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Name:Address:	Gender: M F Age:
	Date of Birth: / /
City: State:	_ Zip:
SSN:/	
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be contacted first.	The maleate the number at which you wish to
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Current Physician:	
Physician Address:	
Physician Address: Physician Phone Number: ()	
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REFERENT INFORMATION	
BY WHOM WERE YOU REFERRED?	EAV: ()
PRONE: ()	FAX: ()

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Blake Bazel, Ph.D., Licensed Clinical Psychologist 1677 Wells Road, Suite A Orange Park, Florida 32073

PSYCHOLOGIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

APPOINTMENTS
Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES □The standard fee for the initial intake is

\$160.00 and each subsequent session is \$135.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment can be made by check, cash, or credit card (MasterCard, Visa, American Express, or Discover). Any checks returned to my office are subject to an additional fee to cover the bank fee that I incur.

PROFESSIONAL RECORDS I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

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confidentiality.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

- 2. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
- 3. I would have to contact the appropriate agency, including Child Protective Services and/or the Department of Children and Families, if I have good reason to believe that you or other persons are abusing or neglecting a child or vulnerable adult.
- 4. I would have to contact the appropriate agency and/or mental health facility if I believe that you are in imminent danger of harming yourself.
- 5. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

CONTACTING ME: If I am not immediately available by telephone, you may leave a message and your call will be returned as soon as possible. If, for any number of unseen reasons, you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact Community Mental Health Services in your county, 2) go to

your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

Y□ Your signature below formation in this form and agree to
Date
Date
al Psychologist Date

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CONSENT TO PSYCHOTHERAPY indicates that you have read the infoits terms.	Your signature below mation in this form and agree t		
Signature of Patient	Date		
Printed Name of Patient	Date		
Blake Bazel, Ph.D., Licensed Clinical	Psychologist Date		

Release of Information (to Insurance)

Client	
Name:	
Address:	
Phone number:	
I authorize Dr. Blake Bazel , Ph.D. ar release billing information which may in type of services, diagnoses codes, substand/or treatment plans to my insurance of collecting insurance benefits or for a sessions.	nd all business partners to nclude client name, date and ance abuse information e company/ies for the purpose
Information to be shared:	
Billing	
I understand that my records are prote	cted under State and Federal
confidentiality regulations and cannot written consent unless otherwise providules ounderstand that I may revoke this the extent that action has already been automatically one year from the date significant that it is a significant to the confidence of the confide	ded for in the regulations. I consent at any time, except to taken. This consent expires
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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:	DATE:			
Over the last 2 weeks, how often have you been bothered by any of the following problems?			light.	N day
(use "✓" to indicate your answer)	Hol al all	Several days	More than he	WEATH BUFFY THE
Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
	add colur	nns:	+	+
(Healthcare professional: For interpretati please refer to accompanying scoring ca		TAL:		
10. If you checked off any problems, how			Not difficult a	t all
difficult have these problems made it for you to do your work, take care of things at			Somewhat di	flicult
home, or get along with other people?			Very difficult	
			Extremely dif	ficult

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at http://www.pfizer.com. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

Name.		t de view for a constituent and interesting to deposit and analysis of the view of the vie	Dale:	eritariya karan yayan ilgi sa karan karan karan karan ya
	PRESENTING PROBL			
Describe the problem that bro	rught you here today:			
Please check all of the behav Distractibility Hyperactivity Impulsivity Boredom Poor memory/confusion Sessonal mood changes Sadness/depression Loss of pleasure/interest Hopelessness Thoughts of death Self-harm behaviors Crying spells Loneliness Low self worth Guitt/shame Fatigue Other:	and the state of t	u consider problem petite ition im people im home fort ughts shavior fits ments in	alic: Suspicion/pai Pacing thoug Excessive en Wide mood s Sleep probler Nightmares Eating proble Gambling pro Computer ad Problems witl Parenting pro Sexual proble Relationship Work/school Alcohol/drug	rancia hts ergy wings ns blems siction h pomography blems ems problems
e your problems affecting an Handling everyday tasks Work/School Recreational activities	Self esteem Housing Sexual activity	☐ Relationship ☐ Legal matter ☐ Health	• 🗆	Hygiene Finances
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Yes No Have you ev	er had thoughts, made sta	lements, or attempt	ed to hurt some	ne else? If yes.
	cently been physically hurt			/ /*

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Stepfather) 		Manic Depression	ربار ويونيسيون ويويسون ويونيون
Siblings			Suicide	
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INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

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