Anna Hiatt Nicholaides, PSY.D.
2200 Arch Street, Suite 200, Philadelphia, PA 19103
(267) 702-6623
anna.nicholaides@gmail.com

Demographic Information

1. Contact Information

Date: _____

Last Name:_____ First Name: _____ Middle Initial:_____

Date of Birth:_____ Age:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Wohone: _____ Cell Phone: _____

Email: _____

How and when do you prefer to be contacted: _____

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
 Yes No

If yes, please explain: _____

_____

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please explain: _____

_____

Reason for today's appointment: _____

_____

How did you hear of this practice: Web Referral Other: _____

2. Employment Information

Are you currently employed ? Yes No

Position:_____ Length of employment: _____

3. Educational Information

Please indicate highest level of education completed.

 GED High School Trade School College Graduate
Highest Degree: _____ Certifications: _____

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4. Medical Information

Primary Care Physician: _____ Phone: _____

Please list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, convulsions, seizures and/or any other medical conditions you have had since childhood.

_____

_____

_____

Please list all prescribed and over the counter medications, drugs or other substances (vitamins, herbs) you take or have taken in the last year.

_____

_____

_____

What type of physical exercise do you get on a weekly basis?

_____

_____

_____

Do you have any problems sleeping? ☐ Yes ☐ No
If yes, please explain.

_____

_____

_____

How much beer wine or hard liquor do you consume on average each week? _____

How much tobacco do you smoke or chew each week? _____

Do you have a history of drug and/or alcohol problems? ☐ Yes ☐ No

If yes, please provide details about your use of drugs or chemicals, such as amounts, how & why you used them and treatment, if any.

_____

_____

_____

Insurance ID number (for insurance purposes): _____

Social Security Number (for insurance purposes): _____

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5. Family & Social Information

Please fill in the following information for significant family members.

Relative	Name	Age	Living/ Deceased	Illnesses	Occupation
Spouse or Significant Relationship -married – yes or no -how long have you been together &/or married ? _____					
Children &/or stepchildren					
Father					
Mother					
Stepparents					
Grandparents					
Uncles/Aunts					
Brothers					
Sisters					
Other Significant Family members/relationships					

Please describe you parents' relationship with each other.

_____

_____

_____

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Please describe your relationship with each parent.

Please describe any drug or alcohol use and mental or emotional difficulties that run in your family.

Please describe you relationship with your brothers and/or sisters.

Please describe you relationship with your present spouse or partner.

Please describe your relationship with your children or stepchildren.

Are you currently involved in any legal cases or lawsuits? ☐ Yes ☐ No
If yes, please explain.

Were you ever arrested or charged with a crime. ☐ Yes ☐ No
If yes, please explain.

Thank you for your time in completing this for.
Once completed this is a strictly confidential patient medical record.

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Checklist of Concerns

Name: _____
Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

❑ I have no problem or concern bringing me here
❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
❑ Aggression, violence
❑ Alcohol use
❑ Anger, hostility, arguing, irritability
❑ Anxiety, nervousness
❑ Attention, concentration, distractibility
❑ Career concerns, goals, and choices
❑ Childhood issues (your own childhood)
❑ Codependence
❑ Confusion
❑ Compulsions
❑ Custody of children
❑ Decision-making, indecision, mixed feelings, putting off decisions
❑ Delusions (false ideas)
❑ Dependence
❑ Depression, low mood, sadness, crying
❑ Divorce, separation
❑ Drug use—prescription medications, over-the-counter medications, street drugs
❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
❑ Emptiness
❑ Failure
❑ Fatigue, tiredness, low energy
❑ Fears, phobias
❑ Financial or money troubles, debt, impulsive spending, low income
❑ Friendships
❑ Gambling
❑ Grieving, mourning, deaths, losses, divorce
❑ Guilt
❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems
❑ Housework/chores—quality, schedules, sharing duties
❑ Inferiority feelings
❑ Interpersonal conflicts
❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility
❑ Judgment problems, risk taking
❑ Legal matters, charges, suits
❑ Loneliness
❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings
❑ Motivation, laziness
❑ Nervousness, tension
(cont.)

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Adult Checklist of Concerns (p. 2 of 2)

❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems (see also "Career concerns . . . ")
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

_____

_____

_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____

_____

_____

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OUTPATIENT SERVICES CONTRACT

Informed Consent

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES
I am a licensed psychologist in the State of Pennsylvania (License Number: PS 016827) who provides psychotherapy for individuals and couples.

PSYCHOTHERAPY
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

MEETINGS
I schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although we may agree to meet more or less frequently. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 2 business days advance notice of cancellation.

The cancellation policy applies to all clients, including those with insurance. Insurance companies do not reimburse for missed sessions. Therefore, you will be responsible for my full fee. This policy exists to protect against financial loss associated with appointment no-shows or last-minute cancellations and to allow me adequate time to fill in cancellations with other individuals who are in need of my services.

CONFIDENTIALITY
In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

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.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child or elderly person is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will only tell you about these consultations if I feel that it is important to our work together.

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If you have questions about this document, please discuss them with me at any time.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____
Name (printed) Signature

_____
Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

□ Copy accepted by client □ Copy kept by therapist

Once signed this is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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Agreement to Pay for Professional Services

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person, by phone, email or certified mail that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship. If payment is not made the therapist may use legal means to obtain it.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons may make payments on my (or this client's) account.

I have also read and signed this therapist's informational forms (Consent to Treatment, HIPPA, Confidentiality, Information patients have a right to know, the limits of confidentiality via email) and agree to act according to everything stated there, as shown by my signature below and on each of those forms.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

□ Copy accepted by client □ Copy kept by therapist

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CONFIDENTIALITY AND THE USE OF EMAIL AS A FORM OF COMMUNICATION

I, _____ understand that communicating with my therapist through email is NOT a confidential means of communication. Communicating through email has several risks. Which include, but are not limited to, the following:

- The email could fail to be received and that confidentiality could be breached
- An email could fail to be received if it is sent to the wrong email address or if it just is not noticed by the recipient
- Confidentiality could be breached in transit by hackers or internet service providers and at either end by others who had access to the account or the computer.

By signing below, I am stating that I understand that email is not confidential and I have been informed of the issues of confidentiality with email. Additionally, by signing below I am agreeing to release my rights to confidentiality when I communicate with my therapist through email.

_____ _____

Patient Signature Date Psychologist's signature Date

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HIPAA "Notice of Privacy Practices"

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS
AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED,
AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

As a rule, I will disclose no information obtained from your contacts with me, or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, [some because of policies in this office/agency,], and some required by law. If you wish to receive mental health services from me, then under the Federal HIPAA regulations, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I. Uses and Disclosures Requiring Authorization or Consent

HIPAA allows health care providers to use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes. **In my own practice however, I do not disclose information routinely in these circumstances, so this will require your permission in advance, either through your consent at the onset of our relationship** (by signing the attached general consent form), **or through your written authorization at the time the need for disclosure arises.** You may revoke your permission to release PHI, in writing, at any time, by contacting me. If there is an emergency and I cannot ask your permission, I am allowed to share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you. Mental Health Medical Records is the term used for my formal record of the services provided to you, and these contain the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. (Under HIPAA Regulations, such notes are given a greater degree of protection than the PHI or formal record, because they are considered my own private communication. However, Pennsylvania law does not protect such records from subpoena.)

II. Possible Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances by policy, or if legally required:
· **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Pennsylvania law to report the matter immediately to the Pennsylvania Department of Public Welfare.

· **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Pennsylvania law to immediately make a report and provide relevant information to the Pennsylvania Department of Health.
· **Health Oversight:** Pennsylvania law requires that I report misconduct by a health care provider of my own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report that you are in treatment if I believe that your condition places the public at risk. Pennsylvania Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.
· **Court Proceedings:** If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization, or if a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court.

· **Serious Threat to Health or Safety:** Under Pennsylvania law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you

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when necessary to prevent an immediate, serious threat to your own health and safety.
· **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Definitions

To help clarify the terms, here are some definitions:
· **"PHI" (Protected Health Information**) refers to information in your health record that could identify you.
· **"Treatment, Payment and Health Care Operations"** --Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of a disclosure related to treatment would be when I consult with another health care provider, such as your PCP or psychiatrist. --Payment is when I obtain reimbursement for your healthcare. Examples of disclosure for payment purposes are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. --Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. **NOTE:** In this office, my colleagues do not have access to my records and your records are kept in a locked filing cabinet.
· **"Use"** applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
· **"Disclosure"** applies to activities outside of my office, such as releasing, transferring or providing access to information about you to other parties.
· **"Consent"** is a general permission that allows me to use and disclose your health care information for routine purposes of treatment, payment and operations. For example, under the law, you must sign this consent form before I can begin to see you for therapy or provide other mental health services.
·**"Authorization"** is required by law and involves your written permission to use and disclose information not covered by the consent form. There are a few cases (see above) in which I am allowed, even required, to use and disclose your information without your consent or authorization. I will keep a record of disclosures, and this will be available to you.

IV. Patient's Rights and Provider's Duties:

· **Right to Request Restrictions-**You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
· **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations --** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
· **Right to an Accounting of Disclosures -** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process
. · Right to Inspect and Copy - In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
· **Right to Amend** - If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a

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reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· **Right to a copy of this notice -** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

SIGNATURE:_____ EFFECTIVE DATE: _____

□ Copy accepted by client □ Copy kept by therapist