Lacy M. Suby, PLLC
Licensed Clinical Social Worker

2755 10th Avenue North
Grand Forks, ND 58203-2136
Phone: 701-738-0888
Mobile: 701-330-4348
Fax: 701-757-1431
www.thezonegf.com

INTAKE FORM

GENERAL INFORMATION

First Name: Last Name: Middle Initial: Gender:

Date of Birth (mm/dd/yyyy): Social Security Number:

Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Email:

EMERGENCY CONTACT

Name (First, Last): Phone: Relationship:

Do you authorize this person to discuss care or treatment with the office in the case of an emergency?

☐ **YES** ☐ **NO**

INSURANCE INFORMATION (*please bring insurance card(s) to first appointment)*

PRIMARY INSURANCE: Policy Number: Group Number:

Policy Holder Name (First, Last M.I.): Gender:

Date of Birth (mm/dd/yyyy): Relationship:

Address:

City: State: Zip Code: Phone:

SECONDARY INSURANCE: Policy Number: Group Number:

Policy Holder Name (First, Last M.I.): Gender:

Date of Birth (mm/dd/yyyy): Relationship:

Address:

City: State: Zip Code: Phone:

GUARANTOR ***if other than the patient*** *(person ultimately responsible to pay the patient's bill)*

Name (First, Last): Relationship:

Address:

City: State: Zip Code: Phone:

BILLING & APPOINTMENT INFORMATION

Read and Sign

You are about to take a very important step in your mental wellness plan. As your mental health provider, you will be entering into a protected relationship with Lacy M. Suby, PLLC.

1. I authorize Lacy M. Suby, PLLC 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 Lacy M. Suby, PLLC to release my medical records and billing information to my Primary Care Physician and Referring Physician as needed for treatment/continuity of care purposes.
3. I authorize my insurance benefits to be paid to Lacy M. Suby, PLLC.
4. If a requested insurance claim is filed, I understand I will receive a bill each month if my account has a balance due. I understand I am responsible for any charges not paid by insurance or beyond insurance coverage.
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 required by insurance.
7. I understand it is my responsibility to provide advance notice of cancellation of my appointment if I am unable to attend the scheduled appointment for courtesy purposes.
8. I understand if I do not cancel and do not show for my scheduled appointment, I will incur a **$50.00 no show fee**, of which will be my responsibility and not billed to insurance.
9. I understand that Lacy M. Suby, PLLC reserves the right to cancel future appointments in the event I do not cancel and do not show for three scheduled appointments without contacting the provider.
10. I understand that the provider reserves the right to discontinue services if I owe a balance of $1000.00 or more on my bill and am not compliant with an agreed upon payment plan.
11. I understand I have confidentiality rights. However, confidentiality does not apply under certain circumstances. Lacy M. Suby, PLLC is obligated by law to report any suspicion of abuse/neglect of a child, vulnerable adult or elderly adult (physical, emotional and/or sexual). Lacy M. Suby, PLLC also has a duty to protect if it is suspected anyone is in danger of harming themselves (to include suicidal behavior) or has made threats to harm someone else.

Signature of patient: _____

Printed name of patient: _____

Relationship to patient (if a minor): _____

Date (mm/dd/yyyy): _____

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS

First Name: Last Name: Middle Initial:

Date of Birth (mm/dd/yyyy): Phone Number:

I authorize: Lacy M. Suby, MSW, LCSW
2755 10th Avenue North, Grand Forks, ND 58201
Phone: (701) 738-0888 *Mobile*: (701) 330-4348 *Fax*: (701) 757-1431

To release and exchange with: _____

Items to be released:
☐ Progress Notes ☐ Acknowledgement of Care

I authorize verbal and/or written exchange of my medical information. The information is to be used for:
☐ Continuity of care ☐ Supervision
☐ 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 authorization for release of patient medical records 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.

Provider'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.

Signature: Date (mm/dd/yyyy):

Printed name: Relationship to patient:

Witness: Date (mm/dd/yyyy):

Authorization for Electronic Communication

As a convenience to me, I authorize Lacy M. Suby, PLLC to communicate with me regarding my treatment via electronic communications (email or text message) and to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by email or text message:

- Such communication does not provide a completely secure means of communication.
- Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, Lacy M. Suby, PLLC shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Lacy M. Suby, PLLC to me.

Text Communication: ☐ **YES** ☐ **NO**
Authorized phone number(s): _____

Email Communication: ☐ **YES** ☐ **NO**
Authorized email address(es): _____

Other: ☐ **YES** ☐ **NO**
Authorized service(s): _____

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time.

I understand that Lacy M. Suby, PLLC may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Lacy M. Suby, PLLC in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

Signature: Date (mm/dd/yyyy):

Printed name:

Relationship to patient (if other than self):

MENTAL HEALTH HISTORY/STATUS

What problems are you seeking help for? _____

_____

_____

_____

Symptoms experienced currently or in the recent past. Please check ALL that apply:

☐ Depressed mood
☐ Loss of interest in activities
☐ Lost or gained weight
☐ Fatigue
☐ Irritable
☐ Feelings of worthlessness
☐ Guilt
☐ Hopelessness
☐ Difficulty concentrating
☐ Poor appetite
☐ Poor grooming
☐ Mood swings
☐ Binge/purge behaviors
☐ Sexual dysfunction
☐ Social isolation
☐ Thoughts of death or suicide
☐ Self harm
☐ Crying spells
☐ Racing thoughts
☐ Easily distracted
☐ Excessive worry
☐ Restlessness/feeling on edge
☐ Difficulty falling/staying asleep
☐ Restless unsatisfying sleep
☐ Tense/unable to relax
☐ Panic attacks
☐ Heart palpitations
☐ Chest pain
☐ Choking sensations
☐ Shortness of breath
☐ Dizziness
☐ Fear of social situations
☐ Afraid to leave home
☐ Upsetting memories
☐ Flashbacks
☐ Grief/recent loss
☐ Never tired
☐ Inflated self esteem
☐ Excessive talking
☐ Violent thoughts/behaviors
☐ Anger outburst
☐ Careless, high-risk behavior
☐ Financial problems
☐ Impulsive behavior
☐ See/hear things that are not real
☐ Suspect things may not be real
☐ Unreasonable fear
☐ Repetitive thoughts/behavior
☐ Work/school problems

Current Psychiatric Treatment

Are you currently seeing a psychiatrist? ☐ **YES** ☐ **NO**
If yes, whom and where? _____

Medications currently prescribed: _____

_____

_____

_____

Past Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? ☐ **YES** ☐ **NO**
If yes, when and where? _____

Have you ever had outpatient treatment by a psychiatrist? ☐ **YES** ☐ **NO**
If yes, when and by whom? _____

_____

Have you ever received counseling or psychotherapy in the past? ☐ **YES** ☐ **NO**
If yes, when and by whom? _____

_____

Do you have history of experiencing suicidal thoughts? ☐ **YES** ☐ **NO**
Do you have history of engaging in suicidal attempts? ☐ **YES** ☐ **NO**

Do you have history of experiencing self-injury thoughts? ☐ **YES** ☐ **NO**
Do you have history of engaging in self-injury behavior? ☐ **YES** ☐ **NO**

Do you have history of thoughts wanting to harm someone? ☐ **YES** ☐ **NO**
Do you have history of physically harming another person? ☐ **YES** ☐ **NO**

Substance Abuse History

Drug of choice:	Age of first use:	Lased used:	Length of use:	Route of administration:	Frequency of use:	Last used:
Alcohol						
Amphetamines						
Methamphetamine						
Benzodiazepines						
Caffeine						
Cocaine						
Ecstasy						
Hallucinogens						
Heroin						
Inhalants						
Marijuana						
Nicotine						
Opioids						
Steroids						
Other:						

History of outpatient treatment for substances? ☐ **YES, where:** _____ ☐ **NO**
History of inpatient treatment for substances? ☐ **YES, where:** _____ ☐ **NO**
Any other history of addictions? ☐ **YES** ☐ **NO**
If yes, please explain? _____

GENERAL MEDICAL HISTORY

Primary Care Physician: _____

Please list any medical problems you may have: _____

_____

_____

_____

_____

Are you on any medications for any general medical problems you may have? ☐ **YES** ☐ **NO**

If yes, what medications? _____

_____

_____

Please list any serious medical procedures you have had in the past: _____

_____

_____

Allergies: _____

_____

SOCIAL HISTORY

Born/raised in: _____

Raised by: _____

Strengths/conflicts within relationship with parents/primary caregiver(s)? _____

_____

_____

_____

Number of siblings & ages of siblings: _____

_____

Strengths/conflicts within sibling relationship(s)? _____

_____

_____

Family stressors or other special circumstances during childhood and/or currently:

Are you currently in a romantic relationship? ☐ **YES** ☐ **NO**

Duration:

Strengths/conflicts within your relationship?

Do you have any children? ☐ **YES** ☐ **NO**

If yes, names & ages:

Strengths/conflicts within your relationship(s) with children?

Any history of abuse (physical, emotional, sexual)? ☐ **YES** ☐ **NO**
Please explain (if willing/able):

Any history of trauma or significant distress: ☐ **YES** ☐ **NO**
Please explain (if willing/able):

Highest level of education: _____

Current employment and last three jobs: _____

_____

_____

_____

Have you ever been convicted of any crimes, served time, or been on probation? ☐ **YES** ☐ **NO**
Details: _____

_____

Cultural, spiritual and/or religious identification and/or involvement: _____

_____

Activities you enjoy doing or hobbies you have: _____

_____

DEVELOPMENTAL HISTORY

Problems during mother's pregnancy with you: _____

Birth stressors/complications: _____

_____

Infancy complications: _____

_____

Childhood health:

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

☐ Sitting	☐ Speaking words	☐ Dressing self
☐ Rolling over	☐ Speaking sentences	☐ Engaging peers
☐ Standing	☐ Controlling bladder	☐ Tolerating separation
☐ Walking	☐ Controlling bowels	☐ Playing cooperatively
☐ Feeding self	☐ Sleeping alone	☐ Other: _____

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
☐ Bizarre behavior
☐ Self-injurious threats or acts
☐ Frequently tearful
☐ Frequently daydreams
☐ Lack of attachment
☐ Distrustful
☐ Extreme worrier
☐ Impulsive
☐ Easily distracted
☐ Poor concentration
☐ Often sad
☐ Breaks things
☐ Other: _____

Intellectual/academic functioning (check all that apply):

☐ Normal intelligence
☐ High intelligence
☐ Learning struggles
☐ Authority conflicts
☐ Attention problems
☐ Underachieving
☐ Learning disabilities
☐ Individualized Education Plan (IEP)
☐ 504 Plan
☐ Other: _____

Describe any other developmental problems or issues: _____

_____

FAMILY MEDICAL/MENTAL HEALTH HISTORY

List any history of illness (mental or physical) among relatives:

Mother's side Father's side

_____

_____

_____

_____

List any history of alcohol and/or drug abuse among relatives:

Mother's side Father's side

_____

_____

_____

_____

Please list any additional notes that you think would be helpful for treatment below:

_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Generalized Anxiety Disorder 7 (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* = _____				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

NOTICE OF PRIVACY PRACTICES

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

Lacy M. Suby, MSW, LCSW
Mental Health Therapist
2755 10th Ave N
Grand Forks, ND 58203

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

First Name: Last Name: Middle Initial:

Date of Birth (mm/dd/yyyy): Social Security Number:

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

Signature: Date (mm/dd/yyyy):

Signature or Parent, Guardian or Personal Representative

* *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.).*

Signature: Date (mm/dd/yyyy):

Printed name:

Relationship/Legal Authority:

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

Signature of Staff member:

Date (mm/dd/yyyy):