Anderson Center for Mindfulness

Patient Information

First Name: ______________________ MI:_____ Last Name:______________________ Gender:____________

Birth date: _____________ Relationship Status: _______________ Phone#: ______________________________

Street Address: ______________________________City: ________________State: ______ Zip:____________

Who is financially responsible for this account?:____

Relationship to patient and Contact phone:____

How were you referred to our office?:____-

Employer/School Information of Patient:

Name of Employer:____________________________Occupation:___________________ Years Employed: ____

Address: ____________________________________City:________________ Phone:_____________________

Name of School: (if Student) _________________________Current Grade:___________________________

Insurance Information:

Relation to Patient: _____________________ Phone: _________________Birth date: ____________________

First Name: ____________________________ MI:____Last Name:__________________Gender:___________

Street Address: ______________________________City:______________State:____Zip Code:______________

Employer of Insured: __________________________________Phone:_____________________________

Insurance Filing: We are a provider for many major insurance companies. Patient/Parent (if a minor) is required to pay their portion on the day of service. It is the responsibility of the patient/parent for non covered services to be paid when received. This includes but are not limited to phone consultations, medical records, completion of forms, requested letters, late cancellation/missed appointment fees. Be sure you give us the current and correct insurance card at all times.

Important Information:

- *Unpaid balances over 60 days are eligible for outside collection.*
- *Initial assessment does not guarantee a follow up appointment at this practice.*
- *A fee of $ 50.00 will be charged to the account for appointments canceled less than 24 hours prior to appointment day and for missed appointments.*
- *Phone consultations are $25.00 each 15 minutes.*
- *There will be a $ 30.00 charge for any monies returned for nonpayment by any institution.*
- *This practice reserves the right to dismiss any patient who is non compliant regarding treatment or office policies/procedures.*
- *Our office transmits information electronically. If information is received in error by a third party, I absolve this practice of all liability.*
- *I understand information will be given to insurance companies for payment of my treatment and the medical billing company for payment of my treatment. Otherwise visits will not be filed, and I will pay on cash basis for services.*
- *I will need to sign an authorization to release any information except to insurance provider.*

Signature of Patient:____Date:_______________________

Signature of Parent or Legal Guardian:__________________________Date:______________________

Anderson Center for Mindfulness

Patient Information Medical/Mental Health

Patient Name: ______________________________ Birth Date: ____________________

Primary Physician: ______________________ May we contact your Physician? **(Circle)** Yes / No

Sign & Date (agree to contacting your physician): _________________________ Date:__________

Personal Medical/Mental Health (PROBLEM AREAS): ________________________________

____

Family Medical/Mental Health History: ______________________________________

____

Habits:

Smoking: __________ **Packs Daily:** __________ **How long?** ____________________

Coffee: __________ **Other Caffeine:** __________ **What Type:** __________ **How Much:**________

Drugs: __________ **What Type:** __________ **How Often:** __________ **How Long:** _______

Alcohol: __________ **Type:** __________ **How Often:** __________ **How Long:** ________

Sleep Disturbance: _______ **Snoring:** _______ **Awakening:** _______ **Daytime Drowsiness:** __________

Exercise:______ **Type:**______________________________ **How Often:**__________

EMERGENCY CONTACT: ________________________ **Relationship:**__________________
Contact Number: ____________________

Sign and date to give permission to call:______________________ **Date:** ________

In cases of Couples and/or Family counseling sessions all who attend need to sign and date stating they understand the confidentially of the sessions at Anderson Center for Mindfulness.

Print Name: ____________________ **Signature:** ____________________ **Date:**__________

Print Name: ____________________ **Signature:** ____________________ **Date:** _________

Print Name:____________________**Signature:**____________________**Date**__________

May we text you appointment reminders? Yes:_____ **No:**_____

I understand my medical records contain information concerning psychological/psychiatric, substance abuse or other information shared as part of my medical records for treatment. I understand my consent remains in effect until I give written notification to discontinue to my practitioner.

Print Name:____________________________________**Date:**____________________

Signature:_____________________________________**Date:**____________________

Anderson Center for Mindfulness

Universal Medication Form

Patient Name: ______________________________ Date of Birth: __________

Medications:

Include all prescription and over the counter medications. This includes vitamins, aspirin, tylenol, and herbal supplements: Ginseng, Gingko Biloba, Melatonin, St. John's wart, etc.......

Name of Medication	Strength	Prescriber	Condition

1.______________________________

3.______________________________

2.______________________________

4.______________________________

5.______________________________

6.______________________________

7.______________________________

8.______________________________

9.______________________________

10.______________________________

Please be sure to keep your counselor up to date with any medication changes.

Informed Consent Regarding Limitations on Confidential Communications

I understand that information about my treatment and communications with my therapist may not be released without my written authorization. However, these communications or this information may have to revealed without my permission, as explained below.

1. If necessary to protect my safety or the safety of others.
   (a) If I am clearly dangerous to myself my therapist may take steps to seek involuntary hospitalization and may also contact members of my family and others.
   (b) If I threaten to kill or seriously hurt someone and the therapist believes I may carry out my threat, or if the therapist believes I will attempt to kill or seriously hurt someone, my therapist may: tell any reasonably identified victim; notify the police; or arrange for me to be hospitalized.

2. If necessary for me to be hospitalized for psychiatric care.
3. If a judge thinks the evidence about my ability to provide care or custody in a child custody or adoption case are necessary.
4. In court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption.
5. If the therapist believes a child, a disabled person, or an elderly person in my care is suffering abuse or neglect.
6. To provide information regarding my diagnosis, prognosis and course of treatment, or for purposes of utilization review or quality assurance to a third party payer.
7. In a legal proceeding where I introduce my mental or emotional condition.
8. If I bring an action against the therapist and disclosure is necessary or relevant to a defense.
9. If necessary to use a collection agency or other process to collect amounts I owe for services.
10. If a court orders access to my records in a criminal case.

I have had the opportunity to discuss this informed consent statement with my therapist. I understand its meaning and consent to receiving services based on this understanding.

Print Name:__________________________ Signature:__________________________ Date:_______

Therapist Signature:____ Date:__________

Therapy

Psychotherapy is about healing and mindful self-awareness. It is a collaborative process between you and your therapist. The therapeutic relationship allows for a safe place for you to take an active role in your honest, personal growth. Therefore, the therapeutic relationship is strictly a professional one that abides in rules of confidentiality and healthy boundaries. The therapeutic process includes exploring uncomfortable aspects of your life. Due to that exploration, you may feel worse before you feel better. However, psychotherapy has been shown to have many benefits. Therapy can often lead to significant reduction of emotional stress, improved relationships, greater personal awareness and insight, increased ability to respond to stress and resolution for specific problems. You may of course discontinue treatment at any time, but it's always a good idea to discuss such a decision with your therapist, so alternatives can be explored.

Contact Outside of Session:

I conduct therapy only in person, and only by appointment. Brief phone calls are accepted but if you need more than five minutes to resolve an issue, we will schedule an appointment. I will respond to all phone calls within 24 business hours but please be advised my practice is not geared to the provision of emergency services. If you are having severe emotional crisis and feel you need immediate attention, you should call 9-1-1 or go to your nearest hospital emergency room. Texting is not confidential. Texting is only to be used to request that I call you or to schedule an appointment or as an appointment reminder, if you so choose.

Therapy Session:

Your session will be between 45-60 minutes in duration. The time scheduled for your appointment is a special time set for you and you alone. Therefore, it is important to let your therapist know if you need to cancel with at least 24 hours notice. If you miss a session with less than 24 hours notice, there will be a $50 fee. If you arrive late to your appointment, your session will be shorter. Please understand that if you arrive more than 15 minutes late to your appointment, you will be charged a $50 fee.

By signing below, you acknowledge that you have read and understand the above information and you are consenting to psychotherapeutic treatment.

Your name (PLEASE PRINT): ____

Signature:____Date:________________

Witness:____Date:________________