Therapy Zone
1165 South Columbia Rd Ste D
Grand Forks, ND 58201
Phone: (701) 738-0888
Cell: (218) 791-5669
Fax: (701) 757-1431
Diane@thezonegf.com

Forms for New Patients of Diane K. Baumbach, LICSW

Please print and fill out all forms completely, signing pages 2, 3 and 9.

Bring completed forms to first session or fax to: (701) 757-1431. Any questions please call (701) 738-0888.

Diane K. Baumbach, MSW, LICSW, BCD

Child and Family Therapist
1165 S. Columbia Rd., Ste D
Grand Forks, ND 58201-4007
701-738-0888

Please complete all information correctly and legibly or **you will be responsible for the bill.**

PATIENT INFORMATION:

Last name: _____ First Name:_____ M.I. _____

Birth date: _____/_____/_____ Medication Allergies: _____Sex: M or F

Patient's Marital Status: _____ Patient's Spouse's Name:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Referring Doctor: _____ Primary Doctor: _____

RESPONSIBLE PARTY (if other than patient):

Last name: _____ First Name:_____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Employer's Name: _____ City: _____ State: _____

INSURANCE INFORMATION:

Primary Insurance	*Secondary Insurance (if applicable)*
Card Holder _____	Card Holder _____
Birth Date _____	Birth Date _____
Address (if different) _____	Address (if different) _____
_____	_____
Phone # _____	Phone # _____
Employer _____	Employer _____
Insurance Company _____	Insurance Company _____
Policy ID # (begins with a letter)	Policy ID # (begins with a letter)
_____	_____

BILLING INFORMATION – Read and sign:

1. I authorize Diane K. Baumbach, MSW, LICSW to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize Diane K. Baumbach, MSW, LICSW, to release my medical records and billing information to my Primary Care and Referring Physician.
3. I authorize my insurance benefits to be paid to Diane K. Baumbach, MSW, LICSW.
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.
7. I understand I am responsible for payment of my bill beyond insurance coverage.
8. I understand that my scheduled time slot will be forfeited if I miss three scheduled sessions without contacting the provider and per the provider's discretion.

Name of person completing this form (please print) _____

Signature of person completing this form_____ Date: _____

Relationship to Patient: _____

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS

Patient Name: _____
Date of Birth: _____ Phone: _____

I authorize: Circle One
Diane K. Baumbach, MSW, LICSW, BCD
Jessica Hermanson, MSW, LICSW
Katie A. Benson, MSW, LICSW
Jodi Tescher, MSW, LICSW
Jasmyne J. Ramirez, MSW, LICSW
Danielle Conrad, MSW, LICSW

To release and exchange with clinicians who provide services at
1165 S. Columbia Rd, Ste D
Grand Forks, ND 58201
Phone: (701) 738-0888
Fax: (701) 757-1431

Clinicians practice in an office setting with other social workers and counselors, but are not a partner of the other parties. Other parties who share this office space are not responsible for the work of Diane K. Baumbach and owe no duty to her clients.

Items to be released:
___ Progress Notes
X Acknowledgement of Care

I authorize verbal and/or written exchange of my medical information.
The information is to be used for:

X Office work related to Management of care
X Supervision
X Referral
___ Other _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OF FEDERAL LAW I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATE TO:

1. **Substance Abuse**
2. **Mental Health (includes psychological testing)**
3. **HIV-Related Information (AIDS related testing)**
4. **Developmental Disabilities**
5. **Adoptee/Adopting Parents**
6. **Physical Abuse**

This release of information consent form remains in effect for 12 months or until the patient or legal guardian shall revoke this authorization. However your revocation will not be effective to the extent that action that relied on the authorization of this consent and was obtained as a condition for insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to re-discloser by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Therapy Zone's policy for release of medical records:

a) **No charge for medical records released to physician(s) or other health care providers.**
b) **A fee schedule is applicable for medical records released directly to patient(s) or nonmedical related parties.**

Copying fee: $_____

Signature: _____ Date: _____

Relationship to client_____

Witness: _____ Date: _____

Name _____ Date _____

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems	**Duration** (months)	**Additional information**:

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
elimination disturbance	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]	dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	circumstantial symptoms	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
psychomotor retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	concomitant medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
generalized anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) _____	[ ]	[ ]	[ ]	[ ]

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] [ ] Prior outpatient psychotherapy?
No Yes If yes, on _____occasions. Longest treatment by _____ for _____ sessions from ____/_____ to _____/_____
Provider Name Month/Year Month/Year

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

[ ] [ ] Has any family member had outpatient psychotherapy? If yes, who/why (list all):_____
No Yes _____

[ ] [ ] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?
No Yes If yes, on _____occasions. Longest treatment at _____ from ___/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

[ ] [ ] Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes,
No Yes who/why (list all):_____

Name _____ Date _____

[ ] [ ] Prior or current psychotropic medication usage? If yes:

No	Yes	Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

[ ] [ ] Has any family member used psychotropic medications? If yes, who/what/why (list all):_____

No Yes _____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

_____

toward others

from others

Parents' current marital status:

[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ___

Describe parents:

	Father	**Mother**
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse
[ ] experienced physical/verbal/sexual abuse

Special circumstances in childhood:_____

_____

_____

IMMEDIATE FAMILY

List all persons currently living in patient's household:

Name Age Sex Relationship to patient

_____

_____

_____

List children <u>not</u> living in same household as patient:

_____

_____

_____

Frequency of visitation of above: _____

Describe any past or current significant issues in <u>immediate family</u> relationships: _____

_____

_____

_____

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

_____

List name of primary care physician:

Name _____ Phone _____

List name of psychiatrist: (if any):

Name _____ Phone _____

List any medications currently being taken (give dosage & reason):

_____

_____

_____

Is there a history of any of the following in the family:

[ ] tuberculosis
[ ] birth defects
[ ] emotional problems
[ ] behavior problems
[ ] thyroid problems
[ ] cancer
[ ] mental retardation
[ ] heart disease
[ ] high blood pressure
[ ] alcoholism
[ ] drug abuse
[ ] diabetes
[ ] Alzheimer's disease/dementia
[ ] stroke
[ ] other chronic or serious health problems _____

_____

Name _____ Date _____

Describe any serious hospitalization or accidents:
Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date: _____ Age _____ Reason _____

List any known allergies: _____

List any abnormal lab test results:
Date _____ Result _____
Date _____ Result _____

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used:

(complete all that apply)	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol					
[ ] amphetamines/speed					
[ ] barbiturates/owners					
[ ] caffeine					
[ ] cocaine					
[ ] crack cocaine					
[ ] hallucinogens (e.g., LSD)					
[ ] inhalants (e.g., glue, gas)					
[ ] marijuana or hashish					
[ ] nicotine/cigarettes					
[ ] PCP					
[ ] prescription_____					
[ ] other_____					

Treatment history:

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)
[ ] stopped on own (age[s]_____)
[ ] other (age[s]_____
describe:_____

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests
[ ] overdose [ ] loss of control amount used [ ] relationship conflicts
[ ] other _____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:

[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
_____
birth weight ____lbs ___oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:

[ ] chickenpox (age _____) [ ] lead poising (age _____)
[ ] German measles (age _____) [ ] mumps (age _____)
[ ] red measles (age _____) [ ] diphtheria (age _____)
[ ] rheumatic fever (age _____) [ ] poliomyelitis (age _____)
[ ] whooping cough (age _____) [ ] pneumonia (age _____)
[ ] scarlet fever (age _____) [ ] tuberculosis (age _____)
[ ] autism [ ] mental retardation
[ ] ear infections [ ] asthma
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems _____
_____

Name _____ Date _____

Delayed developmental milestones (check only those milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other _____
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):

[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things
[ ] other _____

Social interaction (check all that apply):

[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other _____

Intellectual / academic functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation

Current or highest education level _____

Describe any other developmental problems or issues: _____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income

Social support system:
[ ] supportive network
[ ] few friends
[ ] no friends
[ ] distant from family of origin

Legal history:
[ ] no legal problems
[ ] now on probation
[ ] court ordered this treatment
describe last legal difficulty: _____

Cultural/spiritual/recreational history:
cultural identity (e.g., ethnicity, religion): _____
describe any cultural issues that contribute to current problem: _____
currently active in community/recreational activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: _____

SOURCES OF DATA PROVIDED ABOVE: [ ] Patient self-report for all [ ] A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Family History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Developmental History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Emotional/Psychiatric History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Medical/Substance Use History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

Socioeconomic History
[ ] patient self-report
[ ] patient's parent/guardian
[ ] other (specify) _____

NOTICE OF PRIVACY PRACTICES

Please read this notice and **sign and date** the attached acknowledgement.

Diane K. Baumbach, MSW, LICSW
Child and Family Therapist
Therapy Zone
1165 S. Columbia Rd., Ste D
Grand Forks, ND 58201-4007

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act has given you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for you visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment activities and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified by removing all references to individually identifiable information.

We may contact you to provide appointment reminders and information about treatment alternative or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relaying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosers of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we much abide by it unless you agree in writing to remove it.
- The right to reasonable requests to review confidential communications of protected health information from us at alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosers of protected health information.
- The right to obtain and we have to obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of out legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy has been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S. W.
Washington, D.C. 20201
(2202) 619-0257
Toll Free: 1-877-696-6775

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Diane K. Baumbach's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Diane K. Baumbach.

_____
Signature of Patient/Client **Date**

_____
Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____
Signature of Staff Member **Date**

PERMISSION TO TREAT A MINOR

I, _____, hereby authorize Diane K. Baumbach, MSW, LICSW,

at The Zone to provide psychotherapy to_____, a minor.

I attest to the fact that I have the legal authority to grant this permission.

_____

Signature

Date: _____

Relationship to child: ____Parent ____Legal Guardian ____Court appointed Custodian

Agency Representation: _____