Return Client Questionnaire

Client Name:____

Street Address: ________________________________ City:__________________ State:__________

Zip:________________ Home Phone:___________________ Work Phone:___________________

Date of Birth: ____/____/________ Age: __________

Parent/Guardian (for Minors only):____

Name of School (If Applicable):___________________________________Grade:__________

Client's Occupation:___________________________ Employer:___________________________

Client SS#:____

In Emergency Contact:__________________________________At:______________________

Primary Care Physician:________________________________Phone:___________________

Updated Insurance Information
Name of Insurance Company:____
Policy Holder (Subscriber):__________________________________ DOB:______________
Subscribers Place of Employment:____
Clients Relationship to Subscriber:____
Subscribers Address:____
Contract #_________________________________Group #:__________________________

I authorize payment of medical benefits to the provider for services rendered, if applicable. I further authorize release of information to the above designated insurance carrier. Confidentiality procedures of the managed care and/or insurance company cannot be guaranteed by the psychotherapist. Information may be shared with the collection department, outside collection agency, our attorney, credit bureau, law enforcement, or IRS

I have read the above and accept this policy as outlined:

Signature of client:____Date:___________

What is the reason for your appointment today? (What are your symptoms, when did they start, how long do they last, how often do they happen?)

Current Symptoms:	YES	NO
Have you been down, depressed, or hopeless in the past month?		
Are you bothered by little interest or pleasure in doing things?		
Has your appetite changed (eating more or less)?		
Has your sleep been disturbed (insomnia or over-sleeping)?		
Do you feel worthless or guilty?		
Do you have sudden or unexpected bouts of anxiety or nervousness?		
Do you often feel tense, worried, or stressed?		
Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling?		
Do you worry about a lot of different things?		
Do you avoid placed or situations because of anxiety or worry?		
Do you have recurrent, persistent or unwanted thoughts or do repetitive behaviors?		
Have you been through any significantly stressful periods on the past 6 months?		
In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical or sexual assault/abuse, military combat or child abuse?		
Since you experienced any of these stressors, have you been easily startled?		
Angry or irritable?		
Emotionally numb or detached from your feelings?		
Prone to physical reactions when reminded of the event?		
Do you use prescription medicines or street drugs to relax, calm your nerves, or get high?		
Have you made an effort to cut down on your drinking or drug use?		
Have you been annoyed by people who criticize your drinking or drug use?		
Do you ever feel guilty about your drinking or drug use?		
Do you ever drink or use drugs to steady your nerves, get rid of a hangover, or relieve withdrawal symptoms?		

Have any major life events occurred since your last appointment with GPS? If yes, please explain:

Have you received any mental health, therapy, or psychiatric services since your last appointment with GPS? If yes, please explain:

Have you been diagnosed with a mental illness since your last appointment?

If yes, what is your diagnosis?

Are you taking any psychiatric medications at this time? If yes please include name, dosage, and frequency.

Have you been hospitalized since your last appointment?

Are you having thoughts of suicide?

Have you attempted suicide in the past?

Do you physically hurt yourself?

Are you experiencing abuse or violence?

Has your living situation changed since your last appointment? Do you feel safe in your current living situation?

Has substance use changed since your last appointment? Please explain.

Please list what you believe to be your strengths and abilities.

Who is supportive of you at this time?

Please list anything that is holding you back.

What are some of your needs?

Do you have any specific preference for your care? If yes please describe:

Is there anything else that you would like your therapist to know or be updated on?

913 W. Holmes Road, Suite 143 Lansing, MI 48910 Ph (517)667-0061 Fax (517)507-4888

Nicole Dingwell, LMSW CAADC CSAT CSOTS
Jessica Perry, LMSW
Amie Pierce, LPC CSOTS
Stacy Piper Harris, LLPC CSOTS

Bob Clark, MA LPC
Amy Hines, MA LLP LMSW
Ronald Penfield, LMSW ACSW
Dave Ware, LMSW ACSW

Attendance Policy

- **No-Show -** Failing to attend a scheduled appointment without notifying the clinic
- **Late Notice Cancellation -** Canceling an appointment without a minimum of 24 hours notice to allow use time to fill the missed appointment slot
- **Arriving Too Late to Be Seen -** Arriving greater than 15 minutes late for a scheduled appointment. Being excessively late for an appointment creates problems for those who are scheduled after you.

______Initial

All the above will be treated the same.

Most importantly, regular attendance at scheduled follow-up appointments is crucial for the success of your treatment.

- ***Additionally, missed appointments complicate access to the clinic for others and place our ability to continue to provide services in jeopardy.***

GPS is a non-profit organization and while our goal is not financial gain, the clinic must pay for itself. Missed appointments cost our facilities thousands of dollars annually and ultimately may prevent us from providing services at their current levels in the future.

- ***We require a minimum of 24 hours notice prior to any canceled appointment.***

This allows us time to fill the appointment slot to maximize access to our clinic.

- ***Failure to provide 24 hours notice prior to missing a scheduled appointment, no-showing for scheduled appointments, or arriving too late to be seen will be treated the same.***
- ***We have a very strictly enforced policy that 2 no-shows, late notice cancellations, and/or late arrivals can be reason to terminate treatment.***

We understand that occasionally unforeseen events prevent people from attending their appointments, which is why we allow for

- 1 no penalty missed appointment during a 6 month period.

We will make every effort to work with you to schedule appointment times/days that are easiest for you to attend and contact you with appointment reminders. In the event this occurs, however, no exceptions will be granted to this policy.________initial

Medicaid/Healthy Michigan
After a missed appointment as defined above, Healthy Michigan (Medicaid) clients will be removed from their current appointment time and moved to a waiting list with their therapist in order to be rescheduled at the earliest convenience of the therapist who manages their schedule. __________initial

Commercially Insured Clients
No Attendance fee for missed appointments as defined above $30__________initial

I understand it is my responsibility to contact my therapist directly (not at main number) at (ph) ___________________________________ in order to cancel or reschedule my appointment with minimum 24 hours notice or I will either be charged a no show fee (commercial insurance holders and self pay) or removed from my therapists current schedule and placed back on when there is an opening (Healthy Michigan).

I understand that GPS and my therapist set aside this time for me specifically and expect that I will attend regularly. Upon my second missed appointment as defined above I may be discharged from the clinic altogether at the discretion of my therapist and I may not be able to secure another appointment with anyone at GPS.

____________________________________ ______________________
Signature Date

____________________________________ ______________________
Therapist Date

Notification of Recipient Rights

On _______/______/__________ I was given a copy of ***Your Rights,*** the booklet which serves as a summary of the rights of mental health services as guaranteed under Chapter 7 of the Michigan Mental Health Code. The procedure for filing a Recipient Rights complaint was explained to me in a manner in which I could understand and I had the opportunity to ask questions. I have also been notified of which person(s) to contact if I have questions about my rights or to report violations of my rights.

________________________		________________________	__________
Consumer Signature	Date	Parent/Guardian Signature	Date
________________________		________________________	__________
Please print name		Please print name	

. . . .

. . . (THIS SECTION FOR STAFF USE ONLY)

☐ 1. The recipient (or parent/guardian on behalf of the recipient) appeared to understand his/her rights.

____	________________________
Staff Name (with title)	Date of Rights Notification

☐ 2. The recipient (or parent/guardian on behalf of the recipient) did not appear to understand his/her rights.

☐ 3. The recipient or parent/guardian refused to sign.

☐ 4. Parent/guardian was not present to sign for the recipient.

☐ 5. Rights information not offered due to extenuating circumstances as described below.

If one or more boxes is checked for items 2, 3, 4, and 5 above, please explain each below. Use back of this form if more space is needed.

____

____

____

____

____ ________________________

Staff Name (with title)

GPS – Guide to Personal Solutions

913 W. Holmes Road Suite 143
Lansing, MI 48910
www.guidetopersonalsolutions.com

Nicole Dingwell, LMSW CAADC
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Acknowledgement of Notifications

I acknowledge the receipt of the Agency's Client Responsibilities, Grievance Procedure and Consent for Treatment and GPS's Social Media Policy and I understand and agree to comply with these policies. I understand that these policies will always be available to me on the Agency's website but that I may always request a hard copy if I am unable to access them.

I also acknowledge the receipt of the HIPAA Notice of Privacy Practices for my review. I understand that the HIPPA form will remain available on GPS's website but that I may always request a hard copy if I am unable to access it.

I would like for the agency/therapist to email me, I understand there will be no information exchanged regarding my clinical care, only arrangement of appointments. Yes No

My email address is ____.

It is ok for the agency software to email me Yes No OR text me Yes No an *appointment reminder* the day before my appointment.

Please use email address _________________________________ and/or text number

_______________________________________.

_____________________________________ _________________

Client/Guardian Signature Date

____

Client/Guardian Printed Name

_____________________________________ _________________

Witness Date