PEMBERTON & YOUNG COUNSELING

Damon Pemberton, LCSW • Krista Pemberton, LCSW • Maureen Young, LCSW

Pemberton & Young Counseling, LLC • 1345 W 9th Ave, Suite 201 • Anchorage, Alaska 99501
Phone: 907.258.8003 Fax: 907.258.8004 • info@pemyoung.com • www.pembertonandyoung.com

PATIENT REGISTRATION

PATIENT INFORMATION

Last name: _____ First Name: _____ M.I.: _____
DOB: _____ SSN: _____ Gender: M / F / O
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which Number is best to contact you? ☐ Home ☐ Work ☐ Cell

Email Address: _____

☐ I authorize the use of this email address for scheduling and billing purposes

Emergency Contact Name & Phone: _____Relation to patient: _____

PARENT/GUARDIAN/RESPONSIBLE PARTY: Who is responsible for costs not covered by insurance?
Last Name: _____ First Name: _____ M.I.: _____
Relation to Patient: _____ *Photo ID and Proof of Guardianship Required*
Marital Status: M / S / D SSN: _____ DOB: _____ Gender: M / F / O
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer's Name & Phone: _____

PRIMARY INSURANCE - *ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____ Provider Phone Number: _____
Claims Address: _____
Policy #: _____ Group #: _____ Effective Date: _____
Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O
DOB: _____ SSN: _____Employer Name & Phone: _____

SECONDARY INSURANCE: ☐ Y ☐ N

Insurance Name: _____ Provider Phone Number: _____
Claims Address: _____
Policy #: _____ Group #: _____ Effective Date: _____
Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O
DOB: _____ SSN: _____Employer Name & Phone: _____

TERTIARY INSURANCE: ☐ Y ☐ N

I hereby declare the information provided herein is true and correct to the best of my knowledge.

Name of Patient: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

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LIMITS OF CONFIDENTIALITY FOR PSYCHOTHERAPY

Any information discussed during therapy sessions, is confidential, and will not be shared without written permission, except under the following conditions:

- The client threatens suicide.
- The client threatens harm to another person(s), including murder, assault, or other harm.
- The client reports suspected child abuse, including but not limited to: physical beatings, sexual abuse and neglect.
- The client reports abuse of the elderly.

State law mandates that mental health professionals are required to report these situations to the appropriate persons or agencies.

In addition, if the client is involved in a legal action and claims mental health issues related to the legal action (i.e., plea of "Not Guilty by Reason of Insanity," or claiming emotional harm in a lawsuit), mental health records may be required to be released.

Communications between clinicians at PEMBERTON AND YOUNG COUNSELING, LLC and the client will otherwise be deemed confidential as stated under Alaska State Law.

Having read and understood the above, I agree to the limits of confidentiality.

Name of Patient [print]: _____

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

Signature of Minor (if applicable): _____ Date: _____

Pemberton & Young Counseling, LLC

Provider Signature: _____ Date: _____

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CONSENT FOR TREATMENT

I _____, hereby consent to psychotherapy treatment with my Pemberton & Young Counseling, LLC Provider. I understand that psychotherapy includes mental and behavioral health care delivery including assessment, diagnosis, and treatment. I have read, understood, and agreed to the Limitations of Confidentiality in Psychotherapy and the Clinic Policies.

I understand I have the following rights with respect to psychotherapy treatment:

- I have the right to withdraw or withhold consent at anytime.
- I have the right to confidentiality as outlined by the provided Notice of Privacy Practices and Limitations of Confidentiality for Psychotherapy.
- I understand that there are potential risks and benefits associated with any type of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve. I understand that benefit from psychotherapy cannot be guaranteed or assured.
- I understand that I have the right to access my medical information and copies of my medical records in accordance with Alaska law.

I have read and understand the information provided above and have had the opportunity to discuss questions with my Provider.

Signature of Patient: _____ Date: _____

Signature of Provider: _____ Date: _____

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CLINIC POLICIES

Thank you for choosing Pemberton & Young Counseling, LLC as your behavioral health provider, we look forward to working with you. The purpose of this form is to provide you with important information regarding our policies and your financial responsibility for payment of services.

FINANCIAL: As a courtesy, we will bill your insurance if you provide **valid proof of coverage** at the time of service. We will make every effort to ensure that claims are complete and accurate when submitted; however, follow up on your insurance claim is your responsibility. **You are expected to pay any/all deductibles and co-pays at the time of service and are responsible for paying any balance that is not covered by your insurance.** Any date of service balance remaining after resolution of your insurance claim will be due (30) days after receipt of billing statement. We accept cash, check, and major credit cards. Billing statements and receipts will be sent electronically if an email address has been provided. Your provision of the email address shall be considered your consent to receive this information electronically. If you fail to pay your final bill or to make financial arrangements to settle your account within thirty (30) days of receiving your statement, your account will be subject to referral to a collection agency.

Responsible Party Initials ____

CHILDREN: A parent or legal guardian must accompany all children under the age of 18 years to the initial intake session and sign all required consents prior to initiating services. I understand that any child under the age of 18 that arrives at the initial appointment without completed parental consents will be rescheduled. I understand that in the case of a child who has legal guardians living in separate households; only one parent/guardian signature is required for treatment. However, your provider will make every reasonable attempt to contact and receive consent and engagement from both legal guardians. I understand that I may be required to provide proof of legal guardianship status.

If your minor child will be attending regular group or individual sessions unaccompanied by a parent, Pemberton & Young Counseling, LLC will require a signed card on file authorization for any copays or coinsurance due at the time of service. Coinsurance or copays for on file credit card authorizations may be processed the following day.

Responsible Party Initials ____

MISSED APPOINTMENTS: I understand that therapy appointments cancelled with less than 24 hours notice will result in a late cancel/ no show fee of $25.00 for the first occurrence. Any subsequent late cancel/no show for appointments will be charged 50% of the appointment cost. Late cancel/ no show charges are not covered by insurance payments and are the responsibility of the patient. Missed appointment fees will be applied to all service types including group, individual and family sessions.

Responsible Party Initials ____

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS: In order to bill my insurance, I understand that my insurance company will have access to necessary behavioral health records from services provided by Pemberton & Young Counseling, LLC. I authorize the exchange of information necessary for payment of services between Pemberton & Young Counseling, LLC and my insurance company. I authorize payment directly to Pemberton & Young Counseling, LLC for services rendered. I also understand that I am responsible for any amount not covered or that is deemed over usual and customary fees by my insurance carrier or agency unless otherwise outlined by in-network insurance agreements.

Responsible Party Initials ____

SELF-PAYING PATIENTS: I understand that I am responsible for my bill and that the total charge is due at the time of service.

Responsible Party Initials ____

TELEHEALTH: "Telehealth" or "Telemedicine" is a service provided for clients physically present in the State of Alaska. State licensure requirements mandate that sessions cannot take place if the client is located in a state in which their provider is not licensed. I understand that telehealth includes the practice of assessment, diagnosis, consultation, treatment, transfer of protected health information, and psychoeducation using interactive audio, video, and data communications. Should telehealth be an option for my therapy I understand that I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pocket costs may be.

Responsible Party Initials ____

Pemberton & Young Counseling, LLC's clinic policies have been reviewed, understood, and agreed to by:

Name of Patient [print]: _____

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY
We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to make changes to this Notice at any time, provided such changes are permitted by applicable law, and to make such changes effective for all health information we may already have about you. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for the purposes of treatment, payment, and health care operations. For example:

Treatment: HIPAA allows us to use and disclose your health information to provide, coordinate, or manage your health care and related services. PEMBERTON AND YOUNG COUNSELING, LLC will not disclose your protected health information without your written or (in rare cases) verbal authorization for release of information, except in cases of emergency.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, accreditation, certification, licensing, or credentialing activities.
Your authorization: in addition to our use of your health information for treatment, payment, or health care operations, you may give us additional written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, *but only if you agree that we may do so.*

Persons involved in care: We may use or disclose health information to notify or assist in the notification of a family member (including identifying or locating), your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common medical practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing health-related services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials: health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, or letters).

PATIENT RIGHTS

Access: You have the right to inspect or copy your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access from us directly, or by using the contact information listed at the end of this Notice. We will charge you a reasonable fee for document production expenses. If you request an alternative format, we will charge a reasonable fee for providing your health information in that format.

Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last six years.

HIPAA ACKNOWLEDGEMENT

I hereby acknowledge receipt of PEMBERTON AND YOUNG COUNSELING, LLC Notice of Privacy Practices. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

Name of Patient [print]: _____

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

PSYCHOTHERAPY PAPERWORK

ADULT HISTORY FORM

_____

Name of Patient

_____ ___/___/_____

Person Completing Date

It is very important to gather an individual's history to formulate a complete understanding of symptoms, identify a specific diagnosis and develop a meaningful treatment plan. Although this form is lengthy, taking your time to respond to the questions with complete and accurate responses will greatly help in understanding the symptoms you may be experiencing.

You may wish to ask others including your spouse, family, or friends for information to help your memory. Should certain questions not pertain to you, please mark with N/A. In some cases, you may not have enough information to answer a particular question. If so, please indicate this on the form.

Please return this completed form to our office as soon as possible.

REFERRAL INFORMATION

Who were you referred to us by: _____

What therapy services are you seeking?

☐ Individual ☐ Family ☐ Couples ☐ Group

Provide a brief history of your symptoms that have lead you to seek therapy:

_____
_____
_____
_____
_____

On the scale below, how would you rate the severity of your present symptoms?

☐ Mildly Upsetting ☐ Moderately ☐ Severe ☐ Very Severe
☐ Extremely Severe ☐ Totally Incapacitating

FAMILY INFORMATION

Marital Status:
☐Single ☐Married ☐Divorced ☐Remarried ☐Widowed ☐Committed Relationship

Please list marriages and/or significant others, current and previous, with dates:

_____
_____
_____
_____

Number of Moves in childhood: _____ Number of Moves in Adulthood: _____

Religious Preference: _____
How often do you attend service? _____

Ethnicity: _____

Do you have children/dependents? ☐ Yes ☐ No

If yes, please list biological, step and adopted children:

NAME	AGE	SEX	GRADE	BIO/STEP/ADOPTED

Other people in household:

NAME	AGE	SEX	RELATIONSHIP

FAMILY HISTORY

Did your parents divorce? ☐ Yes ☐ No If yes, age at divorce: _____

PARENT	NAME	AGE	OCCUPATION	RACE	DECEASED
Mother					Y N
Father					Y N
Stepmother					Y N
Stepfather					Y N
Guardian					Y N

SIBLINGS NAME	AGE	SEX	RACE	EDUCATION (IN YRS)	DECEASED
					Y N
					Y N
					Y N
					Y N

Any family members with the following problems?
(Family defined as brothers, sisters, parents, grandparents, aunts, and uncles).

CONDITION	RELATION
Learning Problems:	
Depression:	
Alcoholism/Drug Addiction:	
Epilepsy:	
Developmental Delays:	
Trouble with the law:	
Hyperactivity:	
Anxious or perfectionist:	
OCD:	
Speech or hearing problems:	
TIC behaviors or nervous habits:	
Psychiatric hospitalization:	
Other behavior or emotional problems:	

Any major medical problems diagnosed in your immediate or extended family (e.g. diabetes, heart disease, high blood pressure, stroke)?

HEALTHCARE HISTORY

Primary Care Physician: _____ Phone: _____
Do you regularly see any physician/therapist other than your primary physician?
☐Yes ☐No If yes, who? _____
Have you ever been treated for any psychiatric or behavioral disorder (e.g., ADHD, substance abuse, depression)? ☐Yes ☐No If yes, please list the disorder, dates, and any medication prescribed:

Have you ever participated in talk therapy or seen a therapist? If yes, please list the dates of treatment and reason for ending therapy:

Have you ever had any of the following?

- ☐Head Injury (TBI)
- ☐Automobile Accident(s)
- ☐Neurological Disease or Injury
- ☐Heart Problems
- ☐Near Drowning
- ☐Alcohol/Substance Abuse
- ☐High Blood Pressure
- ☐Heart disease
- ☐Cancer
- ☐Blood disorder
- ☐Visual Problems
- ☐Serious Infection
- ☐Meningitis
- ☐Encephalitis
- ☐Diabetes
- ☐Liver or Kidney disease
- ☐Stroke
- ☐Prescription Drug Abuse
- ☐Hospitalizations
- ☐Poisoning
- ☐Toxic Exposures
- ☐Headaches
- ☐Paralysis
- ☐Deafness/hearing loss
- ☐Back/Neck injury
- ☐"Nervous Breakdown"
- ☐High Fever
- ☐Seizures
- ☐Other _____

Medications you currently take:

MEDICATION DOSE (Mg) HOW TAKEN (e.g. two times daily, three times daily)

_____

_____

_____

Medications you have taken in the past: _____

Height _____ Weight _____

Do you currently smoke Tobacco? ☐Yes ☐No How much?_____
When did you start? _____ If no, have you ever smoked Tobacco? ☐Yes ☐No
How long since you stopped smoking?_____

Do you currently smoke Marijuana? ☐Yes ☐No How much?_____
When did you start? _____ If no, have you ever smoked Marijuana? ☐Yes ☐No
How long since you stopped smoking?_____

Do you currently drink alcohol? ☐Yes ☐No
Number of drinks per occasion _____ If no, have you ever drank? ☐Yes ☐No
Has your alcohol use ever caused problems? ☐Yes ☐No
Explain: _____

Do you currently or have you used drugs recreationally (e.g., marijuana, cocaine, meth, other illicit drugs or prescription medication)? ☐Yes ☐No Explain: _____

_____

_____

Have you ever been addicted to prescription drugs? ☐Yes ☐No Explain: _____

_____

_____

Please check any you have experienced or are experiencing now:

☐Headaches
☐Fainting Spells
☐Stomach Trouble
☐Bowel Disturbances
☐Insomnia
☐Can't Stay Asleep
☐Feel Tense or Anxious
☐Tremors/Shaky
☐Suicidal
☐Sexual Problems
☐Overly Ambitious
☐Can't Make Friends
☐Can't Keep a Job
☐Financial Problems
☐Concentration Difficulties
☐Unusually Extreme Temper
☐Home Conditions Uncomfortable
☐Dizziness
☐Rapid Heart Beat
☐No Appetite
☐Fatigue
☐Nightmares
☐Overeating
☐Feel panicky
☐Depressed
☐Unable to Relax
☐Shy with People
☐Can't Make Decisions
☐Inferiority problems
☐Memory problems
☐Sensitive to Light
☐Sensitive to Loud Noise
☐Unable to Have a Good Time
☐Don't Like Weekends/Vacations
☐Other _____

_____

_____

DEVELOPMENTAL HISTORY

Place of Birth: _____

Complications at birth? _____

_____

Did your mother smoke, drink, or use drugs during pregnancy? ☐ Yes ☐ No
If yes, what and how much? _____

As a child did you have any of the following?

☐ Premature Birth	☐ Meningitis	☐ High Fevers
☐ Low Birth Weight	☐ Seizures	☐ Birth Defects
☐ Birth Complications/Injury	☐ Recurrent Ear Infections	☐ Hearing Problems
☐ Vision problems	☐ Asthma	☐ Bed-wetting

☐ Other _____

Have you ever:

☐ Been physically assaulted

By whom: _____

For how long/how many times: _____

Treated for: _____

☐ Been sexually abused

By whom: _____

For how long/how many times: _____

Treated for: _____

EDUCATIONAL HISTORY

List schools attended (public or private), grade school through high school:

School Grades City, State

_____

_____

_____

_____

Graduated High School? ☐Yes ☐No GED? ☐Yes ☐No

Estimated high school GPA: ____ Are school records available? _____

Extra Curricular activities: _____

_____

_____

_____

_____

_____

Education support required?

- ☐Started school late
- ☐Held back/repeated grade
- ☐Behavior problems
- ☐Resource/Spec. Ed
- ☐Underachiever
- ☐Learning Problems
- ☐Tutoring
- ☐Poor Motivation
- ☐Remedial Classes
- ☐Attention/Concentration Problems
- ☐Other: _____

Please explain any of the above: _____

What, if anything, detracted from a successful school experience?

Best and worst academic areas?

Trade School/Community College: _____

Academic Focus: _____ Years attended: _____

Estimated GPA: _____ Certification/Diploma? _____

University/College: _____

Major/Minor: _____ Years attended: _____

Estimated GPA: _____ Certification/Diploma? _____

Graduate School: _____

Area of Study: _____ Years attended: _____

Estimated GPA: _____ Certification/Diploma? _____

List apprenticeships, courses, other training: _____

PERSONAL HISTORY

Current Occupation: _____

Current Employer: _____ How Long? _____

Previous Employer: _____ Position: _____ How Long? _____

Previous Employer: _____ Position: _____ How Long? _____

Were you in trouble with the law as a teenager? ☐Yes ☐No
Explain: _____

Have you been in trouble with the law as an adult? ☐Yes ☐No Explain: _____

Hobbies: _____

Recreational Activities: _____

Particular Areas of Interest: _____

MILITARY EXPERIENCE

Branch: _____ Highest Rank: _____
Specialty Areas: _____

DETAIL OF ACCIDENT/INJURY (IF APPLICABLE)

Date of accident/injury: _____
Details of accident/injury:

_____
_____
_____
_____

Loss of consciousness? ☐Yes ☐No
Estimated length of unconsciousness? _____
Specific injuries:

_____
_____

Which, if any, of the symptoms below have you experienced since your injury? If they were present before the injury but changed please explain below:

☐Nausea
☐Vomiting
☐Ringing in the ears
☐Blurred vision
☐Headache
☐Aggression
☐Decreased sexual drive
☐Fainting/blackouts
☐Memory Problems
☐Depression
☐Pain in chest
☐Anxiety
☐Decreased attention/concentration
☐Fatigue easily
☐Poor sleep
☐Decreased energy
☐Weight loss/gain
☐Difficulty with crowds
☐Mood swings
☐Hallucinations

Changes in:

☐Speech/Language ☐Reading ☐Math Skills
☐Thinking ☐Sense of Smell ☐Sense of Taste
☐Anger ☐Stress Tolerance ☐Frustration Tolerance