

Dr. David B. Rosenthal, Psy.D., LPC

PERSONAL DATA INVENTORY

The information requested on this form is important for our records. However, please feel free to not answer any questions you are uncomfortable answering. Those items can be discussed in person if you would prefer.

Date: _____
Name _____ Home phone _____ Work phone _____
Cell Phone _____ Email address _____
Please indicate where we may leave a voice message: Home ___ Work ___ Cell ___
May we contact you by email regarding appointments? Yes ___ No ___
Address _____ City _____ ZIP _____
Occupation _____ Sex _____ Birth date _____ Age _____
Education (last grade or degree completed) _____ Social Security # _____
Marital status: Single ___ Cohabiting ___ Married ___ Separated ___ Divorced ___ Widowed ___

HEALTH INFORMATION

Rate your health: Very good ___ Good ___ Average ___ Declining ___ Poor ___

Your approximate weight ___ lbs. Recent (3 months) weight change: Lost ___ lbs. Gained ___ lbs.

List all important present or past illnesses, injuries, or handicaps: _____

Primary physician _____ Physician's phone number _____

Date of last physical exam _____ Date of last routine blood work _____

Please list any over-the-counter or prescription medications you currently take _____

Please list any drugs you have used for recreational purposes: _____

Have you ever been arrested? Yes ___ No ___

Have you ever experienced a severe emotional upset? Yes ___ No ___

If yes, please explain _____

Have you recently suffered any personal, business, or financial loss? Yes ___ No ___

If yes, please explain _____

Have you ever been the victim of a crime? Yes ___ No ___

Women: Are you pregnant? Yes ___ No ___ Do you have a regular menstrual cycle? Yes ___ No ___

Have you ever terminated a pregnancy? Yes ___ No ___ Have you ever miscarried? Yes ___ No ___

PERSONALITY INFORMATION

Have you previously seen a counselor or therapist? Yes ___ No ___

If yes, please list the dates and name of therapist(s): _____

What was the outcome? _____

Circle any of the following words which currently describe you: active ambitious self-confident
persistent nervous hardworking impatient impulsive moody often-blue excitable imaginative calm
serious easy-going shy good-natured introvert extrovert likable leader quiet stubborn submissive
lonely self-conscious sensitive short-tempered. Other _____

MARRIAGE AND FAMILY INFORMATION

Name of spouse _____ Date of marriage _____ Years married _____
 Spouse's address (if different from yours) _____
 City _____ State _____ ZIP _____ Phone _____
 Occupation _____ Work phone _____ Spouse's date of birth _____
 Spouse's education (last grade or degree completed) _____ Religion _____
 Is spouse willing to come for counseling? Yes ___ No ___ Unsure ___
 Have you ever separated from your current spouse? Yes ___ No ___ When? From _____ to _____
 Have either of you ever filed for divorce? Yes ___ No ___ When? _____
 Age when married: Husband _____ Wife _____
 How long did you know your spouse before marriage? _____
 Length of steady dating with spouse _____ Length of engagement _____
 Give brief information about any previous marriages _____
 Information about children:

*PM	Name	Age	Sex	Living (Y/N)	Lives with you (Y/N)	Marital status

*Check this column if child is by a previous relationship.
 If you were reared by anyone other than your own parents, briefly explain
 How many older brothers _____ and/or sisters _____ do you have?
 How many younger brothers _____ and/or sisters _____ do you have?

RELIGIOUS BACKGROUND

Denominational preference (current) _____ Church Member? Y N
 Church attendance per month (circle one): 0 1 2 3 4 5 6 7 8+
 Church you currently attend: _____ Church denomination in childhood _____
 Note any recent changes in your spiritual life, if any _____

In case of an emergency, please list the name, address, and telephone number of two people in the Lubbock area that we may contact on your behalf.

Name _____	Name _____
Address _____	Address _____
City _____	City _____
Phone _____	Phone _____
Relationship _____	Relationship _____

PROFESSIONAL DISCLOSURE AND STATEMENT OF CLIENT RIGHTS

• **Regarding the nature of Counseling:** As you talk about your thoughts, feelings, and experiences, we will work together as partners to gain the understanding and insight necessary for change to occur. Any goals for counseling and/or decisions you make to facilitate change are ultimately up to you. Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you may end our counseling relationship at any time without any additional moral, legal, or financial obligation, though I do ask you participate in a termination session. At any time, either you or I may initiate discussion of possible positive or negative effects of continuing or not continuing counseling, and/or using or not using certain techniques. You have the right to ask any questions about the procedures used during therapy. If you wish, I shall explain all therapeutic procedures and their

rationales to you.

• **Regarding Counseling Sessions and the Counseling Relationship:** Sessions are usually held weekly for about 50 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me. In the event of an emergency, you may contact me by phone. Due to ethical guidelines, I ask that you do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will best be served if our sessions concentrate exclusively on your concerns. My services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible for me to guarantee you any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

• **Regarding audio/video recording of sessions:** You will be informed of and have the right to prevent any electronic recording of any part of the therapy sessions. Recording of therapy sessions could be used for purpose of review by you, me, or other professionals with whom I might consult in order to maximize the benefit to you of our time together. You also have the right to withdraw your permission to record at any time.

• **Regarding confidentiality:** There are certain situations in which as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies—even if you do not grant permission for me to do so. Those situations are outlined in the document “Notice of Privacy Practices.” If you have any questions about those situations, please review that document.

• **Regarding complaints about treatment I provide:** You have the right to decide not to receive psychotherapy from me. If you wish, I shall provide you with the names of other qualified therapists. A verbal exploration of alternatives to counseling will also be made upon request. If at any time you are dissatisfied with my services, please let me know. You also have the right to address any complaints against licensed professional counselors to the Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, Texas 78756, 1.800.942.5540 or complaints against social workers to the Texas State Board of Social Workers Examiners (same address), 1.800.232.3162.

By signing below you are stating that you have read and understood this policy statement. In addition, you consent to participate in evaluation and/or treatment. You have had your questions concerning this document answered to your satisfaction.

Client: _____ Therapist: _____ Date: _____

PATIENT FINANCIAL CONSENT STATEMENT

• **Fees due when services rendered:** All fees for counseling are due after each session unless other arrangements have been made in advance. David Rosenthal, LPC accepts payment by exact cash or check. If you have any questions concerning your account, please contact the office.

• **Returned check fee:** If a check is returned to us, a processing fee of \$25.00 will be assessed to your account. Additionally, you will need to make a cash or money order payment for the amount of the returned check and the \$25.00 processing fee. David Rosenthal, LPC may require cash payment for future appointments if we receive a returned check.

• **Late cancellations/no shows:** There will be no fee for late cancellations or no shows, however, two or more of these may result in termination and referral to another counselor. A “late cancellation” is defined as canceling within the 24 hour period prior to your appointment. A “no show” is defined as failing to attend an appointment without prior notice.

• **Fee structure:** The standard and customary fee for a session (a session is 50 minutes from start to finish) is \$90.00.

I have read, understand, and agree to the payment information as stated above.

Signature of Client/Responsible Party

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.

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform

you of the uses and disclosures of confidential information that may be made by David Rosenthal, LPC and of your individual rights and David Rosenthal's legal duties with respect to confidential information.

Ways in Which We May Use and Disclose Your Protected Health Information

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

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.
- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third party payer. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.
- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. *For example* – a family member, relative, close friend, pastor, or pastor's representative with whom you have asked us to communicate.

We will use and disclose your protected health information *when required by federal, state, or local law*. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to other persons or agencies – even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an 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 relying on your previous authorization.

Please sign to indicate you understand our operational use of your information for treatment, payment, and health care operations as stated above.

Signature of Client/Responsible Party

Date

Your Health Information Rights:

Although your records are the physical property of David Rosenthal, LPC, the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to David Rosenthal, LPC.

You have:

- The right to request restrictions on certain uses and disclosures of your information. However, we are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. *For example* – a request that we not identify the agency when we contact you. (i.e. "This is David Rosenthal calling.")
- The right to inspect and copy the information we maintain about you. However, we **may deny an individual access**, provided the individual is given the right to have such denials reviewed, in the following circumstances:
 - A health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to **endanger the life or physical safety of the individual or another person**.
 - The information makes **reference to another person** (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to

cause substantial harm to such other person.

- The request for access is made by the individual's personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representatives is reasonably likely to ***cause substantial harm to the individual or another person***.
- If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- The right to billing records.
- The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternate means. For example, at your regularly scheduled appointment, by email, or by fax.
- The right to amend your information if you feel it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to you request within 60 days. In rare cases your request may be denied.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a complaint if you believe we have violated your medical information privacy rights. You have the right to file a written complaint to David Rosenthal, LPC or directly to the Secretary of Health and Human Services.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office. 806 799-3188

Signature of Client/Responsible Party

Date