Molly Kinser Douglas

PATIENT INFORMATION

TODAY'S DATE: _____

Patient Name: _____ _____
Last First Middle Social Security Number

Address: _____ ____/____/____ _____
Street Birth Date Sex

_____ _____
City State Zip Home Phone Number

Parent or Legal Representative: _____ _____
Name Home Phone Number

Address if Different From Above: _____
Street City State Zip

Employer: _____ _____
Work Phone

_____ _____
Home Phone Mobile Phone

Emergency Contact : _____ Phone: _____
(Not At Same Address)

PRIMARY INSURANCE

Insurance Co.: _____ Policy #_____ Grp. #_____

Policy Holder Name: _____ _____
Last First Middle Social Security Number

Address if different : _____ _____ _____
Street Birth Date Sex

_____ _____
City State Zip Home Phone Number

Employer if different from above: _____ _____
Name Work Phone Number

Relationship to Patient: _____

Send Claims To: _____

_____

_____

SECONDARY INSURANCE

Insurance Co: _____ Policy #_____ Grp. #_____

Policy Holder Name: _____ _____
Last First Middle Social Security Number

Address if different : _____ _____ _____
Street Birth Date Sex

_____ _____
City State Zip Home Phone Number

Employer if different from above: _____ **(Over)**
Name Work Phone Number

(Secondary Insurance/Continued)

Send Claims To: _____

_____

_____

Consent To Treat: I authorize Molly Kinser Douglas to administer treatment as deemed necessary for care of the patient named above. If I am not the patient, I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

Assignment of Benefit: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances. Co-payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid or other insurance company benefits be made to Molly Kinser Douglas for any services provided by this practice. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

Signature: _____ _____
Patient or Legal Representative Date

Acknowledgement of Notice of Privacy

My signature below indicates that I have been given an opportunity to read this practice's Notice of Privacy Practices and to have any questions regarding HIPAA answered before signing.

Signed: _____ Date: _____

Print Name: _____

Telephone: _____

If not signed by the patient, please indicate Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

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For Office Use Only:

Form received by: _____ Date: _____
Employee Signature

Acknowledgment refused:

Efforts to obtain:

_____

_____

Reason Patient Refused to sign:

_____

_____

Molly Kinser Douglas, LMHC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient (print): _____ Date of Birth: ____/____/____

S.S. No.: _____ Phone:(home)_____(work)_____

Address: _____

City: _____ State: _____ Zip: _____

I, the undersigned, authorize and request Molly Kinser Douglas, LMHC *to:*

- ☐ Release to
- ☐ Obtain from

Person/organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____FAX: _____

The following information from my medical records for care/treatment that I received from:

_____until discharge or through _____.

- ☐ Any/all or as much information as the releasing healthcare provider, in its sole discretion, deems reasonably necessary for the purposes set forth by me for release.
- ☐ Specific exclusions: _____

Purpose for Disclosure: _____

This authorization is effective for _____ or no longer than 1 year from the date on which it is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Chief Compliance Officer at Molly Kinser Douglas, LMHC. A photocopy or facsimile of this release shall have the same effect as an original. I understand I have the right to inspect the information to be disclosed, and include my written statement about the record, upon proper notification to and under appropriate conditions established by Molly Kinser Douglas, LMHC.

I acknowledge that the information to be released may include material that is protected by State and Federal Law applicable to either mental health, and/or drug and/or alcohol abuse and/or HIV/AIDS, and my signature authorizes release of such information, unless exceptions have been stated above. _____
Initials

PROHIBITION FOR REDISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by Federal and/or State Law. The Authorization for Release of Information form Does not authorize re-disclosure of medical information Beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, and State Law (Iowa Code ch. 225 and 141) for Metal Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such laws and/or regulations. A general authorization for the Release of Medical Information is NOT sufficient for these purposes. Civil and Criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/SIDS information.

_____/_____
Signature of patient or Representative Date

_____
Relationship to Patient

_____/_____
Witness Date

(A copy of this signed form must accompany released information.)

Release Processed (Initials) _____ (Date) _____

Individuals respond in different ways to trauma. Below is a checklist of typical symptoms and behaviors individuals exhibit when they have been traumatized. Please check-off on the list below if you/your child was exhibiting the symptom before and/or after the trauma, and indicate on a scale of 1 to 10 how often (1 for not often, 10 for often).

Symptom	Before Trauma	After Trauma	Please Describe
Difficulty sleeping			
Nightmares			
Can't stop thinking about the trauma			
Acts like trauma is still happening			
Startles easily, jumpy			
Unusually clingy, afraid to be alone			
Avoids certain people, places			
Daydreams/spaces out			
Difficulty concentrating			
Very forgetful			
Says doesn't remember trauma			
Seems mostly happy			
Seems mostly sad			
Shows little or no emotion			
Stomachaches, physical complaints			
Change in eating habits			
Frequent tantrums			
Very demanding of attention			
Acts younger than his/her age			
Hides food			
Wets bed or soils self			
Urinates in places other than toilet			
Refuses to go to the bathroom			
Washes self excessively			
Acts out the trauma in play			
Aggressive with others			
Destructive			
Lies/steals			
Fascinated with fires or sets fires			
Unusual tics or mannerisms			
Hurts animals on purpose			
Hurts self on purpose			
Talks about or has attempted suicide			
Has few friends/gets teased			
Approaches strangers too easily			
Abuses drugs/alcohol			
Says doesn't like self or body			

Are there any other symptoms or behaviors you are concerned about?