Acknowledgement of Privacy Practices and Informed Consent

I understand that under the Health Insurance Portability and Accountability Act (HIPPA) of 1996, I have certain patient rights regarding my protected health information and had a chance to review and request a copy of the Notice of Privacy Practices. I have also had a chance to review and request a copy of Enlightened Living Therapy's Informed Consent and have access to view these policies on enlightenedlivingtherapy.com. I am also aware of the following:

- **Limitations to Confidentiality**
- **Payments:** Enlightened Living Therapy provides 60 minute sessions.
  - You are expected to make your payment at time of service. Monthly payment plans are not available. Outstanding balances, must be paid in full or a delay in service will occur.
- **Cancellations/No Show/ Late Attendance:**
  - LATE ARRIVALS: Three late arrivals are permissible, however, after the third late arrival, referrals will be provided and you will be discharged from services at Enlightened Living Therapy.
  - Late arrival: arriving 15 minutes, or more, past the scheduled appointment time.
  - CANCELLATIONS & NO SHOWS: Late cancellation is defined as failing to cancel your appointment more than 24 hours prior to your scheduled appointment time. No show is defined as not showing up for your appointment and not calling Enlightened Living Therapy to cancel your appointment. Two late cancellations, no show appointments, or a combination of the two will be permitted without charge. After two late cancellations, no shows, or a combination of the two have been met, a $75.00 fee will be charged for future occurrences.
  - After three late cancellations, no show appointments, or a combination of the two, referrals will be provided to other therapists and you will be discharged from services at Enlightened Living Therapy.

Assignment of Benefits & Authorization to Release Medical Information

I hereby assign all medical benefits, to include all major benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plan to Enlightened Living Therapy. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not they are covered, and paid for, by insurance. Should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation fees, and court costs. I hereby authorize Enlightened Living Therapy to release all information, reports, and records if necessary, for the purpose of treatment, payment, and healthcare operations, including the discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors. If I have a liability injury, I understand that I have the option of using my health insurance, if available or I will be expected to pay for treatment.

Print Name: _____ Date: _____

Signature: _____

Registration Form

Name: _____ Date of Birth: _____ Gender/Sex: _____

Race: _____ Religious/Spiritual Identity: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Home Phone: _____ Cell #: _____

Social Security #: _____

Would you like to use text to communicate & receive text message reminders? ☐No ☐Yes

Would you like to receive calls, voice messages, & reminder calls? ☐No ☐Yes

E-mail Address: _____

Would you like to use e-mail as a form of communication and to receive appointment reminders/ changes?

☐No ☐Yes

Emergency Contact: _____Ph.#_____ Relationship: _____

Primary Insurance Holder Information:

(You can skip this part if you are the primary policy holder, skip to Insurance Policy Details)

Name: _____ Date of Birth: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to You: _____ Home Phone: _____

Insurance Policy Details

Primary Insurance Company: _____Member ID#: _____

Group #: _____ Employer: _____

Secondary Insurance Company & Member ID#: _____

Employment Status

☐ Full time ☐ Retired ☐ Student
☐ Part time ☐ Disabled ☐ Unemployed
☐ Care provider for family and household responsibilities ☐ Intern/ Volunteer
☐ Military Service

Education

Please check all that you have completed:

☐ Elementary	☐ Middle School	☐ High School
☐ GED	☐ Trade School	☐ Associates Degree
☐ Bachelor's Degree	☐ Master's Degree	☐ Doctorate's Degree

Are you currently attending an education program? ___ Yes ___ No
If yes, what is your field of study? _____

Please list any learning disabilities.

_____

Legal

Current legal problems:

_____

Are you currently involved with Child/Adult Protective Services? ☐No ☐Yes
Have you been involved with Child/Adult Protective Services? ☐No ☐Yes

Please provide information & dates on current & past legal problems/ charges and the consequences faced:

_____

_____

Medical Information

Please check any of the following medical conditions that apply to you

☐ asthma	☐ migraines/headaches	☐ diabetes
☐ visual impairment	☐ miscarriage/stillbirths	☐ anorexia/bulimia
☐ hearing impairment	☐ heart condition	☐ arthritis
☐ stomach problems	☐ head injury	☐ difficult pregnancies
☐ ulcers	☐ gynecological problem	☐ cancer
☐ physical disabilities	☐ high cholesterol	☐ fibromyalgia
☐ obesity	☐ chronic pain	☐ abortion
☐ stroke	☐ bowel disorder	☐ insomnia
☐ seizures	☐ back pain	☐ STI (sexually transmitted infection
☐ sexual difficulties	☐ fertility issues	
☐ blood pressure problems	☐ thyroid problems	

Other diagnosed medical conditions or problems: _____

_____

Previous medical hospitalizations or surgeries: _____

_____

Current medication and reason for taking:

_____

_____

Substance Use History

Do you have a history of alcohol use/ dependence/ or treatment? ☐ Yes ☐ No

Do you have a history of drug use/ dependence/ or treatment? ☐ Yes ☐ No

If yes, please list drug/s of use:

_____

Please list treatment history related to substance use and dates:

_____

_____

Do you have a current problem with alcohol use/ dependence? ☐ Yes ☐ No

Do you have a current problem with drug use/ dependence? ☐ Yes ☐ No

Emotional Health History

What brings you to therapy? _____

_____

_____

_____

Symptom Checklist: Please check any of the following that apply to you

- ☐ depressed mood
- ☐ irritability
- ☐ sleep problems
- ☐ loss of interest in once enjoyable activities/relationships
- ☐ poor concentration
- ☐ difficulty making decisions
- ☐ worthlessness
- ☐ shame
- ☐ guilt
- ☐ low self-esteem
- ☐ fatigue
- ☐ social withdrawal/isolation
- ☐ weight gain/loss
- ☐ Over eating/ binge eating
- ☐ anxiety/worries
- ☐ restlessness
- ☐ racing thoughts
- ☐ muscle tension
- ☐ obsessive thinking
- ☐ panic attacks
- ☐ anger
- ☐ nightmares
- ☐ trauma
- ☐ mood swings
- ☐ divorce/separation
- ☐ major losses/changes
- ☐ death of a loved one
- ☐ sexuality issues
- ☐ sexual problems
- ☐ relationship problems
- ☐ compulsive behaviors
- ☐ aggressive behavior
- ☐ technology addiction
- ☐ gambling problem
- ☐ financial problems
- ☐ housing issues
- ☐ family substance use
- ☐ domestic violence
- ☐ family violence
- ☐ emotional abuse
- ☐ childhood emotional/physical neglect
- ☐ childhood abuse
- ☐ childhood sexual abuse
- ☐ delusional thoughts
- ☐ paranoid thoughts
- ☐ hearing voices or seeing things that others don't hear/see
- ☐ other: _____

Please list past mental health diagnoses: _____

Have you been in a controlled Environment in the past 30 days?

- ☐ No
- ☐ Jail
- ☐ substance use treatment
- ☐ Medical Treatment
- ☐ Psychiatric Treatment

Mental health treatment history, check all that apply:

- ☐ none
- ☐ mental health therapy
- ☐ outpatient
- ☐ inpatient
- ☐ hospitalized for mental health
- ☐ crisis/ emergency services

If past hospitalization occurred, please list when, length of stay, and reason for hospitalization(s):

_____

_____

Have you struggled with suicidal thoughts or thoughts of wanting to die in the past? ☐ Yes ☐ No

Are you currently struggling with suicidal thoughts or thoughts of wanting to die? ☐ Yes ☐ No

Have you attempted suicide in the past? ☐ Yes ☐ No

Do you have a history or current problem with self-mutilation?

☐ None ☐ Cutting ☐ Skin picking ☐ Hair pulling ☐ Burning

☐ Other_____

Have you experienced homicidal thoughts or thoughts of wanting to hurt someone in the past?

☐ Yes ☐ No

Do you have past or current issues with stalking or obsessive behaviors or thoughts of wanting to hurt someone?

☐ Yes ☐ No

Do you have a past or current history of violent behavior?

☐ Yes ☐ No

Are you currently struggling with homicidal thoughts or thoughts or plans of wanting to hurt someone?

☐ Yes ☐ No

Family History

As a child, did anyone in the home have a significant drinking, drug use, or psychological problem?

☐ Yes ☐ No

Is there a family history of alcohol or drug use/dependence?

☐ Yes ☐ No

Is there a family history of mental illness?

☐ Yes ☐ No

If yes, please list mental illness(s)?

Did anyone in the home have violent behavior?

☐ Yes ☐ No

How would you describe the relationship with your **mother** or primary caregiver growing up?

☐ loving and supportive ☐ conflict ☐ hostile ☐ emotionally abusive
☐ physically abusive ☐ estranged ☐ controlling ☐ neglectful/ unavailable

How would you describe the relationship with your **father** or primary caregiver growing up?

☐ loving and supportive ☐ conflict ☐ hostile ☐ emotionally abusive
☐ physically abusive ☐ estranged ☐ controlling ☐ neglectful/ unavailable

How would you describe the relationship(s) with your **siblings/cousins** growing up?

☐ loving and supportive ☐ conflict ☐ hostile ☐ emotionally abusive
☐ physically abusive ☐ estranged ☐ controlling ☐ neglectful/ unavailable

How would you describe your childhood?

☐ loving and supportive ☐ conflictual ☐ hostile ☐ emotional abuse
☐ physical abuse ☐ estranged ☐ controlling ☐ sexual abuse
☐ close family relationships ☐ positive/ happy ☐ lonely ☐ physical/ emotional neglect

Current Family Information

Relationship status:
☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ In a relationship ☐ Single ☐ Widowed

Does anyone in the home have a significant drinking, drug use, or psychological problem?
☐ Yes ☐ No

Do you feel safe within your home?
☐ Yes ☐ No

Are you currently experiencing family violence?
☐ Yes ☐ No

Please identify the number of children you have and ages:

_____Daughters _____Sons _____Step children _____Adoptive children

_____ Foster children _____None

Ages:_____

Who lives in your household?

Name/s	Relationship to you	Age/s

How would you describe your **current relationships with friends**:
☐ loving and supportive ☐ conflictual ☐ hostile ☐ emotionally abusive
☐ physically abusive ☐ estranged ☐ controlling ☐ neglectful/ unavailable
☐ close family relationships ☐ positive ☐ happy

How would you describe your **current relationship with your child/children:**
☐ loving and supportive ☐ conflictual ☐ hostile ☐ emotionally abusive
☐ physically abusive ☐ estranged ☐ controlling ☐ neglectful/ unavailable
☐ close family relationships ☐ positive ☐ happy

How would you describe your **current relationship with intimate partner(s):**
☐ loving and supportive ☐ conflictual ☐ hostile ☐ emotionally abusive
☐ physically abusive ☐ estranged ☐ controlling ☐ neglectful/ unavailable
☐ close family relationships ☐ positive ☐ happy ☐ sexually abusive

How would you describe your **current relationship with family:**
☐ loving and supportive ☐ conflictual ☐ hostile ☐ emotionally abusive
☐ physically abusive ☐ estranged ☐ controlling ☐ neglectful/ unavailable
☐ close family relationships ☐ positive ☐ happy

Strengths

How do you relax & manage stress in your life?

_____

_____

What do you like to do for fun? _____

_____

What are you most proud of achieving? _____

_____

What are your strengths and skills (compliments you hear from others?

_____

_____

Please describe the goals/changes you hope to achieve in therapy:

_____

_____

_____