Mary Beth Griffis, MA, LMHC MH8742

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## Welcome

Welcome to my office. If this is your first time to counseling you may have questions. Please feel free to ask anything that comes to mind. There are no inappropriate questions here. People come to this office “as is” and I hope you will be at ease. Together we will seek the answers to the questions or concerns you have.

Most clients who come to counseling find a once/week visit to be the most helpful. Others come every other week or as needed. As we work together, we will find a schedule that is right for you.

Most sessions run 60 minutes. I will do my best to get you out on time, but session can run over from time to time. Please let me know if you have a tight schedule.

I reserve a time for you that will fit into both of our schedules. I do not double book appointments and often try to leave a little time between appointments if possible to facilitate record keeping. Therefore, I will charge you my regular appointment fee if I do not receive at least 24 hours notice of a cancellation. Of course there are times when things come up, such as illness where no fee will be incurred. Your insurance company will not pay for missed appointments, therefore you will be responsible for this cost if you do not cancel 24 hours in advance.

The best way to reach me is by phone at 407-782-0134. I check my phone regularly and will do my best to get back to you within 24 hours. You may call me to make appointment changes. Please remember email and texting does not meet HIPPA guidelines and confidentiality is not assured.

My regular fee is per counseling hour. Your insurance may cover all or part of this fee. You will need to contact them for this information. If I am an in-network provider with your insurance company you may be responsible for a co-pay.

Please take a few minutes to read and fill out this packet. Some of this paperwork helps me identify the issues you are dealing with and will help us set up goals for counseling. Some of this paperwork is mandated by the law. We can address together any questions or concerns you have about any of this paperwork or the counseling process.

I look forward to meeting and working with you.

*Mary Beth*

*Mary Beth Griffis, MA, LMHC*

MH8742

# Intake Information

*Please fill out the following information.*

Today's Date ____________________________ Date of Birth ________________________________

Name ______________________________________________________________________________________
*first* *middle* *last*

## CONTACT INFORMATION

Address ___________________________________________________________________________________
*street* *city* *zip code*

May I send mail here? □ Yes □ No

Please provide that information below that you would *prefer* for me to use.

Home Phone: _____________________________ May I leave a message here? □ Yes □ No

Mobile Phone: _____________________________ May I leave a message here? □ Yes □ No

Work Phone: ______________________________ May I leave a message here? □ Yes □ No

## EMERGENCY CONTACT

Name: ____________________________________________________ Relationship: _________________________

Home Phone: (______) _________________________ Mobile Phone: (_________) ________________________

## PRESENTING ISSUES AND GOALS

Please describe the circumstances that contributed to your seeking counseling at this time.:

______________________________________________________________________________________________

______________________________________________________________________________________________

What do you hope to gain or change while coming to counseling?

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

## EMPLOYMENT INFORMATION

Employer: ____________________________________________ Length of Employment: ___________

Occupation: ____________________________________ Average Hours Worked Per Week: ___________

## RELATIONAL INFORMATION

Current Relational Status: □Single □Dating □Engaged □Married □Separated □Divorced □Widowed

Are you content with your current status? □ Yes □ No. If No, Briefly Explain: ______________________

_____________________________________________________________________________________

If Married, How Long? _____ Number of Previous Marriages for You: ____ For Your Partner: ____

If Separated or Divorced, How Long: ___________If Widowed, How Long: ___________________

Partner's Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev.

_____________________________________________________________________________________

What words would you use to describe your partner?

_____________________________________________________________________________________

Is your partner supportive of your seeking counseling? □Yes □No □Unsure □Partner Doesn't Know

With whom do you currently live? (Check All that Apply):

□ Alone □ Spouse □ Children □ Parent(s) □ Sibling(s)

□ Boyfriend □ Girlfriend □ Roommate □ Other: ______________________________

Do you have a personal support system? □ Yes □ No. If yes, please state who and their relationship to you.

_____________________________________________________________________________________

## SUBSTANCE USE

Do you drink alcohol? □ Yes □ No If yes, how much? ___________ How often? ____________________

Have you ever felt the need to cut down on your drinking? □ Yes □ No If yes, please explain.

_____________________________________________________________________________________

Have you felt annoyed by someone criticizing your drinking? □ Yes □ No If yes, please explain.

_____________________________________________________________________________________

Have you ever felt bad or guilty about your drinking? □ Yes □ No If yes, please explain.

_____________________________________________________________________________________

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? □ Yes □No

Do you use caffeine? □ Yes □ No Drink caffeinated beverages? □ Yes □ No If yes, how much per day? _____

Do you use illegal substances? □ Yes □ No If yes, which ones and how often? ___________________________

Have you used illegal substances in the past? □ Yes □ No.

If yes, please explain how much and how often and if you stopped what led you to stop.

______________________________________________________________________________

## MEDICAL INFORMATION

Primary Physician: ___________________________ Phone: (_______) ___________________________

Address: ____________________________________ City: _______________ Zip: ____________

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine):

______________________________________________________________________________

Are you currently receiving medical treatment? □ Yes □ No. If Yes, Please Specify:

______________________________________________________________________________

Please list any conditions, illnesses, surgeries, hospitalizations, traumas or related treatments you have had.

(please use the back of this paper if necessary)

______________________________________________________________________________

______________________________________________________________________________

May I contact your physician to consult with him/her about your treatment? ___________________________

## MEDICATIONS

Please list all current medications you are taking, including those you seldom use or take only as needed (Use the back of this paper if necessary)

Medication: ______________ Dosage: _____ □ Improves □ Prevents □ Controls: ___________

Medication: ______________ Dosage: _____ □ Improves □ Prevents □ Controls: ___________

Medication: ______________ Dosage: _____ □ Improves □ Prevents □ Controls: ___________

Medication: ______________ Dosage: _____ □ Improves □ Prevents □ Controls: ___________

Are you taking these medications according to your doctor's recommendations? □ Yes □ No

If no, please briefly explain: ______________________________________________________

______________________________________________________________________________

## PHYSIOLOGICAL SYMPTOMS

Please check any of the following physiological symptoms/sensations that apply to you presently or in the recent past:

| | | | | | |
|---|---|---|---|---|---|
| Headaches………... | □ Past | □ Present | Dizziness………….. | □ Past | □ Present |
| Stomach Trouble…. | □ Past | □ Present | Visual Trouble……. | □ Past | □ Present |
| Sleep Trouble…….. | □ Past | □ Present | Trouble Relaxing…. | □ Past | □ Present |
| Weakness………… | □ Past | □ Present | Tension……………. | □ Past | □ Present |
| Rapid Heart Rate… | □ Past | □ Present | Difficulty Breathing.. | □ Past | □ Present |
| Intestinal Trouble…. | □ Past | □ Present | Hearing Noises…… | □ Past | □ Present |
| Change in Appetite. | □ Past | □ Present | Tiredness………….. | □ Past | □ Present |
| Pain…………...……. | □ Past | □ Present | Other_______________ | □ Past | □ Present |

Have you had a significant (10 pounds or more) weight loss or gain within the past year? _____ If yes, please explain______________________________________________________________________________

______________________________________________________________________________

## CURRENT STATUS

Please check any of the following problems which pertain to you:

| | | | | | |
|---|---|---|---|---|---|
| Stress……………… | □ Past | □ Present | Nervousness…......…. | □ Past | □ Present |
| Anxiety……………. | □ Past | □ Present | Panic………...………. | □ Past | □ Present |
| Unhappiness……… | □ Past | □ Present | Depression…....……... | □ Past | □ Present |
| Guilt………………... | □ Past | □ Present | Apathy………...……... | □ Past | □ Present |
| Feeling controlled... | □ Past | □ Present | Grief…………....…….. | □ Past | □ Present |
| Hopelessness…..….. | □ Past | □ Present | Compulsive behavior..... | □ Past | □ Present |
| Inferiority Feelings.. | □ Past | □ Present | Unwanted memories...... | □ Past | □ Present |
| Loneliness………… | □ Past | □ Present | Shyness……………...… | □ Past | □ Present |
| Fears………………. | □ Past | □ Present | Relational Problems...... | □ Past | □ Present |
| Communication…… | □ Past | □ Present | Physical Abuse…....…. | □ Past | □ Present |
| Obsessive Thoughts | □ Past | □ Present | Emotional Abuse....…. | □ Past | □ Present |
| Verbal Abuse…..….. | □ Past | □ Present | Sexual Abuse…......….. | □ Past | □ Present |
| Temper……………. | □ Past | □ Present | Anger………….....……. | □ Past | □ Present |
| Aggressiveness…..... | □ Past | □ Present | Bad Dreams……...…. | □ Past | □ Present |
| Concentration…….. | □ Past | □ Present | Unwanted Thoughts...... | □ Past | □ Present |
| Memory problems.... | □ Past | □ Present | Loss of Control…....…. | □ Past | □ Present |
| Impulsive Behavior.. | □ Past | □ Present | | | |
| Hallucinations........... | □ Past | □ Present | Sexual Problems....…. | □ Past | □ Present |
| Pregnancy Problem ... | □ Past | □ Present | Hearing voices.............. | □ Past | □ Present |
| Trauma……………. | □ Past | □ Present | Eating Problems....…. | □ Past | □ Present |

| | | | | | |
|---|---|---|---|---|---|
| Indecisiveness........... | □ Past | □ Present | Work Stress................ | □ Past | □ Present |
| Career Choices…..... | □ Past | □ Present | | | |
| Verbal Abuse............. | □ Past | □ Present | Parenting concerns........ | □ Past | □ Present |
| Difficult Children...... | □ Past | □Present | Financial Concerns........ | □ Past | □ Present |
| Recent Loss……….. | □ Past | □ Present | Disaster……………........ | □ Past | □ Present |
| Fatigue…………….. | □ Past | □ Present | Sleep problems............. | □ Past | □ Present |
| Worthlessness............ | □ Past | □Present | Chronic pain................. | □ Past | □ Present |
| Recent Death……...... | □ Past | □ Present | Marital Problems........... | □ Past | □ Present |
| Legal Matters…......... | □ Past | □ Present | Abortion………...…… | □ Past | □ Present |

## CURRENT LEVEL OF DISTRESS

Indicate how distressed you are today by circling the appropriate number below. (1 = Very Little Distress; 10 = Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing suicidal thoughts? □Yes □ No

Have you experienced suicidal thoughts in the past? □ Yes □ No

Have you ever attempted suicide? □Yes □No. If please state when and how: ________________________

________________________________________________________________________________

Have any of your friends or family attempted suicide? □ Yes □ No

If yes, when and who? ____________________________________________________________

## PREVIOUS COUNSELING

Please list any previous counseling, psychiatric treatment, or residential treatment, or residential/in-patient care you have received (use the back of this paper if necessary.)

Therapist: ______________________________ Location: __________________________________________

Dates: _________________________________ Reason: _______________________________________

Therapist: ___________________________ Location: __________________________________________

Dates: _________________________________ Reason: _______________________________________

## SPIRITUAL BACKGROUND

Would you like your faith to be a part of the counseling process? □ Yes □ No If yes, with which religious organization do you identify? ______________________________________________________________________

## INSURANCE INFORMATION:

Name of Healthcare Insurance Company: ____________________________________________

Name of Insured: ________________________________________________________________

Member Identification Number: ____________________________________________________

Information provided to the insurance company may include a procedural code which indicates the type of treatment and the amount of time you were seen as well as diagnostic information for the purpose of reimbursement for services.

Information obtained during the clinical process will not be released without your written consent unless court ordered. Confidentiality may also be waived in situations where a client is a danger to self or others, or there are indications of child abuse or elder abuse.

## INFORMED CONSENT

By signing below you indicate the following:

I understand the law protects the relationship between a client and a psychotherapist and information cannot be disclosed without written permission unless there is a court order, I am a danger to myself or others, or there are indications of child abuse or elder abuse.

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee.

I understand my therapist is available after regular business hours and on weekends by phone, however an immediate response is not guaranteed. Phone consultations after hours in excess of 10 minutes will be billed the regular hourly fee. In case of emergency I may need to contact 911 or a local mental health facility or hospital.

I understand that my participation is purely voluntary and that I may withdraw whenever I wish. All records are the property of Mary Beth Griffis, MA, LMHC.

I have read and understand the information on this form. I give consent for treatment of myself or the client indicated below. If the client is a minor, I agree that I have the authority to seek treatment on his or her behalf. I understand that I may discuss with my therapist all aspects of my treatment and any issues on this form.

Signed ________________________________________________________ Date __________________

My name (please print) ______________________________________________________________________

Minor's signature: __________________________________________________________________________

Minor’s name (please print) __________________________________________________________________

*Mary Beth Griffis, MA, LMHC*

MH8742

# Notice of Privacy Practices

1. **This notice describes how psychological and medical information may be used and disclosed and how you can access this information. Please review it carefully.**

2**. Safeguarding Your Protected Health Information**

Individually identifiable information about your past, present, or future health concerns, the provision of healthcare to you, or payment for healthcare is considered “Protected Health Information” (PHI). By law I am required to insure that your PHI is kept private. This notice explains how, when, and why I may use or disclose the *minimum necessary PHI* to accomplish the intended purpose of the use or disclosure.

3**. How I May Use and Disclose Your Protected Health Information**

I use and disclose PHI for a variety of reasons. I may use and/or disclose your PHI for purposes of providing or coordinating treatment to obtain payment for services provided, and to complete healthcare operations related to the performance or operation of this practice. The following offers more description and some examples of the potential uses and disclosures of your PSI:

1. **Uses and disclosures related to treatment, payment, or health care operations do not require your prior written consent**.
   - ❖ **For treatment.** I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care. I will usually get your written permission before I do this.
   - ❖ **For health care operations.** I may disclose your PHI to your your insurance company for the purposes of fee reimbursement.
2. **Uses and Disclosures for Which Special Authorization Will Be Sought**. For uses beyond treatment and operations purposes, I will ordinarily seek to obtain your authorization before disclosing your PHI. However, disclosure of your PHI may be made without your consent or authorization when:
   - ❖ To report known or suspected child abuse or neglect to the Florida Department of Children and Families as required by law.
   - ❖ To report known or suspected abuse of neglect of an elderly or disabled person to the Central Abuse Hotline as required by law.
   - ❖ When there is serious threat to the health or safety of yourself or others. If a client intends to harm himself or herself, I will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, I will take further measures without their permission that are provided to me by law to ensure their safety. If a client is threatening serious bodily harm to another person/s, I must notify the police and inform the intended victim.
   - ❖ In certain judicial or administrative proceedings such as Health Oversight activities, unopposed subpoenas or court orders, certain law enforcement activities and Worker’s Compensation claims.

*As a mental health worker I am a mandatory reporter in cases of abuse of a minor or an elderly person and am required by law to report knowledge of this information.*

4. **How You May Have Access to or Control of Your Protected Health Information.** The following is a description of the steps you may take to access or otherwise control the disposition of your PHI:

- ❖ **To request restrictions on uses/disclosures**: You may ask that I limit how I use or disclose your PHI. I will make every effort to honor your request, but I am not legally bound to agree to the restriction. To the extent that I do agree to such restrictions, I will abide by such restrictions except in emergency situations. I cannot agree to limit uses/disclosures that are required by law.

- ❖ **To choose how I contact you**: You may ask that I send you information at an alternative address or by alternative means. I will agree to your request so long as it is reasonably easy for us to do so.

- ❖ **To inspect your PHI**: You have a right to receive a treatment summary of you PHI. If you request a treatment summary one will be provided to you, however there may be a reasonable charge.

- ❖ **To request amendment of your PHI**: If you believe that there is a mistake or missing information in our record of your PHI, you may request in writing that I correct or add to the record. If I approve the request for amendment, I will change the PHI and so inform you. I will also inform any others who have a need to know about such changes.

- ❖ **To receive this notice**: You may receive a paper or electronic copy of this notice upon request.

5. **Concerns**: If you are concerned that there has been a violation of your privacy rights or if you disagree with decisions made about access to your records, you may contact me directly or send a written complaint to the Secretary of the US Department of Health and Human Services.

6. **This notice of privacy is available in its entirety at your request. This notice is effective April 14, 2003**.

7. **Acknowledgment:** I have reviewed a copy of this notice:

Printed Name: ___________________________________________

Signature: ______________________________________________

Date: __________________________________________________