Green Valley Works

Creating a Spectrum of Opportunity

NEW CLIENT INFORMATION: DATE:____________________

CLIENT NAME: ___________________________________ **DATE OF BIRTH:** _____/______/_____

IF MINOR, NAME OF PARENT/GUARDIAN: _________________________________ **PARENT CELL PHONE:**____________________

HOME PHONE: _______________________ **CELL PHONE:** _______________________ **WORK PHONE:** _______________________

MAY WE CONTACT YOU AND LEAVE MESSAGES AT THESE NUMBERS: HOME: ____YES ____NO **CELL:** ____YES ____NO

HOME ADDRESS: ____

(STREET) CITY, STATE, ZIP

MAY WE MAIL INFORMATION TO THIS ADDRESS? ____YES ____NO **IF NO, PLEASE LIST MAILING ADDRESS:**

____

(STREET) CITY, STATE, ZIP

EMAIL: ____ **MAY WE EMAIL INFORMATION TO YOU?** ____YES ____NO

SEX: _________________________ **MARITAL STATUS:** _________________________ **EMPLOYED?** ____YES ____NO

CURRENT SCHOOL ATTENDING (IF MINOR): ___________________________________ **GRADE:** _________________

FINANCIALLY RESPONSIBLE PARTY:

NAME: ____ **DATE OF BIRTH:** _____/______/_____

EMPLOYER:____ **OCCUPATION:** ____

ADDRESS IF DIFFERENT THAN ABOVE: ____

(STREET) CITY, STATE, ZIP

ADDITIONAL PATIENT INFORMATION:

HOW WERE YOU REFERRED TO OUR OFFICE: ____

PREVIOUS COUNSELING? ____YES ____NO **IF YES, WITH WHOM?**_____________________________ **WHEN?** ________________

FAMILY PHYSICIAN: ____ **DATE OF LAST PHYSICAL:** ___________________________

OVERALL HEALTH: ________________________________ **ANY CHRONIC HEALTH CONDITIONS:** _______________________________

CURRENT MEDICATIONS: ____

NAMES/AGES OF OTHER FAMILY MEMBERS LIVING IN THE HOME: ____

____

OTHER INFORMATION YOU WANT US TO KNOW: ____

____

CONFIDENTIALITY STATEMENT:
All information shared in this treatment is confidential except in circumstances governed by law. If you like us to confer with another healthcare professional, school, attorney, or anyone else pertaining to the client, you will need to sign a "Release of Information" form. Both parties agree to take all reasonable measure to ensure confidentiality with any communication over the telephone and/or internet.

__________ ___ /___ /___
INITIAL DATE

PAYMENT IS DUE AT THE TIME OF SERVICE:
Unless other arrangements are made before appointment date, payment is due at the time of service. At this time we accept cash, check and can accept VISA/MASTERCARD/AMERICAN EXPRESS via our invoicing system.

__________ ___ /___ /___
INITIAL DATE

Green Valley Works

Creating a Spectrum of Opportunity

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, ____________________________________, authorize Mary Holman-Anderson and Green Valley Works
(Client/Parent/Guardian)

(if a minor) regarding: ____
(Minor Child's Name)

Initial those that apply to you:

_____To disclose and discuss clinical and treatment information with __________________________________,
(Other Mental Health Provider's Name)
or ____.
(Attorney or Law Firm)
Contact Phone Number and Address: ____

_____To exchange clinical information, such as diagnosis, treatment goals, and medication issues with my

Physician ____________________________________, for the purpose of treatment planning and coordination.
(Physician's Name)
Contact Phone Number and Address: ____

_____To disclose and discuss clinical and treatment information with __________________________________,
(School Name)
and/or ___________________________________.
(Counselor/Teacher)
Contact Phone Number and Address: ____

_____To disclose and discuss clinical and treatment information with __________________________________.
(Other)
Please explain: ____.

Contact Phone Number and Address: ____

_____ I prefer that no clinical and/or medical information be released at this time.

I, the undersigned, understand that I may revoke this consent at anytime except to the extent that action has been take in reliance on it and that in any event this consent shall remain in effect unless revoked or replaced.

____ ________________________________
Client Name (Please Print) **Witness**

____ ________________________________
Client or Guardian Signature **Date**

Green Valley Works

Creating a Spectrum of Opportunity

NOTICE OF PRIVACY PRACTICE:

UPON REQUEST we will provide a notice describing how psychological and health information about you may be used and disclosed and how you can obtain access to this information.

I have read and received (if requested) and understand the privacy practices information. I understand that my signature on this form acknowledges recept of these documents and acceptance of the condtions of the privacy policy of Green Valley Works, LLC.

STATEMENT OF UNDERSTANDING:

I have read and understand this information sheet and informed consent:

____ ________________________________

Client Name (Please Print)

____ ________________________________

Client or Guardian Signature **Date**

____ ________________________________

Green Valley Works Representative **Date**

Regarding the release of mental health medical records for adults and minors:

Sec. 611.0045(c) If the professional denies access to any portion of a record, the professional shall give the patient a signed and dated written statement that having access to the record would be harmful to the patient's physical, mental, or emotional health and shall include a copy of the written statement in the patient's records. The statement must specify the portion of the record to which access is denied, the reason for denial, and the duration of the denial.

__________ ___/___/___

INITIAL DATE