ADULT ASSESSMENT

Name: **Date:**

What is the reason you are seeing a psychologist?
Who referred you?

SYMPTOM CHECKLIST

check all that apply	
___ cry easily	___ anxiety/constant worrying
___ feel irritable	___ phobias
___ feel depressed or sad	___ times when heart races or can't breathe and feel will die
___ feel guilty	___ frequently having repetitive thoughts
___ feel tired/no energy	___ need to have everything in an exact order
___ appetite/weight change	___ engage in repetitive behaviors
___ loss of interest in doing things	___ difficulty making and keeping friends
___ difficulty concentrating	___ problems starting projects
___ problems controlling impulsive behavior (ex. Spending, gambling)	___ do things to get rid of weight (throwing up, using diuretics, excessive exercise)
___ periods don't need sleep AND not tired	___ have been physically abused
___ periods of increased energy	___ have been sexually abused
___ periods increased sexual desire/appetite	___ feel unsafe or threatened
___ hearing voices, seeing things others don't see	___ thoughts of seriously harming someone
___ currently had thoughts of harming yourself	Other_________________________________

If you have seen a therapist please list the name and address of the provider:
If you have seen a psychiatrist please provide the psychiatrist name and address:
Admitted to a psychiatric unit ___**YES** ____ **NO**
Dates and Hospital :

FAMILY PSYCHIATRIC HISTORY

Please Check All That Apply

	FATHER	MOTHER	SIBLINGS	MOTHER'S RELATIVES	FATHER'S RELATIVES
Aggression/ Defiance					
Attention/ ADHD					
Impulse Control					
Bipolar Disorder					
Depression					
Anxiety					
Schizophrenia					
Motor or Vocal Ticks					
Rituals (ex. hand washing)					
Obsessions					
Learning disabilities					
Thyroid problems					
Drug abuse					
Antisocial behavior (stealing etc.)					
Huntington's Disease					
Dementia					
Self harm/Suicide					

CURRENT MEDICATIONS

Name	Dose	Prescribed By	Reason for taking it

Please list all known allergies:

Are you in chronic pain**?** ___**YES** ____ **NO**

Do you have any medical concerns: ____**YES** ___**NO**

Please list:

Substance Use

Please fill in for all the substances you use

	Daily	A Week	Weekly	Rarely	Never	In Past
Alcohol						
Marijuana						
Cocaine/Crack						
Speed/LSD/Crystal Meth						
Intravenous (IV) Drugs						
Heroin						
Ecstasy						
Inhalants						
Tobacco						

Arrested in pending DUI charges: ____ **YES** ____ **NO**

FAMILY ASSESMENT

Please elaborate on anything below

Marital Status

Single___ Married___ Re-Married___ Separated___ Divorced___ Widowed____

How many times have you been married?

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727 S. Fayetteville St.
Asheboro, NC 27203

Are you currently experiencing marital problems? ____**YES** ___**NO**

Who do you live with?

If you have children:

Name	**Age**	**Gender**	**Full/Step/Adopted Partner's Child**	**Who they live with**

Are you experiencing conflicts with your children? ___ YES ___ NO

Are you experiencing conflicts with your parents? ___ YES ___ NO

How many siblings do you have? Number of Sisters ___________
Number of Brothers__________

Are you experiencing conflicts with siblings? ___ YES ___ NO

<u>Other Areas of Functioning</u>

What is the highest level of education you completed?

GED____ High School Diploma ____ 14 years____ 16 years____ 18 years____ 20+ years____

Didn't finish high school ____

Do you currently have legal concerns? ___**YES** ___**NO**

If you are working, what is your job? ______________________
How long have you had this job?

Do you currently have financial concerns? ___**YES** ___**NO**
Are you on disability? ___**YES** ___**NO**

Applying for it? ____**YES** ____**NO**

Is religion important to you? ___**YES** ___**NO**
If so what religion:

Anything else I need to know?

______________________ ____________
Client's Signature Date

Patient Information Sheet
Asheboro Behavioral Medicine

DATE COMPLETED ________________________

Patient Full Name: ____

Street Address: ____

City: ___________________________ **State:** ___________ **Zip Code:** _________

Phone Number: Hm:___________ **Wk:**_____________ **Cell:**___________ **Sex: M** ☐ **F** ☐

Date of Birth: ___________ **Marital Status:** _________ **Soc. Sec. #:** _________________

Employer: ______________________________________ ☐ **Full-Time** ☐ **Part-Time**

RESPONSIBLE PARTY Name: ____

Street Address: ____

City: ________________________ **State:** ___________________ **Zip Code:** _________

Phone Number: Home: _______________ **Phone Number: Hm:**___________
Wk:_____________ **Cell:**___________

Employer: __________________________ ☐ **Full-Time** ☐ **Part-Time**

Relationship to Patient: ______________________

PRIMARY CARE PHYSICIAN: ____

Street Address: __________________________________ **City:** ___________________

State: ______________ **Zip:** _______________ **Phone Number: (___)**___________

EMERGENCY CONTACT Name: ____
(Parent or Guardian for Minors)

Phone No: Home: _________________ **Work:** ____________

REFERRED BY: ____

Asheboro Behavioral Medicine, PLLC
727 South Fayetteville Street
Asheboro, NC 27203

AUTHORIZATION FOR TWO WAY RELEASE OF PROTECTED INFORMATION

This form is a two way consent form and when completed and signed by me or my legal representative I understand that it authorizes the release of my protected health information to and from the person I delegate below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal or state privacy regulations.

PATIENT: ____________________ DOB: ______________

I, hereby authorize Asheboro Behavioral Medicine, PLLC to release my behavioral health records including if relevant records pertaining to substance abuse/treatment to:

NAME ____

(Of Organization, MD, or School you Are Giving Permission to Release Information To)

ONLY LIST ONE PERSON PER FORM

And I AUTHORIZE: ____

(WRITE SAME NAME AS YOU WROTE ON LINE ABOVE) to release information to Asheboro Behavioral Medicine, PLLC

Indicate any limitations or exclusions to this consent: __________________________

The purpose of this disclosure is: Provide Continuity of Care: Other: ______________

I understand that unless earlier revoked, this authorization will expire one year from the date that I sign this.

I understand that I have the right to revoke this authorization at any time by given written notification to Asheboro Behavioral Medicine, PLLC. However, the revocation will not be effective to the extant that action has been taken in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim. Asheboro Medicine, and its employees, is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing below I indicate that I have read all of the above and understand and agree.

______________________________	______________________________
(Patient/Legal Representative)	Relationship to Patient
______________________________	______________________________
(Date)	Witness

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

PLEASE USE A SEPARATE CONSENT FORM FOR EACH AGENCY

ASHEBORO
BEHAVIORAL MEDICINE
727 S. Fayetteville St., Ste C
Asheboro, NC 27203
336-625-2073 336-625-2737 (FAX)

BILLING AUTHORIZATION

I understand that if I do not provide the correct and updated insurance information I will be billed for the session. I also understand that Asheboro Behavioral Medicine has the right to terminate services for non-payment.

__________________________ ______________________

Signature Date

I agree to have Asheboro Behavioral Medicine submit claims to insurance agencies on my behalf. I understand that I am responsible for payment of services and claims not covered by my insurance.

__________________________ ______________________

Signature Date

I DO NOT agree to have Asheboro Behavioral Medicine submit claims to insurance agencies on my behalf. I understand that I am responsible for payment for all services and failure to do so gives Asheboro Behavioral Medicine the right to terminate services.

__________________________ ______________________

Signature Date

ASHEBORO
BEHAVIORAL MEDICINE
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336-625-2073 336-625-2737 (FAX)

EMERGENCY CONTACT & APPOINTMENT REMINDERS

We are currently trying to remind people of their appointments. There are also times that we may need to reach you for other reasons or to reschedule an appointment due to an unforeseen emergency or illness. It is helpful if we have all of your current contact information so that we can provide better service to you. Please let us know if anything changes. Thank you.

Patient's Name______________________________ DOB:____________________

Parent/Guardian's Name (If patient is a minor) ______________________________________

HOME PHONE_________________________________Is it Ok to leave a msg? _____Yes _____No

WORK PHONE_________________________________Is it Ok to leave a msg? _____Yes _____No

CELL PHONE__________________________________Is it Ok to leave a msg? _____Yes _____No

Which Number is best to reach you at during the day?

Home Work Cell

Which number is best to reach you at night? (after what hour usually?________

Home Work Cell

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HIPPA CONSENT FORM

FOR THE SECURITY AND DISCLOSURE OF PROTECTED HEALTH INFORMTION

TO OUR PATIENTS:

Patient information will be maintained by Asheboro Behavioral Medicine as described by the Notice of Privacy practices available upon request by asking your therapist in compliance with federal and state regulations.

Asheboro Behavioral Medicine reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone that you may elect in writing to receive it. We will release information related to work related injury to your employer.

We reserve the right to:

- Call you to remind you of your next appointment and leave information on your answering machine

If there is anyone that you would like us to share your health information with please provide their names below:

____

____

____

I have read and understand my rights:

______________________________ ______________________________

Client or Legal Guardian's Signature Date

____

Witness

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HIPPA CONSENT

FOR THE SECURITY AND DISCLOSURE OF PROTECTED HEALTH INFORMTION

TO OUR PATIENTS:

Patient information will be maintained by Asheboro Behavioral Medicine as described by the Notice of Privacy practices available upon request by asking Dr. Giarmo in compliance with federal and state regulations.

Asheboro Behavioral Medicine reserves the right to release your healthcare information based upon a decision by your psychologist for medical emergency situations and in general for continuity of care.

We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations.

We will release your information to anyone that you may elect in writing to receive it. We will release information related to work related injury to your employer.

We reserve the right to:

- Call you to remind you of your next appointment and leave information on your answering machine

LIMITS OF CONFIDENTIALITY

PATIENT'S COPY

In general, the privacy of all communications between a patient and a psychologist/therapist is protected by law, and we can only release information about our work to others with your written permission. No one outside of Asheboro Behavioral Medicine can have access to the information in your file without your consent except under the following circumstances:

1. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

2. There are some situations in which we are legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we are required to file a report with the appropriate state agency.

3. If we believe that a patient is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

4. Asheboro Behavioral Medicine reserves the right to release your healthcare information based upon a decision by your therapist for medical emergency situations and in general for continuity of care.

5. We reserve the right to dictate notes and letters. The person that does the transcription is trained in the laws governing Confidentiality and cannot reveal anything contained in the transcripts

6. For purposes of covering call information is shared with Asheboro Counseling who is governed by the same statutes governing Confidential Information.

7. We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.

8. If you choose to use health insurance, you must sign a release so that we can release required information to your billing company. While health insurance companies are also bound by confidentiality, Asheboro Behavioral Medicine is not responsible for the protection of your information when the insurance company possesses it.

9. When working with adolescents and children we keep all information discussed in session confidential unless we feel that the child or teen is engaging in a practice that will put them at risk. As a parent or guardian, you are agreeing by your signature below, that you waive all rights under law to the contents of your child/ren’s charts and notes.

10. In the course of couples/family therapy, occasions arise where one or the other participant may have an individual therapist. Asheboro Behavioral Medicine reserves the right to release to the individual’s therapist that information which may benefit that individual with the consent of that one party.

If these situations occur, we will make every effort to fully discuss it with you before taking any action. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

___________________________ ___________________________
Client’s Signature Date

___________________________ ___________________________
Legal Guardian’s Signature Date

___________________________ ___________________________
Therapist Date
Asheboro Behavioral Medicine