George J. Joumas, M.A., L.P.C. **JOUMAS CONSULTING**

4545 East Shea Blvd., Suite 112
Phoenix, Arizona 85028
(602) 392-2012 Confidential Voice Mail / (602) 494-7110 / (602) 494-1724 FAX

Individual, Couple & Family Therapy
Children, Adolescents and Adults
www.joumasconsulting.com

PERSONAL INFORMATION FORM

Today's Date: _____

Patient's Name: _____ SS # _____ - _____ -_____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ E-mail: _____

Home Phone: (_____)_____ Date of Birth _____ Age: _____ ❑ M ❑ F

Employer: _____ Work Phone: _____ Ex _____
May we contact at work: ❑ Yes ❑ No

Spouse's / SO's / Parent's Name: _____ SS # _____ - _____ - _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Date of Birth _____ Age: _____ ❑ M ❑ F

Employer: _____ Work Phone: _____ Ex _____
May we contact at work: ❑ Yes ❑ No

Insurance Information

Name of Responsible Party / Policy Holder: (Patient, Spouse or Parent) _____

Relationship to Patient ❑ self ❑ parent ❑ spouse ❑ other _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ E-mail: _____

Home Phone: (_____)_____ Date of Birth _____ Age: _____ ❑ M ❑ F

Employer: _____ Work Phone: _____ Ex _____
May we contact at work: ❑ Yes ❑ No

Primary Insurance: _____

ID Number: _____ Group Name (Number): _____ SS # _____ - _____ - _____

Referred by: _____

Family Physician: _____ Phone: _____

Emergency Contact (Other than Spouse): _____

Relation: _____ Phone: _____

AUTHORIZATION FOR DIRECT PAYMENT - RELEASE OF RECORDS

I hereby authorize insurance payments directly to George J. Joumas, M.A. I hereby authorize the release and exchange of pertinent psychological, psychiatric, educational, and/or medical records for insurance purposes / case management purposes only.

_____ _____
Signature of Insured or Responsible Party (Parent if Minor) Date

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INFORMED CONSENT FOR TREATMENT

☑ I have chosen to receive psychotherapy / counseling services. I understand that my choice has been voluntary and that I may terminate therapy at any time. I understand that there is no assurance that I will feel better, and that material may be discussed that may be upsetting in nature. I understand that psychotherapy / counseling is a collaborative effort between my therapist and myself. I understand that I have the right to be informed of the various steps and activities involved in receiving services**.** I will attempt to work with my therapist to develop and follow a plan of treatment. I also understand that I have the right to humane care and protection from harm, abuse, or neglect. I understand that I have the right to make an informed decision whether to accept or refuse treatment.

☑ I understand that confidentiality of all records or information collected about me, and all information discussed in consultation and / or therapy sessions will be held in accordance with state and federal laws (42 CFT Prt 2) and cannot be released or disclosed without my written consent unless otherwise provided for in state and federal regulations. I understand that state and local laws require that my therapist report all cases of physical or sexual abuse of minors or the elderly. I understand that state and local laws require that my therapist report all cases in which there exists a clear danger to self or others.

☑ I understand that George J. Joumas, M.A. will respond to written and phone request for medical records in a timely fashion. Request for release of records should include a signed written authorization of release identifying the individual and/or organization to which the records are released, and that confidential medical records are stored, accessed and released in accordance with Arizona state regulations (32-3211).

☑ I understand that insurance companies require that my name and an identification number be place on every page of my medical record, and that a chart number (i.e..., JG1999125, initials date of intake) will be used rather than my insurance ID (social security number).

❑ (Initial) I understand that my portion of therapeutic expenses (insurance co-pay or deductible) is due at the conclusion of each session, and that I am responsible for payments not made by my insurance (within the limits of my insurance contract). I understand that I will be charged a fee of $35.00 for any check returned for [NSF] non-sufficient funds. I also understand that I will be responsible for my portion of balances and fees (collection fee of 50% of balance) for balances that have not been paid in 90 days and turned over to a collection agency, and subject to reporting to credit bureau. I also agree to give accurate and current billing information (i.e..., insurance and billing address) and understand that incorrect information may result in my account being turned over immediately to a collection agency.

❑ (Initial) I understand that George J. Joumas, M.A. requires the minimum of a 24 hour notice if I will be unable to attend my appointment. I understand that if I no show for a scheduled appointment or fail to give minimum of a 24 hour notice, **I will be charged full fee for that session** (unless limited by my insurance). If I need to cancel with less than 24 hours, I will leave a message with the answering service and not on Mr. Joumas's voice mail. I also understand that George Joumas holds himself responsible and abides by this same no show / late cancellation policy. Mr. Joumas will reimburse you should he no show or late cancel an appointment, or offer you a free makeup session. I also understand that a pattern on my part, of no show or failure to give notice of cancellation, will be discussed with my therapist with regards to current motivation or appropriateness for treatment and may result in a therapeutic discharge and/or referral back to my insurance company. I also understand that there will be additional fees for reports (e.g. for purpose of disability, legal, court, etc.).

☑ I understand that in the case of a "*If this is a life threatening or other emergency"* (as instructed on Mr. Joumas's voice mail) "*I will call* ***602-494-7110 and ask that I be contacted immediately. After normal office hours please call my service at 480-308-1513 and ask that I be contacted immediately. If they are not able to reach me immediately, please call your referring insurance or managed care company and ask for a Crisis Case Manager and / or call 911.****"* I understand that many insurance companies require me to call their Crisis Manager if I am unable to reach George Joumas immediately.

☑ I have read and understand the above.

_____ _____
Patient's Signature Date

☑ I have also received and read **HIPAA Notice of Information Practices and Privacy Statement**.

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date

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PERSONAL INTAKE / HISTORY

Patient Name: _____ Education _____ Current School: _____

Current Relationship Status: ❑ Single ❑ Living with Partner ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
Number of Marriages / Significant Partner Relationships _____ Religious / Spiritual Tradition: _____

PRESENTING PROBLEMS

Brief explanation of why you are currently seeking psychological support. _____

_____

_____ **What is the duration of this problem (s)** _____

CURRENT SYMPTOMS CHECKLIST

Do you have any of the current or past psychological problems? *Please check appropriate boxes that apply* ❑

SYMPTOM OR PROBLEM	❑ NO	❑ current problem	❑ past problem	Age when first a problem
Depression	❑ no	❑ current	❑ past	_____
Bipolar disorder	❑ no	❑ current	❑ past	_____
Anxiety / Panic disorder	❑ no	❑ current	❑ past	_____
Obsessive - Compulsive Disorder [OCD]	❑ no	❑ current	❑ past	_____
Post Traumatic Stress Disorder [PTSD]	❑ no	❑ current	❑ past	_____
Psychosis, delusions, hallucinations	❑ no	❑ current	❑ past	_____
Paranoia	❑ no	❑ current	❑ past	_____
Attention Deficit / Hyperactivity Disorder [ADHD]	❑ no	❑ current	❑ past	_____
Other learning / educational disorder	❑ no	❑ current	❑ past	_____
Suicidal thoughts / feelings / ideation	❑ no	❑ current	❑ past	_____
Homicidal thoughts / feelings / ideation	❑ no	❑ current	❑ past	_____
Self-mutilation	❑ no	❑ current	❑ past	_____
Anger, agitation or aggression	❑ no	❑ current	❑ past	_____
Victim of emotional, physical or sexual abuse	❑ no	❑ current	❑ past	_____
Perpetrator of emotional, physical or sexual abuse	❑ no	❑ current	❑ past	_____

SUBSTANCE USE HISTORY

Gambling or other addictive behavioral problems	❑ no	❑ current	❑ past		_____
Eating disorder, bingeing and / or purging	❑ no	❑ current	❑ past		_____
Other _____	❑ no	❑ current	❑ past		_____

SUBSTANCE	AGE 1ST USE	LAST USE	❑ NO USE	❑ current USE	❑ current ABUSE	❑ past Problem
Nicotine, cigarettes, smokeless tobacco	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Alcohol	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Amphetamines , speed or other stimulants	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Barbiturates, downers	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Caffeine	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Cannabis (marijuana) or hashish	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Cocaine, crack	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Ecstasy	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Hallucinogen (LSD, Angel Dust, Mescaline)	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Inhalants (glue, gas) "huff"	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Opiates (Heroin, Methadone, Codeine, etc.)	_____	_____	❑ no	❑ use	❑ abuse	❑ past
Prescription or other _____	_____	_____	❑ no	❑ use	❑ abuse	❑ past

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TREATMENT HISTORY

Have you had any previous psychological consultations? ❑ No ❑ Yes When: _____

Where: _____ Dr. / Therapist: _____

Current or prior psychiatric medications ❑ No ❑ Yes

Have you ever been hospitalized for psychiatric reasons? ❑ No ❑ Yes When: _____

Where: _____ Dr. / Therapist: _____

Any other current psychiatric / psychological supports? ❑ No ❑ Yes Where: _____

Medication	dosage	frequency	start date	end date	side effects	helpful

Other current or prior non psychiatric medications ❑ No ❑ Yes

Name of current psychiatrist: _____ Phone : _____

Medication	dosage	frequency	start date	end date	side effects	helpful

MEDICAL HISTORY

Name of current primary care physician: _____ Phone : _____

Do you have any current or past medical problems ? Please list and include treatments, including physicians and medications.

_____

_____

_____

_____

_____

_____

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FAMILY MEMBERS AND OTHERS NOW IN HOUSEHOLD

Name	Relationship	Age	Occupation	Marital Status

PATIENT'S FAMILY OF ORIGIN (Mother, Father, Siblings, if different from above)

Name	Relationship	Age	Occupation	Marital Status

OTHER HISTORY

Military history: ❑ No ❑ Yes ❑ No Problems ❑ Problems When: _____
Financial: ❑ No Problems ❑ Problems Explain: _____
Living situation / housing: ❑ No Problems ❑ Problems Explain: _____
Employment: ❑ No Problems ❑ Problems Explain: _____
Legal History: ❑ No Problems ❑ Problems Explain: _____
Social support system: ❑ No Problems ❑ Problems Explain: _____
Family: ❑ No Problems ❑ Problems Explain: _____
Cultural / spiritual: ❑ No Problems ❑ Problems Explain: _____

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AUTHORIZATION FOR RELEASE AND / OR EXCHANGE OF INFORMATION

I understand that my records and information obtained during consultation / therapy are confidential and protected under the federal regulations governing *Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFT Prt 2*, and cannot be disclosed, exchanged or obtained without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this authorization at any time, except to the extent that information based on this authorization has already been released, exchanged or obtained. This consent will automatically expire:
❑ 60 Days post completion of treatment ❑ Other _____

Information to be Released, Exchanged, and/or Obtained:
☑ Psychological ☑ Psychiatric ☑ Educational ☑ Testing ☑ Medical ☑ Alcohol ☑ Drug
❑ Other _____

Specific Information to be Released, Exchanged, and/or Obtained:
☑ Diagnosis ☑ Dates of Treatment ☑ Treatment Plan ☑ Treatment Progress ☑ Discharge Summary
☑ Test results / data ☑ History and Physical ☑ Lab results ☑ Summary of Treatment
❑ Complete records ❑ Other _____

Purpose
☑ Facilitate treatment, coordinate services and assure continuity of care ☑ To assist in making referral
☑ Communication with insurance or managed care case management ❑ To arrange leave of absence from work or return to work ❑ To comply with court order, subpoena, employer request, or other appropriate requests for information.
❑ Other _____

When completed and signed, this document authorizes the release and/or exchange of confidential information regarding the following patient:

Name: _____ Date of Birth _____

Between: **George J. Joumas, MA, Shea Mental Health, 4545 E. Shea Blvd., Suite 112, Phoenix, Arizona 85028 (602) 494-7110 , (602) 494-1724 Fax (602) 392-2012 voice mail**

And ☐ **RELEASE** **Insurance Company / Managed Care Case Manager** _____

Primary Care Physician [PCP] _____

_____ _____
Signature of Patient / Parent / Legal Guardian **Date**

_____ _____
Witness **Date**

And ☑ **OBTAIN** **Insurance Company / Managed Care Case Manager** _____

Primary Care Physician [PCP] _____

_____ _____
Signature of Patient / Parent / Legal Guardian **Date**

_____ _____
Witness **Date**

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☑ I have read and understand the above.

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date