Thomas Payne, LMSW
110 East Kingsley Street, Ann Arbor, MI 48104
(734) 995-1385

I am pleased to have the opportunity to work with you. This document contains important information about my professional services and procedures. Please read it carefully and discuss any questions you have with me. When you sign this document, it will represent your informed consent for psychotherapy services.

Consent to Treatment: I understand that the services I and/or my dependent(s) will receive are based on currently accepted practices in the field of mental health. Psychotherapy has both benefits and risks: while it is empirically demonstrated to have beneficial effects on emotions, behaviors and relationships, at times it can also arouse distressing thoughts, feelings and behaviors. There are no guarantees as to the results of treatment or of any procedures. It is important to let me know of any concerns you have about your response to our meetings.

Professional Fees and Insurance Coverage: My fee is $150 for a 45-50 minute therapy session. Your health insurance may cover my services (with conditions regarding number of sessions, fee limits, co-pays and deductibles). If I am a participating provider for your plan I will accept their assigned fee and I will bill them electronically. Your co-pay will be due at each session by either check or cash. If insurance does not cover our work or if I am a non-participating provider for your insurance, payment in full is expected at each session unless otherwise arranged. The returned check fee is $30.

Cancellations: I understand that the full fee is charged for appointments missed and for appointments cancelled less than 24 hours in advance. Insurance will not cover missed appointments. The fee can be waived in the event of medical or other emergencies.

Availability: I routinely check my voicemail and will return your call within 24 hours. Phone calls lasting more than 5 minutes will be billed at the agreed-upon hourly rate. In case of emergency, you should contact UM Psychiatric Emergency Services at 734-996-4747, go to the nearest hospital emergency room, or call 911.

Informed Consents:

My signature below shows that I understand the information provided in this document, and that I consent to treatment. It also serves as acknowledgement that I have received a copy of the HIPAA Privacy Notice.

_____
Printed Name

_____ _____
Signature Date

Payment agreement:

I authorize the release of any protected health information necessary to process insurance claims for payment. I hereby authorize payment of insurance benefits to be made directly to Thomas Payne, LMSW. I understand that I am financially responsible to Thomas Payne, LMSW for services not covered or payable by my insurance carrier.

_____ _____
Signature Date

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Information about you:

Last Name_____ First Name_____

Birth Date_____ Age_____ Social Security #_____

Address_____

_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email (if you want)_____

Emergency Contact: _____Phone: _____

Spouse/Partner Name: _____ Children? (ages): _____

_____

Employer_____

Insurance Carrier_____

Other Information:

Why are you seeking treatment at this time?

_____

_____

Referred by:_____

History of previous therapy (please list all previous contact with mental health professionals, including hospitalization and medications, using back of sheet as necessary)

Name Dates Reason(s)

_____

_____

History of psychiatric medications. Please list all, including dosages, dates of usage, and general response.

Drug Dates of use/current? Response/reason for discontinuing

_____

_____

Any current health problems? _____

Do you drink two or more alcoholic beverages per day? _____

Do you use any drugs? (what? frequency?)_____

Do you have any thoughts/behaviors of harming yourself or others? _____

Family history of addiction, mental illness, suicide or hospitalization? (specify)

_____

Any history of/or current physical/sexual abuse? (specify) _____

Any recent changes in sleeping or eating patterns? (specify) _____

ADULT SYMPTOM CHECKLIST

NAME:_____ AGE:_____ DATE:_____

Please circle the symptoms that apply to you now in the past few weeks:

	Never	Rarely	Sometimes			Always
Depression	0	1	2	3	4	5
Crying spells	0	1	2	3	4	5
Hopelessness	0	1	2	3	4	5
Worthlessness	0	1	2	3	4	5
Sleep disturbance	0	1	2	3	4	5
Trouble falling asleep	0	1	2	3	4	5
Interrupted sleep	0	1	2	3	4	5
Early morning wakening	0	1	2	3	4	5
Oversleeping	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Overeating	0	1	2	3	4	5
Weight loss or gain	0	1	2	3	4	5
If so, how much in the last 3-6 months: Gained:_____Lost:_____						
Lack of interest in usual things	0	1	2	3	4	5
Suicidal thoughts, present	0	1	2	3	4	5
Suicidal thoughts, past	Yes_____No_____					
Suicide attempt, gesture	Yes_____No_____					
Homicidal thoughts	0	1	2	3	4	5
Anxiety, nervousness	0	1	2	3	4	5
Irritability, edginess	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Racing thoughts	0	1	2	3	4	5
Hard to concentrate/ stay focused on task	0	1	2	3	4	5
Fatigue/tiredness	0	1	2	3	4	5
Bursts of energy	0	1	2	3	4	5
Worry	0	1	2	3	4	5
Fears of ordinary things (for example, crowds, germs, doctors, flying, closed spaces)	0	1	2	3	4	5
Yelling/screaming	0	1	2	3	4	5
On the go, hard to relax	0	1	2	3	4	5
Periodic overspending	0	1	2	3	4	5
Gambling problem	0	1	2	3	4	5
Alcohol problem (in the last year)	0	1	2	3	4	5
Drug problem (in the last year)	0	1	2	3	4	5
Blackouts, shakes, tremors	0	1	2	3	4	5
Anxiety/panic attacks	0	1	2	3	4	5
Heart beating fast	0	1	2	3	4	5
Chest pains/tightness	0	1	2	3	4	5
Lightheadedness	0	1	2	3	4	5
Stomach upset	0	1	2	3	4	5
Sexual difficulties	0	1	2	3	4	5
Relationship problems	0	1	2	3	4	5
Work problems	0	1	2	3	4	5
Eating disorder	0	1	2	3	4	5
Suspiciousness/paranoia	0	1	2	3	4	5
Feeling controlled	0	1	2	3	4	5
Hitting/domestic violence	0	1	2	3	4	5
Hearing voices (that others don't)	0	1	2	3	4	5
Seeing things (that others don't)	0	1	2	3	4	5
Need for cleanliness	0	1	2	3	4	5
Need for organization	0	1	2	3	4	5
Counting behavior/thoughts	0	1	2	3	4	5
Rituals that you must do/ need to check and recheck	0	1	2	3	4	5
Unexplained physical symptoms	0	1	2	3	4	5
Trauma, other abuse	0	1	2	3	4	5

Revised 5/06