TJocelyne Counseling
& Consulting Group

Tamarra Aristilde, LMFT, NCC
www.TJocelynecounseling.org

425 Pleasant Street, First Floor. Brockton, MA02301

Adult Intake Form

Name:_____Date: _____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell:_____Work:_____

Email:_____Referred by _____

Please indicate if messages can be left or mail sent:

Home Phone: ☐ yes ☐ no Work Phone: ☐ yes ☐ no Cell Phone: ☐ yes ☐ no Home Address: ☐ yes ☐ no

In case of emergency, please contact_____Phone:_____Relationship: _____

Date of Birth:_____Social Security #:_____-_____-_____

Age:_____Marital Status (circle): S M W Se D # Years Married: Spouse Name: _____

Children (names & ages): _____

Place of Employment: _____ Occupation: _____

Briefly describe why you are seeking therapy at this

time: _____

_____

_____

Primary Care Physician:_____Phone: _____

Do we have your permission to coordinate care with your Primary Care Physician ? ☐ yes ☐ no

Date of last physical examination? _____

Treating Psychiatrist:_____Phone: _____

Current Medications: Dosage Prescribing Physician

_____

_____

_____

_____

Previous Therapist:_____Dates of Service: _____

Issues addressed in therapy: _____

_____

_____

_____

Do you currently have any medical conditions that you are being treated for? ☐ Yes ☐ No

Please explain. _____

If you have ever been hospitalized please list when and for what reason. (Please include pregnancy and abortion)

Have you ever experienced any trauma in your life? ☐ Yes ☐ No If so, please briefly explain. _____

List 5 things about yourself that you like: _____

List 5 things about yourself that you would like to change: _____

What are your major strengths? _____

Have any anniversaries of important or stressful events in your life occurred recently or are any due to occur soon?

List any major problems or stressful events that other family members or close friends are currently dealing with:

What solutions or efforts have you tried to solve the problems that bring you here? _____

Do you have any religious affiliation? _____ If so, what denomination? _____

Are you ☐ practicing or ☐ non practicing in your faith?

Do you want to have your faith integrated into therapeutic treatment? ☐ Yes ☐ No

Family History

Relationship	Living	Deceased	Age	If living, location
Mother:				
Father:				
Brothers:				
Sisters:				

Is there any family history of mental illness? ☐ Yes ☐ No

Are there issues with your family of origin that you believe are influencing the quality of your life today? If so, please describe:

_____

_____

Do you drink alcohol? ☐ Yes ☐ No

If so, how much beer, wine or hard liquor do you consume each week on the average? _____

Have you ever felt the need to cut down on your drinking? ☐ Yes ☐ No

Have you ever felt annoyed by criticism of your drinking? ☐ Yes ☐ No

Have you ever felt guilty about your drinking? ☐ Yes ☐ No

Have you ever had a Driving Under the Influence arrest? ☐ Yes ☐ No Date: _____

Do you smoke cigarettes? ☐ Yes ☐ No How many packs per day? _____

Do you have any compulsive behaviors that you would like to address in therapy? _____

_____

_____

_____

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE

____Aggression
____Alcohol use
____Anger
____Anxiety
____Chronic pain
____Compulsive behavior
____Concentration problems
____Cyber addiction
____Depression
____Disorientation
____Distractibility
____Dizziness
____Drug dependence
____Eating disorder
____Fatigue
____Flashbacks
____Grief
____Hallucinations
____Heart palpitations
____High blood pressure
____Hopelessness
____Hyperactivity
____Impulsivity
____Irritability
____Loneliness
____Memory impairment
____Mood swings
____Obsessive thoughts
____Panic attacks
____Phobias/fears
____Poor judgment
____Self-esteem problems
____Sexual difficulties
____Sleep problems
____Social withdrawal
____Suicidal thoughts
____Thoughts disorganized
____Trembling
____Unresolved trauma
____Worrying
____Other (specify):_____

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST

____Aggression
____Alcohol use
____Anger
____Anxiety
____Chronic pain
____Compulsive behavior
____Concentration problems
____Cyber addiction
____Depression
____Disorientation
____Distractibility
____Fatigue
____Flashbacks
____Grief
____Hallucinations
____Heart palpitations
____High blood pressure
____Hopelessness
____Hyperactivity
____Impulsivity
____Irritability
____Loneliness
____Panic attacks
____Phobias/fears
____Poor judgment
____Self-esteem problems
____Sexual difficulties
____Sleep problems
____Social withdrawal
____Suicidal thoughts
____Thoughts disorganized
____Trembling
____Unresolved trauma

___Dizziness ___Memory impairment ___Worrying
___Drug dependence ___Mood swings ___Other (specify):____
___Eating disorder ___Obsessive thoughts

_____

Alcohol and Substance Use:

Have you ever been treated for Opioid or drug dependence/abuse?
__Yes No

Have you ever felt like you should cut on Opioid or other drug use?
__Yes No

Has a friend or relative ever discussed concerns about your Opioid or drug use? Yes_____
No

Is there a history of problems with Opioid or drug use in your family?
__Yes No

Have you received help for drug or Opioid dependency?___No ___Yes
If yes,

When?_____Where?_____

Check one: Treatment was___helpful___not helpful. Please explain.

_____
_____

D. MEDICATION

Current Prescribed Medications	Dose	Frequency	Purpose and Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your medical history.

_____

_____

Please describe your mental health history.

_____

_____

TJocelyne Counseling & Consulting LLC
Tamarra Aristilde, LMFT
425 Pleasant Street
Brockton, MA 02301

Consent for Treatment

F. Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Authorization to Release or Obtain Health Information (including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize: PRIMARY CARE SERVICE PROVIDER/FACILITY

Name: _____ Mailing

Address: _____ City, State,

Zip Code: _____ Relationship: _____

Telephone Number:___

❒ **RELEASE Information TO** or ❒ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: TJOCELYNE COUNSELING & CONSULTING LLC /TAMARRA ARISTILDE, LMFT, NCC

Mailing Address: 425 PLEASANT STREET FIRST FLOOR, LEFT OFFICE

City, State, Zip Code: BROCKTON, MASSACHUSETTS, 02301

Relationship: BEHAVIORAL HEALTH SERVICE PROVIDE Telephone Number: 5085800364

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal

❒ Changing Provider ❒ Research related treatment

❒ Creating health information for disclosure to a third party.

❒ Other: (Specify)_____

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)

☑ Entire Record ❒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

❒ Alcoholism ❒ Drug Abuse ❒ Mental Health ❒Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

_____ _____
Signature of Individual or Personal Representative authorized by law Date

Please submit medical information to:

Agency Representative	**Title**	**Date**
Telephone	**Fax**	**Email**

Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information you will be given a copy of the signed form, upon request

A separate signed authorization form is required for the use and disclosure of health information for:

- ✓ Psychotherapy notes
- ✓ Employment-related determinations by an employer
- ✓ Research purposes unrelated to your treatment

When required by law or policy, TJocelyne Counseling & Consulting LLC may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

- ✓ An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, TJocelyne Counseling & Consulting LLC will use and disclose your health information as you have authorized on the signed authorization form.

- ✓ You may be required to sign an authorization before receiving research-related treatment.

- ✓ You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by DCF, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to DCF.

- ✓ You may cancel an authorization in writing at any time. DCF cannot take back any uses or disclosures already made before an authorization was cancelled.

- ✓ Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by TJocelyne Counseling & Consulting LLC privacy policies.

Your right to file a privacy complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how DHHS has used or disclosed information about you. Your benefits will not be affected by any complaints you make. DCF cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is:

TJocelyne Counseling & Consulting LLC Privacy Office 508-580-0364
Massachusetts Department of Health and Human Services Secretary 617-573-1600

TJocelyne Counseling & Consulting LLC.
425 Pleasant Street, Brockton MA 02301
Phone: 508-580-0364 Fax: 888-506-6021

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

This information can be made available in Spanish, French and Haitian Creole. Please ask a staff member if you need a copy in either of these languages. Esta información esta disponible en español. Se usted necesita una copia en español, por favor pregunte a miembro del personal. Si vous avez besoin d'une copie en Francais, s'il vous plait addressez vous aux membre du bureau. Si ou bzwen on copi an kreyol,tanpri mande on moun nan biro a.

When we refer to "you" or "your" in this Notice we refer to the person or persons receiving the services provided by *TJocelyne Counseling & Consulting LLC.*. When we refer to disclosures of information to "you", we mean disclosures to adults or children, the parent of the children, guardian or other person legally authorized to receive information about the person or persons receiving services from *TJocelyne Counseling & Consulting LLC.*.

Who follows this Notice:

This Notice applies to all **protected health information** (**PHI**) maintained by *TJocelyne Counseling & Consulting LLC.* for services provided at any office of *TJocelyne Counseling & Consulting LLC.* or services provided at non-office locations by any employee of *TJocelyne Counseling & Consulting LLC.* in the course of their employment. If you have any questions after reading this Notice, please contact the *TJocelyne Counseling & Consulting LLC.* Privacy Officer.

Each time you receive services from *TJocelyne Counseling & Consulting LLC.*, a record of the services provided is created. Typically this record could contain information about the type of service you have received the dates of service and the results of the service provided. At times this will include the reason you have come to *TJocelyne Counseling & Consulting LLC.* for service and the agreed upon goals of the service provided.

This Notice applies to all of the records containing PHI created as a result of services provided by *TJocelyne Counseling & Consulting LLC.*.

Our Pledge to Protect Your Health Information: We are required by law to maintain the privacy of your PHI and provide you with a description of our privacy practices. We will abide by the terms of this Notice.

How We May Use and Share Your Health Information With Others

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. For example, a worker or therapist may use PHI about you or your child from a clinic record to determine which treatment option, such as family or individual therapy, best addresses your needs. Your worker or therapist may discuss information found in your record with our consultants, a colleague or their supervisor to assist in treatment planning for you or your child.

For Payment: We may use and disclose PHI to send bills and collect payment from you, your insurance company, or other payors, such as governmental agencies, for the treatment or other related services you receive from *TJocelyne Counseling & Consulting LLC.*, so *TJocelyne Counseling & Consulting LLC.* can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing and sending claims to your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations: We may disclose PHI about you for business operations of *TJocelyne Counseling & Consulting LLC.*. These uses and disclosures are necessary for *TJocelyne Counseling & Consulting LLC.* to provide quality care and cost-effective services. The operations where we may need to disclose PHI includes, but is not limited to, quality assessment activities, employee review activities, and licensing activities. For example, we may share your PHI with third parties that perform various business activities (such as billing or typing services). We will require these third parties to have a contract with us that requires them to safeguard the privacy of your PHI. Quality assessment activities may include evaluating the performance of your therapist or examining the effectiveness of treatment provided to you when compared to patients in similar situations.

Future Communications and Fundraising Activities: We may use your name, address and telephone number to contact you to provide newsletters, information about programs or other services we offer or to raise money for health programs. We may disclose this information to the *[name hospital and its foundation]* so that the Foundation may contact you relating to raising money for *[above named hospital]*, of which *TJocelyne Counseling & Consulting LLC.* is an affiliate. If you do not want the *[name hospital and its foundation]* to contact you relating to fundraising efforts, you must notify us in writing. Please contact the Privacy Officer to assist you with this request.

Appointments: We may use your PHI for the purpose of sending to you appointment reminders through the mail or by telephone. Messages left for you will not contain specific health information.

Required or Permitted by Law: *TJocelyne Counseling & Consulting LLC.* is required by law to disclose your PHI in certain circumstances:

- For public health oversight activities
- To facilitate the functions of federal or state governmental agencies
- To report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse
- In response to a valid court order
- To the Department of Health and Family Services, a protection or advocacy agency, or law enforcement authorities investigating abuse, neglect, physical injury, death or violent crimes
- To your court-appointed guardian or an agent appointed by you under a health care power of attorney
- Prison officials if you are in custody
- Worker's Compensation officials if your condition is work-related
- If necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

When sharing PHI with others outside of *TJocelyne Counseling & Consulting LLC.*, we share only what is reasonably necessary unless we are sharing PHI to help treat you, in response to your written permission, or as the law requires. In these cases, we share all the PHI that you or the law requires.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your PHI we maintain. To exercise any of the rights discussed in the remainder of this section, please contact the Privacy Officer for *TJocelyne Counseling & Consulting LLC.* [give name and address here].

Right to Request Restrictions: You have the right to request certain restrictions of use and disclosure of your PHI by *TJocelyne Counseling & Consulting LLC.* for treatment, payment or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care. *TJocelyne Counseling & Consulting LLC.* is not required to agree to restrict the use and disclosure of your PHI. A request for restriction must be made in writing using the form available from the Privacy Officer.

Right to Inspect and Copy: With a few exceptions you have the right to inspect and receive a copy of your PHI. Should you wish to review or copy your PHI you should make a request using the form available from the Privacy Officer. We will arrange for your therapist or another health professional in our clinic to review the PHI with you in our office or to copy the information requested. We may charge you a reasonable fee if you want a copy of your PHI.

Right to Amend or Correct Your Record: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is maintained by *TJocelyne Counseling & Consulting LLC.*. Requests for amendment or correction

should be made by submitting a form requesting amendment or correction available from the Privacy Officer. We will respond to your request within 60 days after you submit the form. We are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have a right to request an accounting for disclosures. This is a list of those people with whom *TJocelyne Counseling & Consulting LLC.* may have shared your PHI, with the exception of information shared for purposes of treatment, payment or health care operations or when you have provided us with an authorization to do so. We may charge you a reasonable fee if you request more than one accounting for disclosures in any 12-month period. The request cannot include any disclosures made before January 14, 2015. Requests for an accounting of disclosures should be made by submitting a form requesting an accounting of disclosures to the Privacy Officer. This form is available from the Privacy Officer. We will respond to your request within 60 days after you submit the request.

Right to Request Confidential Communications: You have the right to ask that we communicate your PHI to you in a certain way or a certain location. For example, you can request that we contact you only at work or by mail. We will accommodate reasonable requests.

Right to Revoke Authorization: Uses and disclosures of PHI not covered by this Notice or the laws that apply to *TJocelyne Counseling & Consulting LLC.* will be made only with your authorization. If you authorize *TJocelyne Counseling & Consulting LLC.* to use or disclose your PHI, you may revoke that authorization in writing at any time. We are unable to reverse any disclosures we have made previously with your authorization. To revoke an authorization please contact your therapist or the clinic where you receive services.

Right to Complain: If you believe your privacy rights have been violated, you may file a complaint with [name hospital or health system] or with the Secretary of the Department of Health and Human Services. To file a complaint with *TJocelyne Counseling & Consulting LLC.*, contact the Privacy Officer. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

We reserve the right to revise or change this Notice. Each time you sign consent for treatment at a site covered by this Notice we will provide a copy of this Notice in effect at that time.

Effective Date: March 10, 2016

How to Contact Us

TJocelyne Counseling & Consulting LLC. Privacy Officer:….(508) 580-0364.

Secretary of Department of Health and Human Services……**(617) 573-1600**

PLEASE SIGN AND RETURN THIS PAGE TO YOUR CLINICIAN

Client's Name (print please) _____

By signing below you, the client consent to treatment and attest that you have read understand, and received a copy of the TJocelyne Counseling & Consulting LLC Notices of Privacy Practices.

Client Signature:_____**Date**_____

Therapist/Witness:_____Date_____

Release of Information For Billing Purposes

If you request that I complete insurance forms, you authorize me to make disclosure of your diagnostic information and dates of therapy sessions. Upon revocation of this authorization, further release of information shall cease immediately. This release of information for the purposes of a claim for benefit payment(s) expires upon termination of coverage under the insurance policy or benefit plan or the final determination of the claim, if later.

Executed this _____ day of _____, 20 _____

_____ _____

(PATIENT) (WITNESS)

_____

(Parent, Guardian if REQUIRED)

Insurance Information

Please bring in your insurance card or a copy of the front and back with you to your first session.

Insurance Company _____ Insurance Plan Name _____

Primary Insured's Name _____ Primary Insured's Birth date _____

Patient's Relationship to Insured: _____

Primary Insured's Employer's Name _____

Is there another Health Benefit Plan? ☐ Yes ☐ No If so, what _____

For Office Use Only

Authorization #: _____ # Visits Authorized _____ Copay _____

Dates of Service: _____ to _____