COMPLETE AND RETURN

Charles R. Martin, Ph.D.
Licensed Psychologist - Florida License PY5214

CLIENT INFORMATION FORM

_____ _____

Last Name First Name Middle Initial Birthdate

_____

Street Address Apt. #

_____

City State Zip Code

Okay to send correspondence to this address? Y N

Phone Numbers:		Okay to call?		Okay to leave message?	
Home:	_____	Y	N	Y	N
Work:	_____	Y	N	Y	N
Cell:	_____	Y	N	Y	N

Email address _____ Is it OK to use email to contact you? Yes No
A "yes" means you understand the potential limitations to confidentiality inherent in email communications.

Gender: _____

Race: ☐ Caucasian ☐ African Descent ☐ Native American
☐ Asian/Pacific Islander ☐ Multiracial _____
☐ Hispanic/Latino/a ☐ Other_____

Are there other ways that you identify yourself? (i.e., religious affiliation, sexual orientation, cultural identity, ability, etc.)
_____
_____

Referred by: _____

PRESENT CONCERNS

Please list the reasons/concerns that brought you here today:
_____
_____
_____
_____

Completion of the following information will provide a thorough background in better understanding your concerns.

EDUCATIONAL/OCCUPATIONAL HISTORY

What is the highest level of education you achieved? (i.e. GED, high school diploma, BS, PHD) _____

From what institution (i.e. school, university) did you receive your highest degree?

_____

Are you currently employed? (circle one) YES NO

If yes, please describe your position and work _____

_____

If yes, how satisfied are you with your current employment? _____

Please indicate your history of previous employment

Positions **starting with most recent*	**Month and Year**
	From: To:
	From: To:
	From: To:

Did you have any significant academic, behavioral or social difficulties growing up? (circle one) YES NO

*If yes, please describe*_____

_____

_____

FAMILY HISTORY

The following is a checklist of characteristics or conditions that may run in families. Please put an X in the column if any of your family member(s) have or have had each characteristic or condition. If more than one brother or sister has or has had one of these characteristics or conditions, put an X for each one in the appropriate column (for example, if there were two brothers who had trouble with learning how to read, you would put two X's next to that item under the column "Brother(s)."). The "Others" column (for family members such as cousins, aunts, uncles, grandparents) should be used in the same way.

FAMILY HISTORY	Parent 1	Parent 2	Brother(s)	Sister(s)	Others (specify)
Hyperactive/Attention problems					
Learning difficulties (reading/writing/math)					
Held back in school (retained in a grade)					
Speech problems					
Behavior problems					
Mental Retardation					
An honor student					

FAMILY HISTORY (cont.)	Parent 1	Parent 2	Brother(s)	Sister(s)	Others (specify)
Legal problems due to conduct					
Depression or manic depression					
Drug or alcohol problems					
Tics, movement disorders					
Obsessive Compulsive Disorder					
School avoidance, phobias, panic attacks					
Eating Disorder					
Chronic or significant health problems					

Parent 1: Please circle Father/Mother/Other _____

Name: _____Marital Status: Single/Married/Divorced/Widowed/Remarried/Deceased

If living, this parent's present age _____ School level/Occupation_____

Parent 2: Please circle Father/Mother/ Other _____

Name: _____Marital Status: Single/Married/Divorced/Widowed/Remarried/Deceased

If living, this parent's present age _____School level/ Occupation_____

Siblings: Please circle brother or sister

Brother/Sister's Name: _____Present age _____School level/Occupation_____

Brother/Sister's Name: _____Present age _____School level/Occupation_____

Brother/Sister's Name: _____Present age _____School level/Occupation_____

Current Spouse/Partner(s):

Name: _____Age _____School level/Occupation_____

Length of Relationship _____ circle one: married/lifetime partner living together dating

Name: _____Age _____School level/Occupation_____

Length of Relationship _____ circle one: married/lifetime partner living together dating

Additional? _____

Children:

Additional family members (including adult children or close, extended family):

Name: _____Present age _____ School level/Occupation_____

Name: _____Present age _____ School level/Occupation_____

Name: _____Present age _____ School level/Occupation_____

List everyone with whom you currently live:

_____

If you do not live with your family of origin (i.e. parents, brother, sister, adult children), please describe your current relationships with them: _____

_____

MEDICAL HISTORY

Please rate your overall health (excellent, good, fair, poor)_____

Please list any history of chronic illness, hospitalizations, accidents/injuries/head injuries, loss of consciousness (with date and nature of each)

_____

_____

_____

_____

Please list any regular medications: _____

_____

_____

If you take prescription medications, who is your prescribing physician? _____

Please describe your habits:

Do you use nicotine? _____ If so, how much (#cig./pack per day)_____

Do you use alcohol? _____ If so, how much (#drinks per day/week/month)_____

Do you drink caffeine (tea, coffee, cola)? _____ If so, how much (#8oz. cups/day)_____

Do you use illicit substances? _____ If so, what, how much, and how often_____

_____

PSYCHOSOCIAL HISTORY

How would you describe your relationships with other people at school/work, at social gatherings, in the neighborhood, etc? (i.e. close, pleasant, awkward, distant, tense):_____

How many close friends do you have and how often do you socialize with friends? _____

_____

Have you experienced any recent events you would consider especially stressful (i.e. health problems, job changes, moving, relationship difficulties, etc.).? (circle one) YES NO

*If yes, please describe*_____

_____

Have you ever experienced any of the following? Please circle any that apply.

Emotional abuse by a partner Physical abuse by a partner Sexual Assault

Emotional abuse as a child Physical abuse as a child Sexual Molestation as a child Incest

Have you ever experienced any events you would consider *traumatic or life endangering* (i.e. tornado, fire, car accident, etc.).? (circle one) YES NO

*If yes, please describe*_____

_____

Describe your *general* mood over the last few months. (Any ongoing difficulty with crying spells, seeming sad, anxious, unhappy or depressed?)

_____

_____

Do you have any of the following sleep problems?...

	NO	YES	If yes, please indicate duration and nature of problem including ***how often (____times/night, ____times/week).***
Can't fall asleep			
Wake up in the middle of the night			Usual time(s) of arousal:
Wake up too early in the morning (When: am)			
Restless sleeper (move around excessively during sleep)			
Very hard to wake up			
Nightmares			
Snore			
Fall asleep or get drowsy at school/work			

Describe your energy level. _____ Describe your appetite. _____

Has your appetite changed recently? Have you gained or lost a significant amount of weight recently?

_____

How satisfied are you with your weight and appearance? (Use back of page if necessary) _____

_____

Have you had feelings of hopelessness in the last few months? (circle one) YES NO

Have you had any thoughts about harming yourself or others? (circle one) YES NO

*If yes to either above, please explain*_____

Have you had any experience with prolonged (a day or more) periods of intense energy, which may include a significant decrease in sleep, feeling much more talkative or restless than usual, starting many projects at once? (circle one) YES NO

Have you had any experience with prolonged (a day or more) periods in which you engage in more risk-taking behavior (i.e. hypersexed, spend large amounts of money) than is typical? Or feel extremely grand, powerful? (circle one) YES NO

*If yes to either above, please explain*_____

Have you been troubled by seeing or hearing things you know are not real? (circle one) YES NO

If yes, please explain _____

Have you had episodes of significant anxiety or worries? (circle one) YES NO

Have any had any significant difficulties with fears or phobias? (circle one) YES NO

If yes to either above, please explain _____

_____

Have you had any legal difficulties (i.e. arrests, probation, etc.)? (circle one) YES NO

*If yes, please describe*_____

Do you now or have you ever engaged in any self-harming behaviors? (circle one) YES NO

*If yes, please describe nature and frequency*__

_____

Have you ever participated in individual, family or group counseling? (circle one) YES NO

If yes, please note when, with whom, and what was the outcome? _____

_____

_____

_____

What do you consider to be your strengths? _____

_____

Do you have any religious or spiritual beliefs or practices? If so, please describe _____

_____

_____

Please list any strong interests/hobbies (i.e., what do you like to do for fun?) _____

_____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____

I understand that I am responsible for payment of services rendered regardless of whether these services are covered by an insurance policy or not. I have been given and read a copy of Dr. Martin's statement of "*Policies and Practices to Protect the Privacy of Your Health Information.*"

Signature: _____ Date: _____
(Client or guardian)

Charles R. Martin, Ph.D.
Licensed psychologist

SIGN AND RETURN

2631 N.W. 41st Street, E-6
Gainesville, Florida 32606

(352) 375-7756

Background

I am pleased that you have considered coming to me for individual counseling/psychotherapy. Counseling is an intensive professional relationship, in which often very personal information is shared between two individuals. Such a relationship should not be entered into lightly. The following information is to help you to know me and to know what you can expect from our work together.

My highest degree is a Ph.D. in Counseling Psychology from the University of Florida. I have an M.A.Ed. in Counseling and a B.A. in Psychology from Wake Forest University. I am currently licensed as a psychologist in the state of Florida (#PY5214), and I am a certified hypnotherapist, and certified somatic psychotherapist. I am a member of the American Psychological Association, and a member of the Society of Counseling Psychology. In my private practice, I do counseling, coaching and consulting work with individuals – to help them improve the quality of their personal and professional lives.

I have worked as a psychotherapist in community, university, and hospital settings and have provided consultation services in all of those arenas. My specialty areas include: issues of identity, meaning and purpose; midlife concerns; work and home life balance; and integrating personal development with spiritual development/practices. I also have significant experience with somatic psychotherapy practices, and working with issues of depression, anxiety, stress and trauma, gender identity and expression, and sexual orientation,

My background also includes considerable experience providing coaching and consultation services in business settings, working with a wide variety of professionals.

Approach

I prefer to tailor my approach to the needs of the individual, but there are some elements I commonly bring into all work that I do with clients. My general approach is integral. That is, I draw on personal and transpersonal perspectives in my work with clients as a way of supporting their individual, social and career development. My goal is to help clients learn to draw on their many resources (e.g., physical, emotional, social, cognitive, and spiritual) to help them feel empowered to address the needs of their daily lives.

We have learned much of how we think, feel, and behave from our history and from our environment. Moreover, people develop ways of coping (both healthy and unhealthy) in response to contextual factors that can be familial, cultural, socioeconomic, or religious. We usually make the best choices we can and develop coping strategies based on our experiences and beliefs. Some of the beliefs and behaviors we have acquired serve us well while others do not. At different points in our lives, it may also become clear that some of what we are thinking, feeling, and doing is just not working well for us anymore.

In much of my therapy, I will work with you to identify how you have developed ways of coping in other contexts – ways that may or may not be working presently. One of my goals will be to empower you by helping you become aware of contextual factors that have influenced you, and by helping you free yourself to make different choices. **I do have a strong emphasis on working with and developing *awareness* - of our sensations, feelings/thoughts, behaviors, interactions, and habitual patterns of viewing self and the world.** In addition, I find it's often important to engage somatic practices (sensing, moving, engaging the breath) in therapeutic work, so that we can include body and feeling (not just words and intellect) in our experience of ourselves.

On Therapy

You are responsible for playing an active part in your therapy, and will be part of setting the objectives and goals of your treatment (and revising them) in each stage of the therapy process.

The work we do during sessions will be most effective as you apply your developing insights and skills outside of our meetings. In between sessions, I may encourage you to do specific activities (e.g., write something, read a resource, try out a behavior) to help you in your work. In our work together, you can gain insights, try out new behaviors, get new experiences, receive feedback and support, and develop new empowering beliefs about yourself.

Therapy does have potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your work with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful, and I will do what I can to help you minimize risks and maximize positive outcomes.

If I am not, in my judgment, able to help you, either because of the kind of problem you have or because my training and skills are not sufficient, my ethics require that I inform you of this fact and refer you to another therapist who can meet your needs. I would continue to meet with you until you had established a relationship with a new therapist, and I would assist you in finding this person.

Unless we have arranged otherwise, I am generally not available outside of office hours. If you are experiencing extreme distress and are unable to reach me through the office, you may call the Alachua County Crisis Center at 352-264-6789. The Crisis Center has people available 24 hours a day and is an excellent supportive resource.

Hints for Your Sessions

- For your first sessions, you are interviewing me when I am interviewing you.
- Make a list of any ideas you want to talk about, and don't be afraid to ask me questions.
- When you have thoughts/feelings, express them even if it is a bit uncomfortable. This is how I can really get to know you and help you.
- If you feel you want something different than what you are getting from counseling, or if you are unhappy with what is happening in therapy, I hope you will talk about it with me so that I can respond to your concerns. I take such concerns seriously. We may need to make some adjustments in what we are doing.

Fees

My fee for individual counseling is $175 per session, payable in full at each visit, including the first visit, unless we have made other firm arrangements in advance. Each session is 50-55 minutes long. Many insurance providers provide reimbursement for out-of-network behavioral health services, including psychotherapy. Please understand that you are responsible for payment of services rendered regardless of whether these services are covered by an insurance policy or not.

If you have and use insurance, you are responsible for providing the information needed to submit your bill. You must pay your deductible, if this applies, and any co-payment. You must arrange for any pre-authorizations necessary. If an insurance check is mailed to you, you are responsible for paying that amount at the time of our next appointment.

If you are having a hard time paying for therapy, please discuss it with me so we might determine what options are available to you.

Confidentiality

With the exception of certain specific exceptions outlined below, you have the right to the absolute confidentiality of your therapy. I cannot and will not tell anyone else of the things that you have told me, or even that you are in therapy with me.

To release any information about you, I would need your written permission. You may ask me to share information about you with anyone you choose and you may revoke this permission at any time. Even when I have your written consent to release information, I will still protect your privacy and use my best judgment in sharing only information relevant to that person or that request. There are times that I may consult with professional colleagues to gain greater insight about my work with you. When I do this, I will not share your name or any other information that might identify you.

There are rare circumstances in which there are legal exceptions to your right to confidentiality, and I would inform you of any time when I think I will have to put these into effect. Specifically, (1) If I have good reason to believe that you are abusing or neglecting a child or a disabled or elderly adult, or if you give me information about someone else who is, I am required by law to report this to the Department of Health and Rehabilitative Services. (2) If I have good reason to believe that you are intending to harm another person, I am legally allowed to take actions that I deem appropriate to protect/warn that person (i.e., call the police, inform the victim). (3) If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and inform those whom I believe could be of assistance to you (i.e., a family member, Alachua County Crisis Center). I will explore all other options with you before doing this, and (4) If you are involved in a lawsuit or legal complaint and you bring up the question of your mental health, it is very likely that your attorney or opposing attorney will want access to your records. I will not release them without your written consent or unless I am issued a court order to do so. Please let me know if you are in this kind of situation so that we can discuss how to best maintain your privacy. Your name and any insurance information are accessible to my accounting and billing specialists, who do not otherwise have access to notes or content of our sessions. I have formal business associate contracts with these people, in which they agree to maintain the confidentiality of these data.

Late, Broken, or Missed Appointments

Due to the time commitment I make to you and others, if you are late to session, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four (24) hours' notice, you will be charged the hourly fee, due before or at the next session. I have a private voicemail where you can leave messages if I am not available, and I check it regularly. Please let me know as far in advance as possible if an appointment must be broken (352-375-7756). Note that missed sessions cannot be billed to insurance, so you will be responsible for these payments.

Client Consent to Counseling/Psychotherapy

I have read this statement and have had the chance to ask any questions that I needed to, and I understand it. I agree to undertake counseling with Charles R. Martin, Ph.D. I know I can end counseling at any time I wish and that I can refuse any requests or suggestions made by Dr. Martin.

Client signature: _____ Date: _____

COMPLETE AND RETURN

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

CLIENT NAME (printed) _____

Charles R. Martin, Ph.D. - Licensed Psychologist
2631 NW 41st Street, E-6, Gainesville, FL 32606

Is Granted This Consent

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities).

With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that Notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected health information as specified above.

Signature of Client _____

FINANCIAL AGREEMENT

Dr. Martin's 50-55 minute psychiatric session $175.00

PLEASE NOTE: There are additional charges if sessions continue beyond the scheduled time or if phone calls extend beyond 5-10 minutes.

PLAN A: Cash payments of fees (AKA "private pay")

1) If I file my own insurance or do not have insurance that covers psychotherapy, I will pay the full fee to Dr. Martin on the day that services are rendered.
2) I AGREE TO PAY THE FULL FEE FOR MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE. Payments must be made before or at the time of the next appointment.
3) If I do not honor this financial agreement and develop an outstanding balance, I will pay the charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive the right to confidentiality for purpose of collection of the said fee. Any reasonable attorney fees and costs incurred by Dr. Martin for the collection of the past due account shall be my obligation as well.

PLAN B: Cash plus insurance payment of fees

I authorize the release of medical records and diagnostic information necessary to process this claim. I also authorize any payment of medical benefits to the above referenced provider for services rendered. However, it must be fully understood that the contract is between me and my insurance company and I am fully responsible for any amount not paid by my insurance.

1) **I will submit to the office my co-payment on THE DAY OF MY SESSION. Dr**. Martin will file my insurance and any insurance payments received are to be deducted from the balance of my account.
2) The office does not guarantee that my insurance company will pay. They will make every attempt at the beginning of my health care to receive verification of my policy and what it covers. However, if for some reason, my insurance claim is denied, or payments are requested to be refunded, I am responsible for the full amount of my bill.
3) The office will not enter into a dispute with my insurance company regarding my claim. This is my responsibility and obligation.
4) If my mental health insurance benefits are exhausted within a calendar year, I will be responsible for paying Dr. Martin' full fee until my benefits renew at the beginning of the next year.
5) I AGREE TO PAY THE FULL FEE FOR ALL MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE. Payments must be paid before or at the time of the next appointment.
6) If I do not honor this financial agreement and develop an outstanding balance, I will pay the charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive the right to confidentiality for purpose of collection of the said feel. Any reasonable attorney fees and costs incurred by Dr. Martin for the collection of the past due account shall be my obligation as well.

I understand and agree with all of the above office policies, and will pay fees via **(CIRCLE ONE)**

- Plan A (Cash)
- Plan B (Cash plus insurance)

_____

Signature