health Treatment History: Please list any previous psychological/psychiatric services & related information

Type of Service	Dates of Service	Provider	Reason for Service

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? Poor Unsatisfactory Satisfactory Good Very good

2. Current Symptom List: Please circle all that apply at present:

Poor Memory	Headaches	Nightmares	Stress	Shyness
Impulsiveness	Depression	Sexual Dysfunction	Anxiety	Rage/Anger
Hallucinations	Guilt/Shame	Excitability	Tense	Racing Thoughts
Worthlessness	Panic attacks	Stomach Trouble	Bedwetting	Risky Behavior
Fatigue	Intrusive Thoughts	Helplessness	Worry	Harm to Others

3. Are you having any problems with your sleep habits? □ No □ Yes
   If yes, check where applicable: □ Sleeping too little □ Sleeping too much □ Poor quality sleep

4. How many times per week do you exercise? ___________ Approximately how long each time? ______________

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes
   If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

   Have you experienced significant weight change in the last 2 months? □No □ Yes

6. Do you regularly use alcohol? □ No □ Yes
   In a typical month, how often do you have 4 or more drinks in a 24-hour period? ______

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7. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

   Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes
   If yes, how long have you been in this relationship? ________
   On a scale of 1-10, how would you rate the quality of your current relationship? _______

10. In the last year, have you experienced any significant life changes or stressors: ____

____

Have you ever experienced:

Extreme depressed mood	Yes / No	Wild Mood Swings	Yes / No	Panic Attacks	Yes / No
Rapid Speech	Yes / No	Extreme Anxiety	Yes / No	Phobias	Yes / No
Sleep Disturbances	Yes / No	Hallucinations	Yes / No	Suicide Attempt	Yes / No
Unexplained losses of time	Yes / No	Memory lapses	Yes / No	Eating Disorder	Yes / No
Alcohol/Substance Abuse	Yes / No	Chronic Pain	Yes / No	Repetitive Behaviors	Yes / No
Body Image Problems	Yes / No	Repetitive Thoughts	Yes / No	Homicidal Thoughts	Yes / No

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Diagnosis		Family Member(s)	Diagnosis		Family Member(s)
Depression	Yes / No	__________________	Bipolar Disorder	Yes / No	__________________
Anxiety Disorders	Yes / No	__________________	Panic Attacks	Yes / No	__________________
Schizophrenia	Yes / No	__________________	Substance Abuse	Yes / No	__________________
Eating Disorders	Yes / No	__________________	Learning Disabilities	Yes / No	__________________
Trauma History	Yes / No	__________________	Suicide Attempts	Yes / No	__________________

THIS SECTION TO BE USED ONLY FOR MINOR CHILDREN

Are biological parents: Married Separated Divorced **Child resides with:**
Legal Guardian: **Parenting Plan?** __Yes __No **County of Jurisdiction:**
DCS Involvement? __Yes __No **Previous Abuse Issues?** ___Yes ___No **Circle all that apply:** Emotional Physical Sexual
Name of school: **Grade:**

Do you foresee needing our services for court? __________**Yes** __________**No**

I assert that this information is correct to the best of my knowledge and ability.

____ ____________________

Signature Date

Client Name: **Medical Record:**

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Informed Consent to Treatment

I, ____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at TUCKER-HUGGINS & DRIGGS, hereby referred as the Provider. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand either party may discontinue therapy at any time. The clinic encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

Client's Rights and Responsibilities: I certify that I have received the Client's Rights information and certify that I have read and understand its content.

Expectations: Counseling is based o the relationship you develop with your counselor. Every case is unique, but generally you can expect the following:

- Education: You can expect some information and education about what you are facing.
- Assignments: Homework is a vital part of making the most of your counseling process.
- Client Centered: You can expect to have topics that revolve around you and your concerns.
- Sharing: You will be asked questions and there is an expectation that you will openly share your thoughts and feelings.
- Discovery: Expect to examine yourself through looking at your thoughts, feelings, and behaviors.
- Length of Treatment: Sessions last 45-50 minutes. In most cases, therapy will last a minimum of 10 sessions.
- Frequency of Appointments: One session per week is typical but can be adjusted to meet individual needs.
- Interruptions: It is in your best interest to have uninterrupted care. Time between sessions can substantially lessen the desired effects of treatment.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Provider non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter.

Client Notice of Confidentiality: Federal and/or State law and regulations protect the confidentiality of patient records maintained by the Provider. Please refer to the Privacy of Information Policy that addresses all matters of confidentiality.

Risks: Therapy is very safe, but there are some risks. The biggest risk is the result of change. Change can have an undetermined impact on your life and in significant relationships. Another risk is emotional pain or anxiety but should be elevated with continued treatment.

Benefits: Change is also the most significant benefit of therapy. You will learn new way of interacting, thinking, and behaving. Often changes will result in the reduction of problems and reported symptoms prior to therapy.

About your Counselor: As you review this form with your counselor, he/she should explain their individual counseling style. This should include qualifications, approach to therapy, school of thought, and other information. If you have any questions, now or later, feel free to ask your counselor.

I consent to treatment and agree to abide by the above stated policies and agreements with TUCKER-HUGGINS & DRIGGS.

____ ____________________
Signature of Client *or* Legal Guardian (for clients under 18) Date

____ ____________________
Therapist Date

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Client's Bill of Rights Notification

As a recipient of services at our facility, we would like to inform you of your rights as a patient. The information contained in this brochure explains your rights and the process of complaining if you believe your rights have been violated.

YOUR RIGHTS AS A PATIENT:

1. Complaints. We will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil Rights. Federal and state laws protect your civil rights.
4. Cultural/spiritual/gender Issues. You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however we may deny access to certain records in which we will discuss this decision with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/Legal Advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

YOUR RIGHTS TO RECEIVE INFORMATION:

1. Costs of services. We will inform you of how much you will pay.
2. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
3. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
4. Policy changes.

OUR ETHICAL OBLIGATIONS:

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
7. We hold respect for various institutional and managerial policies, but will help improve such policies if the best interest of the client is served.

PATIENT'S RESPONSIBILITIES:

1. You are responsible for your financial obligations to the clinic as outlined in the Payment Contract for Services.
2. You are responsible for following the policies of the clinic.
3. You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.
5. Therapy is an individual process for which you will need to assume responsibility for making changes.
6. In order to receive the greatest benefit, you need to be actively involved in the treatment process. Goal setting, assignments, and talking are all important and critical to treatment success.
7. Treatment is voluntary and you may end counseling at any time without fear of penalty.
8. You can expect to be treated with respect.

WHAT TO DO IF YOU BELIEVE YOUR RIGHTS HAVE BEEN VIOLATED:

If you believe that your patient rights have been violated contact our Recipient's Rights Advisor or Clinic Director.

Signature: ____ Print Name: ____

Date: ____ Signed by: __client __guardian __personal representative

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This *Notice of Privacy Practices* describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related care services.

I. Uses and Disclosures of Protected Health Information Requiring Authorization

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

II. Treatment

We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

III. Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

IV. Health Care Operations

We may use or disclose, as needed, your protected health information in order to support the business activities, employee review activities, and training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to a medical school student that sees patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law; Public Health Issues as Required by Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers Compensation, Inmates and Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization and opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing; except to the extent that your physician or the physician's practice has taken an action previously on the use or disclosure indicated in the authorization.

V. Complaints

You may complain to use or to the Secretary of Health and Human Services if you believe your privacy rights may have been violated. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

VI. Effective Date

This notice shall go into effect October 1, 2013 and will remain so unless new notice provisions effective for all protected health information are enacted accordingly.

Client Name: **Medical Record:**

YOUR RIGHTS: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your provider is not required to agree to a restriction that you request.

If the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communication from us by alternative means or an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Signature: ____ Print Name: ____

Date: ____ Signed by: __client __guardian __personal representative

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Payment Contract for Services

The following are fees associated with available services that may be provided at your request. Please indicate the services to which you wish to prescribe. Please be aware that ONLY the services indicated on this form, with your signature, will be provided. Any additional requests will require an updated form and signature.

Client Signature	Description of Service	Amount
	Initial Intake and Assessment Appointment	$135.00/Hr*
	Counseling Services, Individual/Family/Marriage	$120.00/Hr *
	Late Cancellation or No Show for Appointment**	$65.00 Each
	Phone Consultation (Client/Attny/PO)	$25.00/15 Min
	Monthly Summaries**	$50.00 Each
	Court Documentation/Reports**	$150.00/Report
	Depositions**	$150.00/Hr
	Court Appearance**	$150.00/Hr with a $750.00/Minimum

*If you utilize insurance coverage, the fee will be adjusted according to the contracted rate.
Requires prepayment of services. Insurance **will not cover these costs.

Should your insurance fail to reimburse for our services, you will be responsible for the full amount due.

Your annual deductible is:______________

Your per visit copay is:__________________

Signature: ____

Print Name: ______________________________________

Date: ____

Signed by: __client __guardian __personal representative

Therapist Signature ____

Date: ____________________________________

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Authorization to Disclose Protected Health Information to Your Primary Care Physician

Communication between your behavioral health provider and your primary care physician (PCP) is important to make sure all care is complete, comprehensive and well-coordinated. This form allows your behavioral health provider at TUCKER-HUGGINS & DRIGGS to share valuable information with your PCP. No information will be released without your signed authorization

Section 1: The Client

First Name	***Middle Initial***	***Last Name***	
Address		***Date of Birth***	***Phone***

I hereby authorize the disclosure of protected health information about the individual named above and declare that I am:
_____ the individual named above **OR** _____a personal representative because the patient is a minor, incapacitated or deceased.

Section 2: Person/Agency Disclosing Information

Provider's Name	*Address*	*Provider's Contact Phone*
□ Laura L. Tucker-Huggins, LPC/MHSP □ Deborah A. Driggs, LPC/MHSP	1810 Ward Drive, Suite 103, Murfreesboro, TN 37129 Fax Number: 615-809-2090	□ 931-212-7227 □ 931 581-0524

Section 3: Recipient of Information

Name of PCP	*Phone*
Street Address, City, State, and Zip Code	

Section 4: Information That Will Be Disclosed

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, and prognosis.

Section 5: The Purpose of the Disclosure

To release behavioral health evaluations and/or treatment information to the PCP to ensure quality and coordination of care.

My signature indicates my willingness to have information provided to my PCP.

Signature: ____ Print Name: ____

Date: ____ Signed by: __client __guardian __personal representative

Section 6: Right to Refuse Disclosure

I am invoking my right for my information to remain completely confidential and thus refusing release of my records to my PCP.

Print Name: ____ Date: ______________________

Signature: ____ Signed by: __client __guardian __personal representative

Client Name: **Medical Record:**