LivelyTherapy

Client Identifying Information –Please provide photo ID

Today's date: _____ SSN: XXX-XX-_____ (last 4 only)

Name: _____ Preferred to be called: _____

Street/Mailing Address: _____

City: _____ State/ZIP: _____

Email: _____ Best Method of Contact: _____

Home Phone: _____ Work/Mobile Phone: _____

May I leave a message at (circle if yes): Home / Mobile / Email

Date of Birth: _____ Age: _____

Emergency Contact (Name/ Relationship / Phone):

_____

(Note: Your Emergency contact will be contacted **only** in the event that your therapist is concerned about your immediate or eminent safety or well being. If you want a friend or family member to be able to speak with your therapist, a separate Release of Information is required.)

Marital Status:

___ Single ___ Married ____ Separated ___Divorced ___ Widowed

If a minor, who has legal guardianship/custody:_____

Level of education/field of study: _____ School: _____

Occupation: _____ Employer: _____

Do you desire that your religion/faith/spiritual orientation be an included as part of your counseling experience?

How did you find out about me and/or who referred you?

_____

For office use: _____

_____

_____

_____

_____

_____

_____

Notice of Privacy Practices

HIPAA is a set of federal regulations that grants rights and sets federal standards of privacy, security, and the sharing of all protected medical information not just electronically stored client data. HIPAA privacy compliance began on April 8, 2008. State statutes that require same level or higher protection of privacy of health information can supersede these regulations. Special kinds of health information have specific laws and rules that have to be followed before that information can be disclosed.

Mental Health Treatment: Mental health treatment records are protected under federal and state laws and regulations and cannot be disclosed without your written authorization, unless otherwise allowed in federal and state laws or regulations. To release mental health treatment information, this authorization must include a statement of the specific information that you are giving permission to release, such as "assessment, treatment plan, attendance, discharge plan." Also, disclosure of your therapist's own notes (psychotherapy notes) needs separate permission. Re-disclosure of your mental health treatment records is prohibited, except in compliance with law or with your written permission.

HIV and Sexually Transmitted Diseases (STD): All information about HIV and sexually transmitted diseases is protected under federal and state laws and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV or STD information, this authorization must include a statement of the specific HIV or STD information that you are giving permission to release. Re-disclosure of HIV information is not allowed, except in compliance with law or with your written permission.

Alcohol and Drug Treatment: Alcohol and/or drug treatment records are protected under federal and state laws and regulations and cannot be disclosed without your written authorization, unless otherwise provided for in federal and state laws or regulations. To release alcohol and drug treatment information, this authorization must include a statement of the specific information that you are giving permission to release, such as "assessment, treatment plan, attendance, and discharge plan." Re-disclosure of your alcohol and/or drug treatment records is not allowed, except in compliance with law or with your written permission.

In addition, a summary of the impact of the federal law is as follows:

Uses and disclosures Requiring Authorization

With your written consent, you may disclose Protected Health Information (PHI) designating: to whom; what types of information; for what purpose; and, how long this release will be in effect or if it will expire at any time, or set certain restrictions. You may revoke the release at any time or set certain restrictions

Uses and Disclosures with Neither consent nor Authorization

- Adult and Domestic Abuse
- Judicial or Administrative Proceedings
- Serious Threat to Health or Safety
- Worker's Compensation
- National Security and Intelligence Activities
- Protective Services for the President and others
- Health Oversight. If a complaint filed against Anna Lively., with the Florida Department of Health on behalf of the Board of Business and Professional Regulations
    - Child Abuse

Client Rights

- Right to Request Restrictions. You have the right to request restrictions on certain information.
- Right to Receive Confidential Communications by Alternative Means and at alternative Locations.
- Right to Inspect and copy. You have a right to inspect and/or copy PHI.
- Right to Amend.
- Right to an Accounting. You have a right to an accounting of any disclosure of your PHI.
- Right to a Paper Copy of this notice
- Right to inform as to how and when you want to be contacted

Counselor's Duties

- Maintain the privacy of PHI.
- Reserve the right to change the policies and practices. If revised, you will be notified at current address

Questions or Complaints

If you believe that your privacy rights have been violated and wish to file a complaint, you may notify Anna Lively, PO Box 752, Balm FL 33503, or you may contact the Florida Board of Clinical Social Work, Marriage & Family Therapy & Mental Health Counseling at http://doh.state.fl.us/mqa/491/soc_consumer.html#Consumer or call them at 888-419-3456. You have specific rights under the Privacy Rule. There will be no retaliation against you for exercising your right to file a complaint. I understand and agree to the conditions of the notification.

_____ _____

Signature of client or guardian Date

_____ _____

Witness Date

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TREATMENT CONSENT FORM

Please read the following information carefully and feel free to discuss with your counselor any questions you might have. Then please sign the form at the bottom signifying that you have read the information regarding confidentiality and acknowledge the extent of information that must be shared for supervisory or training purposes.

1) **Clients are required to pay for services at the time of each visit.** Insurance or other billing arrangements should be made prior to the session and are the responsibility of the client. If requested in advance, you will be provided a receipt for services with all the necessary information to file on your own for out of network benefits or apply towards FSA/HSA benefits. Returned checks will be subject to a $50.00 fee and may require future sessions paid in cash or in advance. Clients are expected to pay co-pays, co-insurance, non-insurance covered services at the time of service unless other arrangements have been made. Telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, sessions beyond standard session time, travel time, etc. will be charged at the same service rate, unless indicated and agreed upon otherwise in advance of service. Please notify your therapist if any problems arise during the course of therapy regarding your ability to make timely payments. Clients are using insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Please be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid), it may be necessary to use legal or other means (courts, collection agencies, etc.) to obtain payment.

2) Your set appointment is a contract whereby you have the exclusive use of the counselor's time for your scheduled appointment. **You are therefore held responsible for the fee for all cancelled appointments.** If you are unable to keep your appointment, please cancel as soon as possible. If this is done at least 48 hours in advance of your appointment time, there will be no charge for the cancellation. A minimum charge of $50.00 (up to your full session fee) will apply for missed sessions. This cannot and will not be charged to your insurance or your EAP and is the personal responsibility of client, and must be paid prior to next session. If you are more than 15 minutes late for a session, it may be necessary to reschedule or private pay for your session as there are minimum time restrictions required in using insurance. If late, your session will still end at the scheduled end time due to scheduling issues and in consideration of other's scheduled clients.

3) The counselor is a consultant and resource professional only, whose intervention may be freely accepted or rejected by the client. Therefore, **decisions made during and after counseling are the responsibilities of the client.** However, non compliance or non participation in interventions (homework, assignments, readings, etc.) as suggested by your counselor may result in your insurance company refusing to pay for services. Please discuss this with your counselor if you have any questions.

4) **CONFIDENTIALITY:** Information shared with a counselor is protected by professional ethics and federal and state law and will not be disclosed without your written permission. There are exceptions and limitation to confidentiality if the following occurs: a) There is a clear and serious indication of doing self-harm b) There is a clear and serious indication of danger to someone else. C) My primary counselor receives a subpoena of which I have been properly notified and have failed to inform her that I am opposing the subpoena or court order. D) There is indication that a child, person with a disability, or elderly person has been abused, exploited, or neglected. E) My account is in delinquent status. Appropriate billing and financial information will be released to a collection agency. No clinical data will be released. F) I send my counselor an email containing private information. Emails may be read/accessed by other people unless sent via secured portal; G) In cases of minors, parents are by law privy to their information unless the parents and the primary counselor have agreed to other alternatives in providing services. Additionally, in an effort to facilitate professional development and quality counseling, we submit ourselves to ongoing supervision. Your signature below grants me permission to disclose information from our counseling sessions for the purpose of

professional supervision (ongoing training) to peer or supervisory professionals without any personal identifying information. Any other disclosure to third parties will be specified in writing through another document.

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW HEALTH, MEDICAL, AND PSYCHOTHERAPY INVORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A) Disclosure – Your counselor may be "In Network" or "Out of Network" for your insurance or EAP benefits. It is your responsibility to verify benefits. You are responsible for all charges not paid by your insurance or EAP company. If you choose to pay for services through insurance or EAP benefits, information about your diagnosis and treatment **may** be given to the insurance company, your employer, their agent, or the national insurance database for payment, and health care operations. We are permitted or required to disclose protected health information for other purposes without your written consent or authorization, such as when there is danger of actual physical harm to your self or someone else, when physical or sexual abuse or neglect of a specific minor child or elderly person becomes known. **Information may be discussed openly if you are seeing a counselor with your relationship or family partner,** or in legal cases, your clinical records and/or the counselor may be subpoenaed by a judge. Other uses and disclosures will be made only with your written authorization and you may revoke such authorization in writing any time. By my signature below, I authorize my counselor to bill my EAP and/or insurance on my behalf for services provided. If I choose NOT to use EAP or insurance benefits, I will notify my counselor and sign a waiver for same.

B) Patient's Rights – With respect to protected health information (PHI), you have the following rights:

a) The right to request restrictions on certain uses and disclosures of protected health information
b) The right to receive confidential communications of protected health information.
c) The right to inspect and copy, at your cost, protected health information, or to have PHI provided to your new mental health provider, at the discretion of this counselor.
d) The right to amend or annotate protected health information.
e) The right to receive an accounting of disclosures of protected health information to others.
f) The right of a patient, including a patient who has agreed to receive the notice electronically, to obtain a paper copy of the notice from the practice upon request.
g) The right to request restrictions on the use of disclosure of your health information, such as to ask us not to give any information to your family, and that would be a restriction we would try to honor.

(**PLEASE NOTE: Electronic communications (email or text) are NOT protected PHI data nor is confidentiality ensured due to the nature and vulnerability of these communications. For this reason, no counseling services will be provided via emails or text. Should you wish scheduling confirmation provided via email or text message, and understand and agree to this exemption to confidentiality, please initial here _____).

3) **Practice Responsibilities** – We are required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the notice currently in effect; and, in case we may wish to make a change in our privacy policies, we reserve the right to change the terms of your notice and to make the new notice provisions effective for all protected health information. We will provide you with a revised notice by mail to your latest known address.

4) **Complaints** – We have a policy for filing an official grievance. For further information please contact the provider as listed under "5. Contact". A formal grievance can be filed with the office of Civil Rights in Washington, DC or the Florida Department of Health.

5) **Contact** – The person to contact for further privacy related information or regarding any grievance is:

Anna Lively, LMHC
Post Office Box 752
Balm, FL 33503
813-928-5335

If you have concerns about confidentiality, please discuss with your counselor the degree to which your confidentiality will or will not be protected and what steps we might take to preserve your privacy. Your signature below gives consent to the above.

I have read and understand the information presented in this form. I consent to receive treatment from Anna Lively, M.S., LMHC (If you are signing on behalf of your dependent, please print his/her name, and your relationship to the client.)

I understand that I have the right to terminate treatment or refuse treatment at any time; I will give counselor notice of my intent to terminate. In the event that I do not communicate with my counselor regarding my absence or in not following up for sessions for a period in excess of 21 days, my file will be closed and I will be considered discharged. I may return and resume counseling services by contacting my counselor.

I realize that all sessions are based on a 50 minute time frame, unless otherwise specified or required by contract or insurance provisions.

I UNDERSTAND AND AGREE THAT ANY APPOINTMENTS I CANCEL WITH LESS THAN 48 HOURS NOTICE ARE SUBJECT TO FULL CHARGE AND WILL NOT BE PAID BY MY INSURANCE/EAP.

Patient Signature	Date
Parent/Guardian	Date
Witness	Date

LivelyTherapy.net

Anna Lively, LMHC, NCC

ADDENDUM TREATMENT CONSENT FORM

REGARDING FORENSIC RECORDS or TESTIMONY (INCLUDING REPORTS)

Documentation for disability claims, court proceedings (including family law matters, personal injury and any other legal proceedings whether pre-suit, in administrative or arbitration tribunals or in the course of litigation) are included as a part of forensic records that are subject to this Addendum.

1) Client waives confidentiality when requesting Anna Lively, LMHC (counselor) to provide copies of their personal PHI, medical records, assessments, notes, treatment plans and/or summaries.

2) Confidentiality can NOT be ensured where there are legal requirements to report (ie: suspected abuse of an elder, vulnerable adult or child or reasonable belief client may harm him or herself or another), or the receipt by counselor of a court order or subpoena.

3) This Counselor is not able to complete FMLA or Disability reports in the course of EAP work or as a part of an EAP session.

4) In the event counselor's records are subpoenaed, court ordered or required incident to any legal proceeding (including a disability claim), client may be responsible to pay counselor's fee of $250.00 per hour (minimum charge for one hour payable **in advance**) for:
   (a) Testimony for sworn or unsworn statements (including depositions)
   (b) Testimony at court
   (c) Treatment summaries
   (d) Phone calls
   (e) Travel time
   (f) Gathering, copying and transmitting records

5) Due to the adversarial nature of court proceedings, it may be necessary for this counselor to terminate the counseling relationship with client in the event she is called as a witness or to provide testimony in a legal proceeding where client is a party. Counselor will provide a referral to another counselor for continued services if needed.

I UNDERSTAND THAT FEES FOR SERVICES ARE TO BE PAID PRIOR TO THE PREPARATION OF REPORTS, INCLUDING SUMMARY REPORTS, APPEARANCE AT COURT PROCEEDINGS OR FOR PROVIDING SWORN OR UNSWORN TESTIMONY. I UNDERSTAND AND AGREE THAT ANY COURT APPEARANCE OR DEPOSITION SCHEDULED AND CANCELED WITH LESS THAN 48 HOURS NOTICE ARE SUBJECT TO A CHARGE OF $500.00.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian if client is a minor Date

_____ _____
Witness Date

Anna Lively, LMHC, NCC, CCMHC **813-928-5335 livelytherapy.net**

Payment Agreement

I. **Responsibility for payment**. I agree to be responsible for payment for all services provided by Anna Lively, LMHC. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance for this account including deductibles, no-show or late cancelation fees (not paid by insurance), co-payments or co-insurance. Non- covered charges, private fee charges, co-payments, and/or co-insurance are due at the time service. If denied/rejected or not covered by insurance or other payor, payment is due within 30 days of the date of service or 5 days of invoice. Initial: _____

II. **HIPPA Agreement/Consent.** Your insurance/EAP may require release of information regarding your therapy. This information may be provided verbally or in writing and may contain the following information: Client's attendance, diagnosis, progress in therapy, treatment summary, the current issues of concerns or clinical interest, compliance with interventions and treatment, assessment and expected prognosis. It is necessary for your consent in order to release this information to your insurance company. By choosing to use your medical/behavioral/EAP benefits, you are agreeing and providing to allow your provider to bill and receive assignment of payments and release information to your insurance company. If you choose **not** to sign this form, therapy may be discontinued or interrupted if you choose to continue to use your insurance benefits, until or unless other arrangements for payment is agreed upon. Initial: _____

III. **Use of EAP Benefits:** EAP is NOT an insurance product. EAP is designed for brief, short term therapy. Your therapist can NOT complete Disability or FMLA assessments or reports using EAP services. Additionally, your EAP will likely require reporting on the subjects including but not limited to: attendance at EAP sessions; missed work or work performance related to mental health concerns; harm/risk assessment including any concerns regarding work place violence; work related concerns; substance use/abuse; referrals provided to client. Initial: _____

IV. **Choosing Private Pay**: You have the right to NOT use your medical/behavioral health benefits and pay privately to maintain confidentiality or for other personal reasons. If choosing to not use your insurance, please read and sign the Waiver on the reverse side. Initial: _____

V. **Cancelation policy**: I understand that appointments must be canceled 48 hours in advance or I will be charged for the session. I also understand that late cancelations or no-shows will be billed to me and not to my insurance company and must be paid prior to rescheduling. Frequent cancelation or no-shows often indicates that client is not able to prioritize counseling, or is not ready. Client may be discharged if late cancelations or no-shows exceed 2 in a one month period. Initial: _____

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE TERMS CONTAINED IN THIS DOCUMENT.

_____

Signature Date:

WAIVER OF USE OF MEDICAL/BEHAVIORAL INSURANCE

After reviewing my insurance benefits and payment options with Anna Lively, LMHC ("the provider") I have elected to NOT utilize my insurance and/or EAP benefits. I agree to pay the agreed upon fee out-of-pocket (cash, check or charge) on the date services are provided. I understand that my insurance will not be billed and my fee will not go towards my deductible. This authorization is valid from the date of my (or my representative's) signature below and shall expire upon the date on which I deliver written notice of termination to the provider. This authorization may be canceled in writing at any time. If I choose to utilize my insurance benefits in the future, I agree to deliver written notice of my request to my provider that will take effect on the date that my notice is signed or delivered (whichever is later), and cannot be back-dated or retroactive.

Upon request, provider will provide a receipt, but will not provide a superbill (bill suitable to submit for reimbursement to insurance).

_____

(Client sign) Date:

Printed Name:

Fees are based on 50 minute session unless otherwise agreed upon based on agreement or insurance requirements.

Intake: _____

(A new intake is required if there is a 6 month lapse in service)

Individual: _____

Couples: _____

Family: _____

Crisis: _____

(Crisis is defined as same day service requiring intervention to manage significant symptoms as a result of a mental health crisis, to prevent escalation of emergent distressing symptoms or requiring referral to a higher level of care)

DASS

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, elevators, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Please turn the page ☞

Reminder of rating scale:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Date of Birth _____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease ----------	( )	( )	_____
Anemia----------	( )	( )	_____
Liver Disease ----------	( )	( )	_____
Chronic Fatigue ----------	( )	( )	_____
Kidney Disease ----------	( )	( )	_____
Diabetes ----------	( )	( )	_____
Asthma/respiratory problems ------	( )	( )	_____
Stomach or intestinal problems ---	( )	( )	_____
Cancer (type) ----------	( )	( )	_____
Fibromyalgia ----------	( )	( )	_____
Heart Disease ----------	( )	( )	_____
Epilepsy or seizures ----------	( )	( )	_____
Chronic Pain ----------	( )	( )	_____
High Cholesterol ----------	( )	( )	_____
High blood pressure----------	( )	( )	_____
Head trauma ----------	( )	( )	_____
Liver problems ----------	( )	( )	_____
Other ----------	( )	( )	_____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason	Date Hospitalized	Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

	Dates	Dosage	Response/Side-Effects
Antidepressants			
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			
Mood Stabilizers			
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			
Sedative/Hypnotics			
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			
ADHD medications			
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other			
Antianxiety medications			
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Other			

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other			_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No

Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____

In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Please describe when, where and by whom: _____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

_____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____Date _____

Reviewed by _____Date _____

Like, Share and/or Follow Lively Therapy, my business Facebook page that has many resources and information about mental health and relationships.

Disclaimer:

Hello! I use the Lively Therapy Facebook page as a platform to share information about mental health and relationships. You may find researched articles, memes, blogs, resources and other information that you might find interesting or helpful. However, before "liking" or engaging with this page, please review the following information: The Lively Therapy page is for information or educational purposes only and is not intended as providing clinical care. I do NOT offer Clinical advice in public comments or in private electronic communications. This page is PUBLIC. If you voluntarily "like" or engage with this page, please be aware that your screen name and any comments made will be visible to others. "Following", "liking" or engaging with this page does not indicate that you are a client or participating in counseling. "Following", "liking" or engaging with this page does not suffice for a therapeutic relationship. If you have any questions about your mental or physical health, please consult directly with your physician or a mental health professional.

Due to privacy issues - please refrain from sharing personal struggles or details in this forum. If you or someone you know is in crisis, call the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255). TTY: 1-800-799-4TTY (1-800-799-4889). You can call and speak with a counselor 24 hours a day, 7 days a week.

If you're struggling with depression, anxiety or relationship problems, the HOPE line may help - Https:/www.thehopeline.com/gethelp/

If you have a hard time talking and would prefer to text, text START or HOME to 741741 to text message with a crisis counselor. Someone is always listening and ready to help.

Warm regards,

Anna

Anna Lively, LMHC, NCC, CCMHC
Livelytherapy.net

Anna Lively, LMHC, NCC, CCMHC
livelytherapy.net
813-928-5335

INFORMED CONSENT TO TELEHEALTH

Telehealth allows my therapist to assess, diagnose, consult, treat and educate using interactive audio, video, telephonic or other data communication as available and appropriate and as determined by my therapist in providing for my mental health care. I hereby consent to participating in psychotherapy via internet video or if not available, telephonic communication connection (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____

Clinician: **Anna Lively, LMHC, NCC, CCMHC**

I understand that I have the following rights with respect to telehealth:

1. I understand that I can withdraw my consent to Telehealth communications by providing written notification to my therapist. My signature below indicates that I have read this Agreement and understand and agree to the terms of this Informed Consent.

2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me while in therapy is confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to a belief that I am at risk of harm to myself or to another; reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where my mental or emotional state is an issue in a legal proceeding.

3. I understand that there are risks and consequences from telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or electronic storage of my medical information could be accessed by unauthorized persons.

4. I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be so advised to continue treatment with a qualified professional and will be provided with references if desired.

5. I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse

6. I understand that the cancelation policy of 48 hours notice remains in effect whether utilizing in person or telehealth sessions. I will be charged a minimum of $50.00 up to my full session fee if I cancel my session in less than 48 hours. This fee will not be paid by my insurance or EAP.

Anna Lively, LMHC, NCC, CCMHC
livelytherapy.net
813-928-5335

Informed Consent to Telehealth

7. By signing this document, I understand that my psychotherapist is not available after hours for crisis situations. I also understand that certain situations including emergencies and crises are not appropriate for telehealth psychotherapy services (audio/video/computer-based services). If I am in crisis or in an emergency, I will immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled intrusive negative thoughts, psychotic, hallucinogenic or delusions symptoms, if I am in a life threatening or emergency situation, or if I am abusing drugs or alcohol or engaging in high risk behaviors that are not safe.

By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies (211), or the National Suicide Hotline at 1-800-273-8255 or text START or HOME to 741741.

I have read and understand the information provided above. I have discussed these points with my psychotherapist, and all my questions regarding the above matters have been answered to my satisfaction. My signature below indicates that I have read this Consent and agree to its terms.

Print Name _____ Date _____

Signature of Patient/Client or Personal Representative _____ Date _____

If signed by other than Patient/Client indicate relationship _____ Date _____

Signature of Psychotherapist _____ Date _____

Anna Lively, LMHC, NCC, CCMHC
livelytherapy.net

813-928-5335

Guidelines for Telehealth/Telemental Services

Guidelines to have a positive telehealth experience

- Your therapist will ask for your location at the time of your call. If you are in a public place, please be specific (ie: I'm in the parking lot at McDonalds on College Ave in Ruskin)
- An Emergency Contact form must be on file prior to your telehealth session
- You will need a laptop, tablet or mobile phone with an internet connection, best with high speed connection
- Engage in sessions in a private location where you cannot be heard by others (your car is an option – but only when NOT traveling; and if in a garage that you leave the garage door OPEN)
- You will be invited to the virtual waiting room via an email. You do NOT have to download any software or app to connect. If you have not received an email invite within 10 minutes of your scheduled appointment time – please call your therapist at the above number.
- Use a private phone
- Do **not** record any sessions
- Password protect any technology you use for your connection with your therapist
- Always log out or hang up once sessions are complete
- To protect your privacy, your therapist will be contacting you from a blocked phone number, however, that number will appear in any text message and the email sender (livelytherapy) will be visible.

Poor quality (choppy, interrupted or static) in a video telehealth session can be frustrating. Here are a few tips that can improve call quality:

1. **Restart your computer before a call.** Other software might be using computer power or interfere with your video or microphone. Restarting your computer will assure your computer is ready for video.
2. **Use fast internet with ethernet cable.** Video quality adapts to internet speed, so the faster your internet connection, the better the video quality you will experience. If your router is a fair distance from your computer – you may need a signal booster.
3. **Use a newer computer with plenty of speed.** Sending and receiving video takes a lot of computer power. Old or slow computers will have a harder time processing the video, which can cause choppiness.
4. **Use low resolution.** If you are experience poor quality, try lowering the resolution. By doing this it requires less bandwidth and computer power, resulting in less choppiness during your call.
5. **Use headphones.** Typically your computer will automatically eliminate echo or audio feedback so you don't hear yourself talking. But if it happens, use headphones.
6. **Users on Home Internet.** Your internet speed may slow down if you have multiple users on your home internet at one time. You may need to consider logging off some users during your telehealth sessions.