



MIND AND BODY
COUNSELING ASSOCIATES

4600 Kietzke Ln, C-129, Reno NV 89502 – 775-507-7222

PATIENT INFORMATION:

Please provide the following information and answer the questions below. Please bring this form to your first session. **Please note: The information you provide here is protected as confidential information.**

Patient's Full Name: _____ Date: _____

Gender: Male _____ Female _____ MTF _____ FTM _____ Questioning _____

Date of Birth: ____/____/____ SS#: _____ Age: _____

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

Home Phone: () _____ Cell Phone: () _____ Work Phone Number: () _____

Where would you prefer that we call you to remind you of an appointment time: Home: ____ Cell: ____ Work: ____

Can we leave messages on voicemail or with someone? YES _____ NO _____

Can we send mail correspondence to your mailing address? YES _____ NO _____

Please provide your e-mail address for correspondence/billing purposes: _____

May we add you to our email list for any upcoming events, newsletters, etc.? YES _____ NO _____

How were you referred to our practice? _____

Patient's Employer: _____ Occupation: _____

Marital Status: (circle one)

Married _____ Separated _____ Divorced _____ Never Married _____ Widowed _____ Domestic Partnership _____

Full name of partner: _____ SS#: _____

Partner's date of birth: _____

Person(s) you are currently living with: _____ (significant other, roommate, etc.)

EMERGENCY CONTACT INFORMATION:

Full Name: _____ Relationship to patient: _____

Main Phone: () _____ Work Phone: () _____



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INSURED/RESPONSIBLE PARTY INFORMATION:

Full name of insured: _____ Relationship to patient: _____

Occupation: _____ SS#: _____ Date of Birth: _____

Employer: _____ Work Phone: () _____

INSURANCE INFORMATION:

Insured's Primary Insurance Company: _____ I.D.#: _____

Group #: _____ Policy #: _____ Phone No: () _____

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

OFFICE BILLING AND INSURANCE POLICY:

1. I authorize use of this form on all my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided in the event that my insurance company does not pay.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-PAY, CO-INSURANCE AMOUNT OR ANY OTHER BALANCES NOT PAID BY YOUR INSURANCE COMPANY THE DAY AND TIME OF SERVICE PROVIDED.

- There will be a **\$50.00 service charge** on all returned checks.
- There will be a **\$50.00 charge** to fill out any paperwork unless it can be done during your session
- Pursuant to the collection policy outlined in the Confidentiality Agreement, in the event that your account goes to collections, there will be a **40% collection** fee added to your balance.

Signature: _____ Date: _____

Name (Print): _____



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Once an appointment has been scheduled, you will be expected to keep the appointment. **Our office policy requires that sessions be cancelled at least 24 hours (*Monday thru Friday*) prior to the scheduled appointment time to avoid being responsible for the charges.** If less than 24 hour notice is given (calls must be made during normal business hours when office staff is available and **does NOT include evenings, weekends, and/or holidays**), you will be charged for the appointment [unless we are able to fill your appointment time with someone on our waiting list, or a patient who calls for an urgent session.] Appointment times are scheduled exclusively for each patient and generally cannot be rescheduled on short notice. *This office cannot bill your insurance company for “no shows” or late cancellations.* **You alone will be responsible for the full \$100.00 fee for any appointments missed for any reason.**

I, THE UNDERSIGNED, HAVE READ AND UNDERSTAND MIND AND BODY COUNSELING ASSOCIATES’ LATE CANCEL/NO SHOW APPOINTMENT POLICY.

Signature: _____ Date: _____

Name (Print): _____

I, THE UNDERSIGNED, HAVE OBTAINED (FROM THE WEBSITE) AND REVIEWED THE NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE AND THE PSYCHOTHERAPIST/PATIENT SERVICE AGREEMENT AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.

Signature: _____ Date: _____

Name (Print): _____



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ASSIGNMENT OF BENEFITS

Patient Name: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Mind and Body Counseling Associates, LLC

Or

If my current policy prohibits direct payment to our office, I hereby also instruct and direct you to make out the check to me and mail it to:

Mind and Body Counseling Associates, LLC

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

_____(initial)

A photocopy of this Assignment will be considered, as effective and valid as the original.

_____(initial)

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____(initial)

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____(initial)

Signature of Patient/Claimant or Policyholder

Date

Name (Print): _____



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CONFIDENTIAL HISTORY INFORMATION:
(Please fill out all sections completely)

Why are you here to see us?

List symptoms:

When did the problem(s) first start?

HEALTH HISTORY:

Please provide information about your Primary Care Physician:

Name: _____ Telephone Number: () _____

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

Are you currently taking any prescription medication?

NO YES (List all current medications, the dosage, and how long you've been taking them):

Have you had any previous illnesses or operations? _____



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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- NO YES/previous therapist/practitioner: _____

Have you ever been prescribed psychiatric medication?

- NO YES (Please list and provide dates)

Are you currently experiencing any medical problems?

- NO YES (Please explain):

What is your height? _____ What is your weight? _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems that you are currently experiencing:

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems that you are currently experiencing:

How would you describe your energy levels? _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

How would you characterize your eating habits? (ex. Healthy, organic, processed foods, etc.)



Please list any difficulties you experience with your appetite or eating patterns:

Have you had any recent changes in your weight?

- NO YES (Please explain):
-

How would you describe your mood lately? _____

Are you currently experiencing overwhelming sadness, grief or depression?

- NO YES (Please indicate for approximately how long) _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

- NO YES (Please indicate when you began experiencing this) _____

Are you currently experiencing any chronic pain?

- NO YES (Please describe) _____

Suicide:

Have you ever thought about suicide?

- NO YES (When was the last time?) _____

Have you ever attempted suicide?

- NO YES (When and how?) _____

Do you have thoughts of suicide now?

- NO YES (Please describe) _____

Do you drink alcohol?

- NO YES (Please describe)

How many drinks do you consume in an average day? _____

At what time of the day do you have your first drink? _____

What is the most you have had to drink in a 24-hour period? _____

Have you ever been told, or have you ever felt, that you should cut down on your drinking?

- NO YES

Smoking:

Do you currently smoke cigarettes/tobacco products?

- NO YES (Please describe) _____

Packs per day? _____ What age did you start? _____

Do you currently use marijuana products?

- NO YES

How often in any given day do you use marijuana? _____



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Do you currently, or have you ever, used any illegal drugs or substances?

- NO YES (Please list and indicate if current or past use)
-
-

Do you gamble?

- NO YES (Please describe)

How often do you gamble? _____

At what time of the day do you start gambling? _____

When was the last time you gambled? _____

Have you ever been told, or have you ever felt, that you should cut down on your gambling?

- NO YES

Do you currently, or have you ever had, any addictions to any of the following? (please circle)

NONE / Drugs / Eating / Gambling / Sexual / Spending / Other (explain) _____

Is there any history of domestic violence in your current relationship?

- NO YES

Is there any history of domestic violence in your past relationships?

- NO YES

Have you ever thought about hurting someone?

- NO YES, When was the last time? _____

Have you ever hurt someone else?

- NO YES, When and how? _____

Are you thinking about hurting someone now?

- NO YES

Have you ever been in a physically, emotionally and/or sexually violent relationship?

- NO YES

Are you currently in a physically, emotionally and/or sexually violent relationship?

- NO YES

When you were growing up, did you witness or experience physical and/or sexual abuse from caretakers?

- NO YES

Have you ever been sexually abused?

- NO YES



What significant life changes or stressful events have you experienced recently: (please circle)

Married Engaged Separated Divorced Breakup of an important relationship

Child left home Death of a spouse, other Bad health (behavior) of a family member

Difficulties with a family member Personal injury, illness Retired Lost job Quit job

Owe money Surgery or illness Changed residence Legal difficulties Birth/adoption of a child

Infertility issues Other (please describe) _____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please circle	List family member
Alcohol/Substance abuse	YES/NO	_____
Anxiety	YES/NO	_____
Depression	YES/NO	_____
Domestic Violence	YES/NO	_____
Eating Disorders	YES/NO	_____
Obesity	YES/NO	_____
Obsessive Compulsive Behavior	YES/NO	_____
Schizophrenia	YES/NO	_____
Bipolar Disorder	YES?NO	_____
Suicide attempts	YES/NO	_____



ADDITIONAL INFORMATION:

Do you have any children?

- NO YES (What are their ages?) _____

Are your parents living?

- YES NO (Please list cause of death) _____

Education:

What is the highest grade you completed in school? _____

Do you have a degree?

- NO YES (What is your degree?) _____

Do you enjoy your work?

- NO (Please explain) YES _____

Is there anything stressful about your current work?

- NO YES (Please explain) _____

Do you consider yourself spiritual or religious?

- NO YES (Please describe your faith or belief) _____

LEGAL MATTERS:

Have you ever been convicted of a felony?

- NO YES (Please describe) _____

Do you have a pending lawsuit of any kind?

- NO YES (Please describe) _____

Did your attorney suggest that you see a therapist?

- NO YES (Please describe) _____

Have you applied for Social Security Disability benefits?

- NO YES (Please describe) _____

If NO, do you intend to apply for Social Security Disability benefits?

- NO YES (Please describe) _____

Do you intend to request this therapist to take you out of work for a short term disability or FMLA?

- NO YES (Please describe) _____



DRUG AND ALCOHOL SCREENING INFORMATION

Please respond to each item for yourself and your partner

1. How often do you have a drink containing alcohol?

- | | | | | |
|-------------------------|-----|---|--------------|---|
| a. Hardly ever or never | You | • | Your Partner | • |
| b. Once a week | You | • | Your Partner | • |
| c. Once a day | You | • | Your Partner | • |
| d. More than once a day | You | • | Your Partner | • |

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- | | | | | |
|------------------|-----|---|--------------|---|
| a. One | You | • | Your Partner | • |
| b. Two to three | You | • | Your Partner | • |
| c. Four to six | You | • | Your Partner | • |
| d. More than six | You | • | Your Partner | • |

3. In a typical week in which you do drink, how many days do you have at least one alcoholic drink?

- | | | | | |
|------------------|-----|---|--------------|---|
| a. One | You | • | Your Partner | • |
| b. Two to three | You | • | Your Partner | • |
| c. Four to six | You | • | Your Partner | • |
| d. More than six | You | • | Your Partner | • |

4. How often do you have six or more drinks on one occasion?

- | | | | | |
|-------------------------------|-----|---|--------------|---|
| a. Never | You | • | Your Partner | • |
| b. Once a year | You | • | Your Partner | • |
| c. Two to six times a year | You | • | Your Partner | • |
| d. More than six times a year | You | • | Your Partner | • |

5. Do you use drugs other than those required for medical purposes?

- | | | | | |
|-----------------|-----|---|--------------|---|
| a. Never | You | • | Your Partner | • |
| b. Rarely | You | • | Your Partner | • |
| c. Occasionally | You | • | Your Partner | • |
| d. Frequently | You | • | Your Partner | • |



6. Have you abused prescription drugs?

- | | | | | |
|-----------------|-----|---|--------------|---|
| a. Never | You | • | Your Partner | • |
| b. Rarely | You | • | Your Partner | • |
| c. Occasionally | You | • | Your Partner | • |
| d. Frequently | You | • | Your Partner | • |

7. Do you use more than one drug at a time?***

- | | | | | |
|-----------------|-----|---|--------------|---|
| a. Never | You | • | Your Partner | • |
| b. Rarely | You | • | Your Partner | • |
| c. Occasionally | You | • | Your Partner | • |
| d. Frequently | You | • | Your Partner | • |
| e. Always | You | • | Your Partner | • |

8. Can you get through a week without using drugs?***

- | | | | | |
|-----------------|-----|---|--------------|---|
| a. Never | You | • | Your Partner | • |
| b. Rarely | You | • | Your Partner | • |
| c. Occasionally | You | • | Your Partner | • |
| d. Frequently | You | • | Your Partner | • |
| e. Always | You | • | Your Partner | • |

*****What we mean by the term “drugs”:**

Opiates (e.g., morphine, codeine, heroin)

Depressants (e.g., barbiturates)

Stimulants (e.g., cocaine, amphetamines)

Hallucinogens (e.g., LSD, Mescaline)

Marijuana, Hashish

Other illegal substances (e.g., Psilocybin, DMT, DET, PCE, PCP, TCP)