Vergal C. "Chuck" Dawson, MA, Counseling Psychology
LMFT Lic. #0695

Client Information overview

Name:

Address:

SSN#

DOB:

circle =Male Female Married Separated Divorced under 18

Cell:

Home:

Office:

EMail addr:

In Emergency contact:

Children and ages:

Name of Employer or School Name and status:

My reason for Counseling is:

My goal in Counseling is:

Past Counseling or Medical history:

Last Physical Exam:

Medication in use:

Physician's name

Psychiatrist's name

Last therapist name

Reason:

Note :Because of confidentiality Chuck does not counsel for use as evidence or testimony.

Signed:

Date:

Thank You for useing this form,

for email only chuck@chuckdawson.com www.chuckdawson.com for messages and fax only:
Box 2480
CORRALES NM 87048
Msg. (505) 898-9370
Fax only: 898-9372

PARTICIPANT INFORMATION

Name_____ Treatment Star Date_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Mobile_____ E-mail _____

Birth date _____ Age_____ SSN_____

Martial Status_____ Employer or School Status_____

Physician's name _____ Phone_____

Psychiatrist's name _____ Phone_____

Last therapist name _____ Phone_____

Insurance Provider _____ Co-pay $_____ Deductible $_____

Emergency Contact:

Name:_____Relationship_____

Address:_____

Home Phone:_____Work Phone _____ Email_____

I hereby request that_____ DATE OF BIRTH_____

(Patient Name)

born _____ and residing at _____

(DOB) (Street Address)

_____

(City/State) (Zip Code) (Telephone Number)

be accepted for mental health treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Vergal C. Dawson.
2. I have been given information regarding my rights and responsibilities as a Vergal C. Dawson patient.
3. I have been given the Notice of Privacy Practices of Vergal C. Dawson which describes how medical information about me may be used and disclosed and how I can get access to this information.
4. I have been given information regarding the cost of services from Vergal C. Dawson. I understand that I am responsible to pay or be responsible to pay a co-pay and that it is payable each time I receive treatment.
5. I understand that Therapy can also include discussions of human sexuality.
6. I understand that I may address any concerns or grievances with my therapist or any other representative of Vergal C. Dawson at any time. I understand that I may also contact the licensing board which regulates my therapists professional practice.
7. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
8. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.
9. I authorize the release of any medical or other information necessary to process claims. I also request payment of governmental benefits either to myself or Vergal C. Dawson.
10. I authorize payment of medical benefits to Vergal C. Dawson for treatment services.
11. I understand that I will be assessed a $75 charge for all appointment cancelled without 24 hour notice.

PATIENT:

_____

Signature of Patient

_____

Date

MINOR (Emancipated Minors Only):
Due to the following reason _____, I
Have the legal capacity under applicable _____ (state) law to apply for consent to such treatment and services mentioned in this form, without parental consent.

_____
Signature of Patient

_____ _____
Witness Date

PARENT OR GUARDIAN:
I, _____, do hereby state that I am the natural parent or legal guardian of the patient; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____
Signature of Patient

_____ _____
Witness Date

BELOW IS FOR PROVIDER TO FILL IN. THANK YOU!

PROVIDER SECTION Axis I: _____

_____

_____

PROVIDER SECTION Axis II: _____

_____

_____

PROVIDER SECTION Axis III: _____

_____

_____

Axis IV: □ Primary Support Group □ Education
□ Social Environment □ Legal □ Other_____

PROVIDER SECTION Axis V: Current GAF_____ Past Year_____

PROVIDER SECTION Treatment End Date_____

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V.C. Dawson, LMFT #0695

COORDINATION OF CARE FORM

Client Name: _____

DOB _____

Most Primary care Physicians, Insurance Co. or others treating professionals will have information that is pertinent to the care of the client. Our policy, if you agree is to notify them and interchange pertinent information such as files, notes, medication etc. . This document is used by me to request or release protected health information and remains in effect for one year from dated and can be revoked at anytime.

I authorize the release of information to: Chuck Dawson, LMFT

_____ print name Relationship:

_____ Print name Relationship

_____ Print Name Primary care Physician

_____ Print Name Therapist

Notice: You may revoke this document at any time in writing. That will not apply to any information that has already been released. I understand that revocation may not apply to my insurance co. when the law provides my insurer with the right to contest a claim under my policy.

Thank you!

I have read and understand the above:

_____ Date

Signature

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INFORMED CONSENT V.C. Dawson, LMFT #0695

RIGHTS

1. You have the right to receive information about your provider, therapists, treatments and alternatives.

2. You have the right to be treated with dignity and respect.

3. You have the right to be involved in decisions about your treatment planning and decisions.

4. You can voice complaints about those who provide care for you.

5. You have the right know about fees in advance.

6. You have the right to review you file (with few exceptions).

7. You have the right to privacy and confidentiality.

RESPONSIBILITIES

1. Appointments must be canceled with 24 hour notice or subject to billing.

2. You have the responsibility to provide your therapist with all information that would be meaningful to your progress.

3. You have the obligation to devote the time and energy in after session hours for working on plans of treatment (homework)

Notice: The provider is under legal obligation to provide information to courts and law enforcement as well as 3rd party payers if subpoenaed or learns of abuse to a child or acquaintances in some cases.

I have read and understand the above:

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SYMPTOM DISTRESS SCALE

During the last seven (7) days, about how much were you distressed or bothered by:

	Not at all	A little bit	Moderately	Quiet a bit	Extremely
A. Nervousness or shakiness inside	1	2	3	4	5
B. Being suddenly scared for no reason	1	2	3	4	5
C. Feeling fearful	1	2	3	4	5
D. Feeling tense or keyed up	1	2	3	4	5
E. Spells of terror or panic	1	2	3	4	5
F. Feeling so restless in arms or legs	1	2	3	4	5
G. Heavy feeling in arms or legs	1	2	3	4	5
H. Feeling afraid to go out of you home alone	1	2	3	4	5
I. Feeling of worthlessness	1	2	3	4	5
J. Feeling lonely even when you are with people	1	2	3	4	5
K. Feeling weak in parts of your body	1	2	3	4	5
L. Feeling blue	1	2	3	4	5
M. Feeling lonely	1	2	3	4	5
N. Feeling no interest in things	1	2	3	4	5
O. Feeling afraid to open spaces or on the streets	1	2	3	4	5
ADD ALL COLUMNS					
TOTAL:[MIN: 15, MAX: 75]					

Other comments you may have:

_____ Date

CLIENT NAME

Vergal C. "Chuck" Dawson, MA, Counseling Psychology
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THE ZUNG SELF-RATING DEPRESSION SCALE

Please read each statement below and decide how much of the time the statement describes how you have been feeling during the past several days. Circle the number in the box that best describes your answer.

Questions	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue.	1	2	3	4
2. Morning is when I feel the best.	4	3	2	1
3. I have crying spells or feel like it.	1	2	3	4
4. I have trouble sleeping at night.	1	2	3	4
5. I eat as much as I used to.	4	3	2	1
6. I still enjoy sex.	4	3	2	1
7. I notice that I am losing weight.	1	2	3	4
8. I have trouble with constipation.	1	2	3	4
9. My heart beats faster than usual.	1	2	3	4
10. I get tired for no reason.	1	2	3	4
11. My mind is a clear as it used to be.	4	3	2	1
12. I find it easy to do the things I used to.	4	3	2	1
13. I am restless and can't keep still.	1	2	3	4
14. I feel hopeful about the future.	4	3	2	1
15. I am more irritable than usual.	1	2	3	4
16. I find it easy to make decisions.	4	3	2	1
17. I feel that I am useful and needed.	4	3	2	1
18. My life is pretty full.	4	3	2	1
19. I feel that others would be better off if I were dead.	1	2	3	4
20. I still enjoy the things I used to do.	4	3	2	1
ADD ALL COLUMNS				
RAW SCORE TOTAL [MIN. 20, MAX 80]		X 1.25=		ZSDS SCORE

Client Name

Date

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Insurance Verification Form

Client Name:_____ DOB: _____

Primary Insurance Company_____

Address:_____

Phone Number:_____

Authorization Number:_____

PROVISIONS Client Deductible Amount_____ClientCo-Pay Amont:_____

(Insurance pays_____% for visits_____-_____ and _____% for visits _____ - _____)

□ 90801 □ 90804 □ 90806 □ 90808 □ 90846 □ 90847 □ 90853

[FOR OFFICE USE ONLY]

□ Entered Claim Date_____

□ Confirmed Insurance Date_____

□ Confirmed with Client Date_____

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YOUR HEALTH INFORMATION RIGHTS. PART ONE OF TWO

1. Your Health Information Rights:
Although all records relating to the treatment you receive at The Therapist are the property of the Facility, you have the following rights with respect to your health information:

- the right to request restrictions on certain uses and disclosures of your health information as provided by 45 C.F.R. 164.522. The Therapist is not required to agree to any requested restriction.
- the right to obtain a copy of this Notice upon request.
- the right to inspect and obtain a copy of your health information as provided in 45 C.F.R. 164.524.
- the right to amend your health information as provided in 45 C.F.R. 164.526.
- the right to obtain an accounting of disclosures of your health information as provided in 45 C.F.R. 164.528. A Request for Accounting of Disclosures of Health Information must be made on the Facility's form. Copies of these forms are available at the Facility.
- the right to receive confidential communications of your health information as provided in 45 C.F.R. 164.522(b), as applicable

2. Use and Disclosure of Your Health Information.
As a general rule, The Therapist may use or disclose your health information in the following ways:

Required by Law: The Therapist will disclose medical information about you when required to do so by law.

Law Enforcement/Litigation: The Therapist may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Public Health: As required by law, The Therapist may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Victims of Abuse: The Therapist may disclose your health information to government authorities, such as social services authorities or protective agencies, if The Therapist reasonably believes that you are a victim of abuse, neglect, or domestic violence.

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YOUR HEALTH INFORMATION RIGHTS. PART TWO

Regulatory Agencies: The Therapist may disclose your health information to a health oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and other health oversight agencies to monitor the healthcare system, government programs, and compliance with civil rights.

Business Associates: The Therapist may disclose certain health information about you to business associates. A business associate is an individual or entity under contract with The Therapist to perform or assist The Therapist in a function or activity which necessitates the use or disclosure of health information. Examples of business associates, include, but are not limited to, consultants, accountants, lawyers, medical transcriptionist and third-party billing companies. The Therapist requires the business associate to protect the confidentiality of your health information.

Routine Healthcare Operations: The Therapist may use and disclose your health information during routine healthcare operations, including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of the Facility.

Harm to self or others: The Therapist is required by law to report any reasonable belief that the client may be at risk for harm to themselves or others to the proper authorities. The Therapist is also required to report any abuse of a minor, protected adult or elder abuse.

Sign and Date: _____

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Should any communications be Electronic:

CONSENT TO TREAT AND COMMUNICATE ONLINE OR BY PHONE

Although every effort is made to safeguard the private and personal information of clients, long-distance service recipients shall be informed of the potential hazards of long-distance communication.

Clients are hereby warned about entering private information when using a public access or computer that is on a shared network. Please exercise caution against using "auto remember" user names and passwords. Also remember employers' policies in relation to the use of work computers for personal communications. End-to-end encryption with conventional email cannot be guaranteed. The limitations of confidentiality due to hacking and other forms of illegal gathering of information on line and through the phone, the possibility of technological failure, anticipated response time to electronic communication and other considerations regarding confidentiality that may be out of both parties control are the nature of using the technology and are to be considered when entering into electronically transmitted or phone generated communications.

It is the responsibility of the client to safeguard the privacy of information on his computer from outside interference. Please secure your correspondence and provide a place of privacy for your sessions.

It is the responsibility of distance clients to provide a detailed list of adjunct services with names and contact information that may be used by the client including local emergency facilities, hospitals and doctors as well as other important names and information that could be necessary in case of an emergency or loss of contact. Termination of services will be confirmed prior to the last session.

It is agreed that;

All sessions are private with full disclosure as to who is present and within hearing range.
No sessions are recorded.
All services are considered to be rendered in the state of New Mexico; and
Any complaints about services should be directed to the New Mexico counseling and therapy board; and
Encryption and othere technologies alone do not insure confidentiality of communications.

I have read the above and I consent to counseling or coaching online with Vergal C. Dawson, LMFT although it cannot be guaranteed that total security and total privacy are possible through internet, phone communication, correspondence or email.

Signed:_____Date:_____

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It is the responsibility of distance clients to provide a detailed list of adjunct services with names and contact information that may be used by the client including local emergency facilities, hospitals and doctors as well as other important names and information that could be necessary in case of an emergency or loss of contact. If any interruption of services in an emergency situations the client should immediately call 911 for assistance.

It is agreed that;

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No sessions are recorded.
All services are considered to be rendered in the state of New Mexico; and
Any complaints about services should be directed to the New Mexico counseling and therapy board
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