2021 21st Ave South Ste 432 Nashville TN 37212
www.sonyathomaslcsw.com
sonya@sonyathomaslcsw.com
615.330.4405

Last Name	First Name	Middle Initial	Date

Age	Sex	Relationship/Marital Status	Referral Source

Street Address	City	State	Zip

Cell Phone	Email Address	Work Phone

*Please place a check by the phone numbers above at which I may contact you and leave a message.

Emergency Contact	Phone	Employer

Spouse/Partner's Last Name	First Name	Middle Initial	Age

Spouse/Partner's Employer	Work Phone	Cell Phone

*Please place a check by the phone numbers at which I may contact or leave a message for your spouse/partner.

Personal Physician	Phone	Date of Last Physical

What has led you to choose counseling at this time?

Responsible Party Payment Information

Name of Person Responsible for Payment

Mailing Address (if different from page 1)

Client Signature

By signing above, I understand that payment/copay is due in full on the day of appointment. Standard rates are as follows:
$110.00 per 60 minute couples therapy session
$100.00 per 50 minute individual therapy session

I understand that Sonya Thomas will provide a receipt for client to submit to their insurance provider for their personal reimbursement (if applicable and requested).

Please be aware that in order for your claim to be considered for reimbursement, your insurance company will require a diagnostic code representing one of the mental/behavioral disorders found in the DSM-5 diagnostic manual and this may become part of your permanent medical record

Payment for appointments missed with less than a 24-hour notice is expected.

Medical/Health History

Name: _____ Age: _____ Sex: _____

Check if you have a history of:

____ APPETITE DISTURBANCE
____ SLEEP DISTURBANCE
____ PHYSICAL HANDICAP
____ HEARING PROBLEMS
____ VISION PROBLEMS
____ SEIZURES
____ HYPERACTIVITY
____ RINGING IN EARS
____ RECENT WEIGHT LOSS/GAIN
____ DENTAL PROBLEMS
____ BACKACHES
____ BEDWETTING
____ ASTHMA
____ MENSTRUAL PROBLEMS
____ ULCERS
____ PREGNANCY
____ CIRRHOSIS OF LIVER
____ FREQUENT COLDS
____ ABORTION
____ EARACHES
____ DIABETES

____ MENTAL RETARDATION
____ HEAD INJURY
____ VENEREAL DISEASE
____ PSYCHIATRIC TREATMENT
____ HIGH BLOOD PRESSURE
____ DIZZINESS
____ SERIOUS ILLNESS
____ ANEMIA
____ HEADACHES
____ NIGHTMARES
____ HAYFEVER
____ STOMACH ACHES
____ BLACKOUTS
____ HORMONE TREATMENT
____ HEPATITIS
____ SKIN RASHES
____ MISCARRIAGE
____ CHRONIC COUGHING
____ OVERWEIGHT
____ LOSS OF ENERGY
____ INSOMNIA

ALLERGIES:

_____

_____

_____

_____

_____

CURRENT STATE OF HEALTH: ____ EXCELLENT ____ GOOD ____ FAIR ____ POOR

MEDICATIONS CURRENTLY TAKEN:

Name	Dosage	Prescribed By
Name	Dosage	Prescribed By
Name	Dosage	Prescribed By

*Please list additional medications currently taken on back.

ALCOHOL/OTHER DRUGS USED? How much? How often?

TRANQUILIZERS/ANTIDEPRESSANTS TAKEN IN THE LAST SIX MONTHS:

How much per day? How long taken?

Results?

HOSPITALIZATION DATES:

PAST PSYCHOTHERAPY/COUNSELING EXPERIENCE:

With whom? Dates/Duration?

Please describe your past experience with psychotherapy/counseling; what was helpful? Unhelpful?:

Informed Consent for Treatment

The counseling relationship is an agreement between two parties, both of whom have responsibilities in the relationship. Your responsibilities as a client include regular attendance, providing twenty four hours notice for appointments that must be cancelled, payment on date of service, and active participation in the counseling process. This includes, but is not limited to, putting into practice new skills you are learning in therapy, following through on agreements you make to yourself and others, working on homework between sessions, reading recommended materials, engaging in self care activities, etc. Therapy, like other things in life, offers no absolute guarantee of success or desired outcome. There are limitations to any form of therapy offered to a client. Limitations are a function of the particular problem in question. I invite you to discuss your concerns with me around the limits that may exist in the therapeutic process or for a desired outcome.

This time has been reserved especially for you, and if you fail to cancel an appointment at least twenty-four hours before the scheduled appointment time, you will be charged full fee for the missed appointment. Please discuss any unforeseen circumstances with me. All charges are your responsibility; if you have problems with payment, please discuss this with me. If you choose to use insurance for reimbursement or payment, please be aware that many insurance companies are now requiring disclosure of very detailed personal information in order to provide you with benefits. When you choose to use insurance, you are agreeing to have information and diagnoses become a permanent part of the insurance company's computer database.

I am a Licensed Clinical Social Worker in the state of Tennessee. This means that I have professional obligations and commitments to you. In order to provide you with the best care possible, I may consult with other experts on treatment issues (without the use of any identifying information). You may allow me to release information to others with your written consent. The information you provide to me during your therapy is legally confidential except as required by law. Exceptions to confidentiality include the threat of serious harm to self or others, including child abuse, suicide, homicide or grave disability. PLEASE ASK ABOUT CONFIDENTIALITY AND KNOW YOUR RIGHTS.

Sexual contact on any kind between a client and counselor is not part of any recognized therapy, is unethical and should be reported to the Health-Related Boards (615 532-5133).

Your signature below indicates that you have read and understand this form.

Signature of client Date

Signature of client Date

NOTICE OF PRIVACY PRACTICES (NPP)
SHORT VERSION

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.

My Commitment to Your Privacy
My practice is dedicated to maintaining the privacy of your personal health information. The guidelines and ethical standards of my profession require this. Also, the guidelines under HIPPA require that I both 1) protect your privacy and 2) provide you with this information. The HIPAA law is complicated and lengthy. This notice is a shorter version of the full, legally required NPP information. You may request a copy from me of the full HIPPA. I can't cover all possible situations, so please talk with me about any questions or problems you may have.

I will use the information about your health, which I get from you or from others, mainly to provide you with treatment, to arrange payment for my services, or for some other business activities that are called in the law "health care operations."
After you have read this NPP, I will ask you to sign a Consent Form to acknowledge receipt of this document. Your signature is needed to enable me to provide the care and treatment needed.

Of course, I will keep your health information private, but there are some times when the law requires me to use or share it, such as:

1. When there is a serious threat to your health and safety or to the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires I do so.

4. For workers compensation and similar benefit programs.

There are some other situations like these that don't happen very often. They are described in the longer version of the NPP.

Your Rights Regarding Your Health Information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment; I will try my best to do as you ask. You can give or restrict permission to talk with immediate family.

2. You have the right to ask me to limit what I tell certain individuals involved in your care of the payment for your care, such as family members and friends. I will keep our agreement, except if it is against the law, or in an emergency or when the information is necessary to treat you.

3. You have the right to look at the health information I have about you such as your medical record, including psychotherapy notes and billing records. You can get a copy of these records if you desire, but you may be charged for copies.

4. If you believe the information in your records is incorrect or incomplete, you can ask me to amend your health information. You have to make this request in writing and include the reasons you want to make the changes.

5. You have the right to a copy of this notice. Again, the expanded version of this NPP is available from my office if you wish or need to see it.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or my health insurance privacy policies, please contact me either in person, by email at sonya@sonyathomaslcsw.com or by phone at 615.330.4405.

Signature

Name (printed)

Date

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information.

Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers including mental health care. All health care providers and agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

The HIPPA law and regulations are extremely detailed and somewhat lengthy. This Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important that you know what patient protections HIPPA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and, as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about ay of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for you thoughtful consideration of these matters.

—*Sonya Thomas, LCSW*

I, _____, understand and have been provided a copy of the Patient Notification of Privacy Rights document which provides a detailed description of the potential uses and disclosures of my protected health information, and well as my rights in these matters. I understand I have the right to review this document before signing this acknowledgement form.

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Name DOB

I hereby authorize the release of the following specific information, including information regarding diagnosis and treatment:

____ Discharge Summaries
____ Physical Exams
____ Psychological Evaluations
____ Social Histories
____ Progress Notes
____ Treatment Plans
____ Other (specify) _____

Check below:

____ From Sonya Thomas, LCSW to _____

____ From _____ to Sonya Thomas, LCSW

I understand that this information will be used for the following purposes:

____ To develop a diagnosis and treatment plan.
____ To process insurance claims
____ Other (specify) _____

This authorization may be revoked at any tie by giving written notice to Sonya Thomas, LCSW, at the above referenced address. If signed where there is no hospitalization, the release will expire after one year. If signed during hospitalization, this authorization will expire six months after the date of discharge. In the event this release is signed after hospitalization, it will expire six months form the date of signature.

_____

Signature Date