INTENSIVE TREATMENT MODALITIES
Alvin Butler, LMHC ♦ Harry Spears, LMHC
225 SW 7th Terrace • Gainesville, Florida 32601
352-379-2829 • 352-379-2843 Fax
www.itmflorida.com

INFORMATION FOR NEW CLIENTS

Effective communication between client and therapist is an important part of the therapy process. The following information covers many of the questions that may arise about therapy and includes a listing of the client's rights and responsibilities. Any questions you may have that are not covered in this notice should be brought to the attention of The ITM Group and Associates staff.

CLIENT RIGHTS

The following is not a list of legal rights, but rather is a statement of what you can reasonably expect from The ITM Group and our Clinicians. As a client receiving treatment at our office you are entitled to:

- Be treated with dignity, courtesy and respect
- Ask Questions relevant to your care.
- Know when your clinician is available to see you, or if not, how long the waiting period would be.
- Be informed about areas of specialization and limitations.
- Ask questions about written materials regarding your treatment.
- Actively participate in developing your treatment goals.
- Be informed regarding fees for treatment and method of payment, including insurance reimbursements.
- Discuss aspects of your treatment with others, including consulting with other clinicians.
- Request that a written report regarding services rendered to a qualified professional, or organization upon your written authorization.
- Request information about the Code of Ethics to which The ITM Group and their Clinicians adheres
- Terminate therapy at any time.
- Confidential communication in accordance with State and Federal law, and best practices of the profession (A copy of our Notice of Privacy Practices is kept in the waiting area)

EMERGENCY PROCEDURES

During after hours or weekends if you have an emergency or a life threatening situation please call the Alachua County Crisis Center (352) 264-6785 or 911.

TREATMENT METHODS

Counseling sessions are generally around 60 minutes in length. The frequency of sessions and the length of your treatment are aspects of therapy that you and your clinician will decide together based on your individual treatment needs and progress. Generally, various modalities of treatment are utilized for different problems. Please ask, if you have any questions about the nature of your treatment.

DISSATISFACTION WITH TREATMENT

Sometimes a client will not obtain the desired results or goals from therapy in the time period expected. This can result in frustration and dissatisfaction. During the process of therapy, emotional distress can arise as difficult issues are processed. Please discuss this with your clinician. If your concerns are not resolved, and adequate progress is not being made or if it becomes apparent that your clinician is not a good "fit" with you, your clinician may either make a referral for more specialized care, or discontinue therapy and assist with a referral to an appropriate therapist, health care professional or treatment program.

You may frequently have questions for our support staff. Jackie Piel manages the front desk and is often the person who schedules appointments and any questions related to insurance or billing just prior to seeing your clinician. The front desk staff will schedule follow up appointments as you leave the office. If there is already someone being served at the front desk, please wait in the waiting room to be served. This allows us to maintain a greater degree of confidentiality. As a service to you, the staff will usually call you the day prior to your appointment as a reminder, however, if they cannot call, THIS REMAINS YOUR RESPONSIBILITY to remember your appointments. We will send you a monthly statement for your records. If you would rather that we not send a statement to a particular address, or call you at a particular number, please let our staff know.

The staff is committed to providing you with care that is helpful. The ITM Group and our clinicians pursue excellence in a variety of clinical treatments. The ITM Group and our clinicians provide individual therapy with a wide population, and perform psychological evaluations. The ITM Group practices in a setting that includes many clinicians, therefore allowing easy referral to a professional that will likely meet your needs. We welcome any suggestions you may have about how we might improve the quality of services we provide.

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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.

FEDERAL LAW REQUIRES THE PROVISION OF THIS NOTICE

We are required by law to maintain the privacy of Protected Health Information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request. WE are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint. Or Privacy Officer is Alvin Butler, LMHC. You can contact the Privacy Officer by calling (352) 379-2829.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAY MAKE TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

We may use information I your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital etc. For example, if we want an opinion about your condition from a specialist to obtain a consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may disclose information from your record to allow "health care operations". These operations include activities like reviewing records to see how care can be improved, contacting you with information about the treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

YOUR RIGHTS

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request for amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices. Including the actions of our staff with respect to the privacy of your health information. You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you five your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or claim under the policy even if you revoke the authorization.

USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE ARE REQUIRED TO MAKE WITHOUT YOUR PERMISSION:

In certain circumstances, we are required by law to make a disclosure of your health information. For example, State Law requires us to report suspected child abuse or neglect. Also, we must disclose information the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

We may use or disclose information from your record if we believe it is necessary to prevent or lesson a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE ARE ALLOWED TO MAKE WITHOUT YOUR PERMISSION:

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations. If you receive mental health care, including treatment for substance abuse, information relating to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or other. We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions and

product defects. We may assist health oversight activities, such as investigations of possible health care fraud, We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even If this is not ordered by a court. WE may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it. If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to saw enforcement officials.

We may use or disclose information from your record for research under certain conditions. Under certain conditions, we may disclose information for specialized government purposes, such as military, nation security and intelligence or the protection of the President.

The confidentiality of protected health information related to alcohol or drug abuse is protected by federal law regulations. Violations of the federal law and regulations is a crime and may be reported to appropriate authorities. We may not disclose any information about you unless you authorize the disclosure in writing, except as specified. We may disclose information about you if a court orders the disclosure. We may disclose information about you in a medical emergency, to permit you to receive needed treatment. We may disclose information about you for purposes of program evaluations, audits or research. We may disclose information about you if you commit a crime on our premises or against any person who work for us or if you threaten to commit such a crime. We are required to disclose information about you if we suspect child abuse or neglect. Except as stated in this Notice, you have the same rights and protections with respect to your health information as described in our general Notice of Privacy Practices.

We may contact you to provide appointment reminders as a courtesy. WE may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

_____

Client Name

_____

Client Signature

_____

Date

PRELIMINARY EVALUATION INFORMATION

Identifying Information **Date**_____

Patient Name:_____SS #:_____
Address:_____City:_____State:____Zip:_____
Phone (H):_____(W):_____Ext:_____
Date of Birth: _____/_____/_____ Sex: Female or Male

Referred By:_____

Place of Employment / Occupation: Yours:_____
Spouses:_____

Highest grade level of education completed:_____
Degree achieved:_____

Presenting Problem

Please describe the problems which have led you to seek treatment or evaluation.

_____
_____

What do you believe to be the most important factor (s) causing the problem (s)?

_____
_____

When did you first notice these problem (s)?:_____

Have there been any family changes (new baby, death, divorce, etc.) Which may be related to these problems?
_____Please explain:_____
_____

Have you ever been seen for counseling or therapy? Yes_____ No_____
As an outpatient (clinic, private, etc.)

Name:_____Phone (____)_____
Address:_____City_____State_____Zip_____
For how long?_____Dates:_____
Name of doctor / therapist_____
Reason for treatment_____

Name:_____Phone (____)_____
Address:_____City_____State_____Zip_____
For how long?_____Dates:_____

Name of doctor / therapist_____
Reason for treatment_____

As an inpatient (in a hospital, residential treatment center, etc.)
Name_____Phone (___)_____
Address_____ City_____State____Zip_____
For how long?_____Dates:_____
Name of doctor / therapist_____
Reason for Admission_____

Name_____Phone (___)_____
Address_____ City_____State____Zip_____
For how long?_____Dates:_____
Name of doctor / therapist_____
Reason for Admission_____

Have you taken standard psychological assessments, (e.g. intelligence testing or personality evaluation)? Yes _____ No _____

Name of Psychologist_____Phone (___)_____
Address_____Dates_____

Medical History

Family Doctor_____Phone (___)_____

Have you ever been in the hospital for medical problems? Yes_____ No _____

Dates	Names of hospital, city & state	Reason for hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any serious or chronic physical or medical conditions (diabetes, etc.)? Yes_____ No_____
If yes, please explain?_____

Are you presently taking any prescribed / non-prescribed medication? Yes_____ No_____, If yes Please explain?_____

Medication	Prescribed by	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies? Yes _____ No _____ If yes, describe what they are and list any medication (s) you take:_____

Have you been injured in any accidents or falls? Yes _____ No _____, If yes, Please describe:

Incident	Age	Injury
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you suffered any complications of illnesses or accidents (high fever, convulsions, coma, etc.)? Yes_____, No _____ If yes, please describe the circumstances:_____
_____

Were you ever unconscious, in a coma, or had a concussion as a result of illness or injury? Yes_____ No____, if yes, please explain:_____

Do you now, or have you in the past, used alcohol or other drugs on a regular basis? Yes ____ No ____ If yes, how often and how much?

Type of Drug (Include alcohol)	How Often?	How much in each episode?
_____	_____	_____
_____	_____	_____

Do you now, or have you in the past, smoked cigarette / cigars / pipes on a regular basis? Yes ___ No____ If yes, how often and how much?_____

Have you experienced difficulty with any of the following?: (Please (check) items that are currently a problem)

_____ Headaches
_____ Numbness / tingling in extremities
_____ Difficulty with hearing
_____Shortness of breath
_____Trouble with swallowing
_____Weight gain or loss in past year
_____Preoccupation with weight
_____Itching of skin
_____Hyperactivity
_____Nervousness
_____Attention / Concentration problems
_____Chronic fatigue or weakness
_____Sudden behavior changes
_____Impulsive: act without thinking
_____Physical assault (s) / abuse
_____Anxiety / panic episodes
_____Problems with sexual behavior
_____Family / relationship difficulties
_____Unusual experiences
_____Suicide attempts
_____Problems with the law
_____Problem maintaining balance

_____Seizure
_____ Fainting or black-out spells
_____Difficulty with vision
_____High blood pressure
_____Diarrhea, chronic
_____Loss of appetite
_____Eating problems
_____Skin rash
_____Crying spells
_____Mood spells
_____Ringing in ears
_____Problems thinking clearly
_____Sudden personality changes
_____Depression anxiety
_____Sleeping problems
_____Financial problems
_____Occupational problems
_____Learning problems
_____Social relationship problems
_____Disturbing thoughts
_____Suicidal thoughts
_____Memory problems / difficulty

Pregnancy Information (Women Only)

Were there any physical or emotional difficulties during pregnancy with your children or during your mother=s pregnancy with you? Yes_____ No _____ If yes, please describe:_____
_____

Were you or were any of your children premature? Yes _____ No _____ If yes, please give the number of weeks early:
_____Self / _____Child_____

Were there any of the following complication? Mother taking medication or drugs (specify):_____
_____ Long labor_____Forceps delivery_____Breech birth _____ Eclampsia_____ Caesarean Section_____ other _____
Were there any immediate complication following delivery of you children or with you? Yes _____
No _____ If yes, please describe:_____
_____

Number of pregnancies _____ Number of miscarriages_____ Weight of largest child at birth _____

Family Information

Has anyone in the family (including grandparent) been treated for a mental health problem? Yes_____
No _____ If yes, please explain:_____

_____

List individuals that live in your home:_____

Family History	**Age**	**State of Health** (If deceased, list cause)	**Occupation**
Father	_____	_____	_____
Mother	_____	_____	_____
Brother (s)	_____	_____	_____
	_____	_____	_____
Sister (s)	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children M F	_____	_____	_____
(circle M F	_____	_____	_____
One) M F	_____	_____	_____
M F	_____	_____	_____

Who In Your Family Had:	**Father**	**Mother**	**Sister (s)**	**Brother (s)**	**G-Parent**
1. Cancer	_____	_____	_____	_____	_____
2. Drinking Problems	_____	_____	_____	_____	_____
3. Allergies or Asthma	_____	_____	_____	_____	_____
4. Strokes	_____	_____	_____	_____	_____
5. ANervous Breakdown@	_____	_____	_____	_____	_____
6. Suicide	_____	_____	_____	_____	_____
7. Convulsions / epilepsy	_____	_____	_____	_____	_____
8. Headaches	_____	_____	_____	_____	_____
9. Diabetes	_____	_____	_____	_____	_____
10. Drug Abuse	_____	_____	_____	_____	_____
11. Ulcers	_____	_____	_____	_____	_____
12. High Blood Pressure	_____	_____	_____	_____	_____
13. Depression	_____	_____	_____	_____	_____

Marital History

Present marital status: Single _____ Married _____ Divorced _____ Widowed _____

If married, Spouses name:_____SS#_____
Date of birth: ____/____/____ Date present marriage began: ____/____/____

Children by present marriage:

Name	Birth Date or Age
_____	_____
_____	_____
_____	_____

Previous marriages:

Date Married	Date Divorced	Reason for Divorce	Children by each Marriage & Ages
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employment

Present job title / job description and organization:

_____

_____

Do you have problems performing your job? (Yes___ No___) If yes, please explain:_____

_____

_____

Do you have problematic relationships with people on the job? (Yes____ No ____) If yes, please explain:

_____

How many jobs have you held within the past five years?_____

Reason for changes in job:_____

_____

I understand that this information will be used in my evaluation and will be included in my records.

Signed_____ Date_____

Patient

Re-Disclosure: Persons, agencies, or institutions to whom this information is disclosed are prohibited by state / federal law from re-disclosure without the specific written consent of the person to whom it pertains. A general authorization for release of medical information is NOT sufficient for this purpose.