Deb Lang, PsyD – Licensed Psychologist – Creating Choices PC

CONFIDENTIAL CLIENT INFORMATION FORM

Full Name: _____ Today's Date: _____

Nickname/Preferred Name: _____ Age: ____ Date of Birth: _____

Complete Address (including zip):
_____
_____

Preferred Contact Phone #'s:
_____/_____/_____
(Home) (Work) (Cell)
Do I have your permission to leave a message at these numbers? _____

Email Address: _____

Person to contact in case of emergency_____ Phone #_____

Your Occupation: _____ Place of Employment:_____

Who suggested that you contact me? _____
(e.g.,- a friend, physician, phonebook)
May I briefly contact this person or agency to acknowledge the referral? ___ Yes ___ No
If yes, your signature_____

Name of your health care provider(s) and date of last visit:
_____

List any health problems for which you are currently receiving treatment.
_____
_____

Please list any medications which you are now taking and the condition for which you take them:
_____
_____

*****Please complete both sides of these sheets******

Please describe any other significant health problems that you have had in the past:_____

_____

Please list the current members of your household:

Name	Age	Relationship	Occupation

Have you been in counseling or therapy before or received any type of psychiatric help? ___ Yes ___ No Hospitalized? ____ Yes ____ No
If you have, please briefly state reason, year and the name of the professional seen:

_____

_____

Briefly describe your reasons for seeking counseling:_____

_____

_____

What are your goals for counseling (what would you like to accomplish or to be different in your life?

_____

_____

Please add any additional information which you feel may be helpful_____

_____

_____

Please circle any of the following problems that pertain to you:

Abandonment	Elevated Mood	Panic Attacks
Abuse	Fatigue	Paranoia
Aggression	Finances	Restricted Eating
Anger	Flashbacks	Sadness
Anxiety/Anxiousness	Grief/Loss	Self-harming behaviors
Binging/purging	Guilt	Harsh/critical/low self-compassion
Chronic pain	Hallucinations	Sleep- falling asleep
Concentration	Hopelessness	Sleep – staying asleep
Compulsive/emotional Eating	Hyperactivity	Self-control
Decreased energy	Impulsivity	Sexual Difficulties
Decreased enjoyment	Inattention	Physical health
Depression	Irritability	Suicidal Ideation – current/past
Dissociation	Isolation	Substance abuse
Divorce/Separation	Legal	Suspiciousness
Eating Issues	Life Change	Trauma - current
Educational difficulties	Memories	Trauma- past
Body Image	Nightmares	Weight loss
Compulsions	Obsessions	Withdrawing/Isolating
Weight Gain	Occupational	Worried

Other_____

Please complete the insurance information on the following page if you would like your bills submitted to your insurance company.

Insurance Information – Please bring a copy of your insurance card-

Insurance Company:_____

Subscriber ID#_____ Group #_____

If the subscriber is someone other than yourself, please provide the following information:

Subscriber's full name:_____

Address:_____

_____

Please note - I am an in-network provider with Allegiance, Blue Cross, Cigna (not EAP), First Choice Health, Medicare, MHNet, and Pacific Source. If you have other insurance, please call them, prior to our first session, to determine whether you require preauthorization.

Thank you for completing this form.

Creating Choices PC - Deb Lang Psy.D. - Licensed Psychologist
P.O. Box 1050- Bigfork, MT 59911

*****Please review the referenced documents before completing this page.*****

Consent for Treatment
I have read, understand and consent to the information provided in the Consent for Treatment Form. I understand that I can discontinue this therapy agreement at anytime, but will be responsible for any fees incurred prior to discontinuing treatment. I agree to waive any right to subpoena the therapist to testify in any court proceedings.

Signed_____ Date_____

Cancellation Policy
I have read and agree to the cancellation Policy.

Signature_____ Date_____

Telepsychology Informed Consent
I have read and consent

Signature_____. Date_____.

HIPAA
My signature below indicates that I have received or read Deb Lang, PsyD.'s Notice of Policies and Practices to Protect the Privacy of Your Health Information.

Signature_____ Date_____

Insurance Authorization
I authorize the release of any information necessary to process my insurance claim and request payment of insurance benefits either to myself or to Deb Lang, Licensed Psychologist.

Signed _____ Date_____

Release of Information
I give my consent for the release of information to/from Deb Lang, Psy.D. and my primary health care provider (physician, nurse practitioner, etc). ***This is not a requirement for treatment.***

_____
Name of provider

Signed_____ DOB:_____ Date_____

Credit Card Charge Authorization Form

****Please do not include your credit card information on this form****

I, _____ (printed name) authorize Deb Lang, Licensed Psychologist, to enter my credit/debit card information into the secure payment site used to process my therapy charges and authorize her to charge agreed upon fees for my therapy services to my card.

I _____ (printed name) authorize Dr. Lang to charge my card for sessions missed without, a minimum of, 24 hours, notice and without a "valid excuse". A valid excuse means that you cannot come to your session, versus you have chosen to do something else. Examples of this include an act of nature/God preventing your arrival, a communicable illness (i.e. cold, flu), hospitalization or otherwise medically incapacitation, involvement in an emergency, or if any of these happen to a family member in your direct care.

I also understand that any outstanding balances over 30 days will be charged to my card unless other arrangements have been made.

I agree to notify Dr. Lang should this card become invalid and to provide her with my new card information.

_____ _____

Signature Date