Driftwood Counseling Services
Shelly M. Wiggins, MA, LPC
MI License # 6401008453
654 E. Main St
Owosso, MI 48867
(517) 749-2235

Personal Information Form

Client Name: ____ M F Date: ______________
Street Address: ____ Home# ___________________
City, State, Zip: ____ Work # ___________________
Date of Birth: ______________________ Social Security: _________________________
Marital Status (Circle one): Married Single Separated Widowed Divorced Other

If you are a parent, please list your child(ren's) names and birth dates:
____
____
____

Current Physical Health: Excellent Good Fair Poor

Please list all current medications:

Medication:	Dosage	How Often	What reason	How long
______________	__________	__________	____________	__________
______________	__________	__________	____________	__________
______________	__________	__________	____________	__________
______________	__________	__________	____________	__________
______________	__________	__________	____________	__________

*******************Please keep therapist informed of all medication changes********************

If you have allergies, please list:
____
____

Physician's Name: __________________ Physician's Address ___________________________________
Date of last physical and/or lab work: _______________ Last hospitalization: _____________

Have you ever been admitted to inpatient treatment for mental health or substance abuse?
Yes______ No _______

If yes, please list date(s) and short explanation:
____
____
____
____

Please list your health concerns, current illnesses, or medical problems?
(Please include any disabilities) ____

____

____

How did you find us? ____

Please indicate the primary problem(s) that lead you to seek counseling today. Check all that apply
[ ] Depressed Mood [ ] Anxiety or Worry [ ] Grief / Loss [ ] Substance use problems
[ ] General Press [ ] Occupational Problems [ ] Relationship / Family Problems [ ] Other:
____

	Lots	4	3	2	Little
Mark how have the problems bothered you in the past 30 days:					
To what extent have the problems interfered in: family-					
Social Life-					
Work/School-					
Health & physical well-being-					

I have received counseling previous: Yes No If Yes, When? ____________
With Whom? ____________ How long? ____________
Are you employed outside the home? Yes No Employer/School ____________
Occupation ____________ Time at present job ____________
(Circle one) Full-time Part-time Unemployed Disabled Retired Volunteer
Stress level of present job (circle one): Not at all Slightly Stressful Very stressful
How satisfied are you with your job? Very unsat. Unsatisfied Satisfied Very satisfied
Are you a veteran of the armed services? Yes No If yes, length of time in service? ______
Where were you deployed? ____________ Did you see combat? Yes No
Highest grade completed in school: ____________
Do you have any legal issues pending? Yes No If yes, please explain:
____

____

IN AN EMERGENCY, PLEASE CONTACT:
Name: ____________________________ Relationship: ____________
Address: ____
Phone (home): ____________________ Phone (work): ____________________

I affirm that information given is complete and accurate to the best of my knowledge:

____________________________ ____________
Signature Date

MENTAL HEALTH SCREEN

Carefully read the following questions/symptoms.
Only circle (O) those that are **TRUE** or **YES.**

1. Have you ever seriously thought about committing suicide or have you ever been treated because of a suicide attempt? (When?)
2. Do you have a plan in case you want to commit suicide?
3. Do you feel sad most of the time?
4. Do you find yourself crying uncontrollably?
5. Do you feel hopeless about the future?
6. Do you think frequently about the death of a loved one?
7. Do you think you will never recover from the death of a loved one?
8. Do you worry that you might do something to make people think you are stupid of foolish?
9. Do you feel nervous in most social situations?
10. Are you fearful of asking a question when there are more than three people around?
11. Do you feel on edge frequently?
12. Do you get attacks of heart racing, sweating, shakiness, nausea and dizziness?
13. Have you experienced a panic attack?
14. Do you have frequent headaches?
15. Do you get stomach or intestinal problems each week?
16. Do you feel tense much of the time?
17. Do thoughts about a traumatic event frequently come into your mind?
18. Do reminder of the event make you shake, sweat or experience a racing heart?
19. Do you try to avoid people, places or activities that would rind you of the event?
20. Have you lost track of time to where you cannot remember events you have been a part of?
21. Do you carry on conversations with yourself as if there were two people present?
22. Do you feel as if you or the world is unreal?
23. Have you forgotten significant events or portions of your life?
24. Do you have trouble concentrating for very long at one time?
25. Do you have trouble being physically still?
26. Are you impulsive?
27. Are you easily startled?
28. Do you make extra effort to always do the right thing?
29. Is it essential that you carefully plan out your day?
30. Do you worry excessively about dirt, germs or chemicals?
31. Are there things you feel compelled to do over and over?

32. Do you worry obsessively that you have forgotten to do something important?
33. Do you have difficulty completing projects?
34. Are you often accused of not getting things done?
35. Did you have problems or issues while you were growing up (paying attention in school, keeping up with school work, staying in your seat, remembering to finish household chores?)
36. When you were growing up, did your parent figure physically abuse you?
37. When you were growing up, did someone older touch you in a sexual manner?
38. When you were a child, were your basic needs ignored or forgotten (i.e. food, clothing, bathing, medical care, etc.)
39. Have other people told you that you are abusive when you express your anger?
40. Have you ever felt badly about hitting or striking someone in anger?
41. Have you felt badly that you used emotionally abusive language on someone you love(d)?
42. Have you ever had unwanted sexual attention paid to you?
43. Do you drink or use recreational drugs to relax or cope with your life?
44. Are family members worried about your use of alcohol, recreation drugs or prescription?
45. Are you worried about how much money you spend on the lottery or at the casino?
46. Have you lied to family members or others to conceal the extent of your gambling?
47. Have you used gambling as a means of escaping from problems or relieving stress?
48. Do you spend more than three hours daily on the computer after your work is done?
49. Do you have physical problems related to your use of tobacco?
50. Is tobacco essential to your enjoyment of life?
51. Do you have trouble falling asleep?
52. Do you frequently wake up in the middle of the night?
53. Do you awaken earlier than usual and then not be able to go back to sleep?
54. Do you have persistent nightmares?
55. After eating, do you purge either by forced vomiting or laxatives?
56. Do you continue trying to lose weight even though others say you are too thin?
57. Are you unhappy with the way your body appears?
58. Do you have a hard time controlling what and how much you eat?
59. Do you have a spiritual life?
60. Do you spend time reading or meditating on spiritual issues?

Driftwood Counseling Services
Shelly M. Wiggins, MA, LPC
MI License # 6401008453
654 E. Main St
Owosso, MI 48867
(517)749-2235

CLIENT RIGHTS

Right to request how we contact you:
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. May we contact you at home (circle one) yes, no? May we contact you at work (circle one) yes, no? May we contact you by cell phone (circle one) yes, no? Where may we contact you? ____

Right to release your medical records:
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records:
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the cost of copying, mailing and supplies.

Right to add information or amend your medial records.
I you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you much contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures:
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures or your health information:
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain:
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: June 1, 2006

Driftwood Counseling Services has been and will always be totally committed to maintaining clients confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Illinois State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Driftwood Counseling Services
Shelly M. Wiggins, MA, LPC
MI License # 6401008453
654 E. Main St Owosso, MI 48867

(517)749-2235

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize **Shelly Wiggin, MA, LPC of Driftwood Counseling Services at 654 E. Main St Owosso, MI 48867**

To release and disclose information from the clinical record of:

____ ____________
(Name of client/recipient of mental health services) (Date of birth)

____
(Facility/Provider)

____
(Address)

Nature of information to be disclosed: ______________________________
(State specific nature of information to be disclosed)

For the purposes of ______________________________
(State specific purpose of information to be disclosed)

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Shelly Wiggins, MA, LPC. I understand that a revocation is not valid to the extent that Shelly Wiggins, MA, LPC has acted in reliance on such authorization. This authorization is valid until (date:) ____________________.

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): ______________ no information release and/or ______________________________

____

A copy of this release shall have the same force and effect as the original.

______________________________ ______________________________
(Client signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

______________________________ ______________________________
(Witness) (Date) (Relationship) (Date)

NOTICE TO RECEIVING FACITILITY/THERAPIST. You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

Driftwood Counseling Services
Shelly M. Wiggins, MA, LPC
MI License # 6401008453
654 E. Main St
Owosso, MI 48867
(517)749-2235

AUTHORIAZATION FOR RELEASE OF INFORMATION

I (We) authorize ____
(Facility/Provider)

____ to release
(Address)

____
(State specific nature of information to be disclosed)

from the clinical record of ______________________________ (____________)
(Name of client/recipient of mental health services) (Date of birth)

To Shelly Wiggins, MA LPC of Driftwood Counseling Services, 654 E. Main St
Owosso, MI 48867 for the purposes of facilitating counseling/consultation, and/or conducting an evaluation.

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Shelly Wiggins, MA, LPC. I understand that a revocation is not valid to the extent that Shelly Wiggins, MA, LPC has acted in reliance on such authorization. This authorization is valid until (date:) ________________________.

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): ____________ no information released and/or ____.

A copy of this release shall have the same force and effect as the original.

______________________________ ______________________________
(Client signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

______________________________ ______________________________
(Witness) (Date) (Relationship) (Date)

NOTICE TO RECEIVING FACITILITY/THERAPIST. You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

Driftwood Counseling Services
Insurance Registration Form

Therapist: Shelly M. Wiggins, MA, LPC
MI License: 6401008453

Intake Date: ______________________ Completed by: ____
Referring Physician: ____

Patient Name: ____ DOB: _______________________
Address: ____ State: ______ Zip: __________
SS#: _______________________ Employer: ____
Phone: ____________________ Work Phone: __________________ Cell Phone: ________________
Sex: Male Female Marital Status: Single Married Divorced Widowed
Diagnosis: ____

RESPONSIBLE PARTY: _____________________________________ SS#: ________________________
Address: ____ State: ______ Zip: __________
Phone: ____________________ Work Phone: __________________ Cell Phone: ________________

Insurance #1:
Policy #: ____ Group #: ___________________
Policy Holder: ____ Phone #: ___________________
Insured DOB: ____ Employer: _________________

Insurance #2
Policy #: ____ Group #: ___________________
Policy Holder: ____ Phone #: ___________________
Insured DOB: ____ Employer: _________________

EMERGENCY CONTACT (other than spouse):

Name: ____ Relationship: _______________
Home Phone: ____ Work Phone: _______________

INSURANCE INFORMATION (please present insurance card for photocopy)

In order to submit a claim for payment to us for services covered under you policy, we must have authorization to release medical information to our billing company and your insurance company.
I herby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance company.

Signature: ____ Date: ___________________________

Witness: ____ Date: ___________________________

Driftwood Counseling Services
Shelly M. Wiggins, MA, LPC
MI License # 6401008453
654 E. Main St
Owosso, MI 48867
(517)749-2235

INSURANCE INFORMATION AND VERIFICATION OF BENEFITS

Clients Name: ______________________ DOB: ______________

Insurance Company: ______________________
Mental Health Outpatient Company: ______________________
Number of verify benefits: ______________________
Information from: ______________________ Date: ______________

Primary Insured: ______________________
Employer: ______________________
I.D.# or Soc. Sec #: ______________________
Policy #: ______________________
Group #: ______________________
Birth Date: ______________________

Effective Date of Policy ______________ LPC Accepted ______________
Max Payable Per Session ______________ Dr.'s Referral needed ______________
Percent Coverage: ______________
Max Payable per Calendar Year: ______________

Number for Precert: ______________
Precertification ID # ______________
Certified by: ______________
Managed Care Company: ______________
# of Sessions Authorized: ______________
Patient Co-pay: ______________

CLAIMS SENT TO: ______________________ Insurance Forms: ______________
Company Forms: ______________
Standard HCFA 1500: ______________

Notes:
____
____