50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317-550-3221
Fax: 317:550-3228
info@ipci.hush.com

Maria P. Hanzlik, PsyD, HSPP-Clinical Psychologist
Jessicah D. Walker, PhD, HSPP-Counseling Psychologist
Josie Gronbach, PsyD-Post-Doctoral Resident

ACKNOWLEDGMENT: RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of HIPAA Notice of Privacy Practices from IPCI effective July 1, 2015.

Patient Name (please print): ________________________________

Patient Signature: ________________________________

Date: ___________________________

(For couples)
Name (please print): ________________________________

Signature: ________________________________

Date: ___________________________

I am a parent or legal guardian of ____________________ (patient name). I have received a copy of Notice of Privacy Practices from IPCI effective July 1, 2015.

Name (please print): ________________________________

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ________________________________

Date: ___________________________

FOR OFFICE USE ONLY:

Notice of Privacy Practices effective July 1, 2015 was given to individual on ______________ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other ____________________

50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317-550-3221
Fax: 317:550-3228
info@ipci.hush.com

Maria P. Hanzlik, PsyD, HSPP-Clinical Psychologist
Jessicah D. Walker, PhD, HSPP-Counseling Psychologist
Josie Gronbach, PsyD-Post-Doctoral Resident

Consent to Treatment-Adult Individual Treatment

I have fully discussed with my clinician the various aspects of the patient agreement. This has included a discussion of my evaluation/intake as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. For therapy regarding sexual concerns, I understand that this type of therapy never includes physical/sexual contact or other such boundary violations. My clinician has discussed with me scheduling, the nature of the fee and policies regarding missed appointments. My clinician has explained to me the limitations of confidentiality. I understand I may withdraw from treatment at any time, but if I decide to do this, I will discuss my plan with my clinician before acting on it. My only financial obligation, should I decide to stop treatment, is to pay for the services I have already received.

I have read the above and fully understand the diagnosis, the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

Please initial after the following statements:
I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered for in-network benefits. ________
Initial

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status. I understand that if collection proceedings are necessary, I will pay all fees associated with collecting this bill. ________
Initial

(*For out-of-network patients)* I understand that clinicians at IPCI are not in-network providers with my insurance company, ____________________. As a result, I understand that I am responsible for payment up front, and IPCI will provide me with the necessary documentation for me to file a claim with my health insurance company if I choose to do so. The cost of the session is ___________________________. _______
Initial

(*If applicable*) I authorize communication between my clinician and referring physician/clinician ___________________________ to inform that I have initiated services (separate release is required

for further exchange of information).

____
Initial

I would like to be contacted for appointment reminders and other correspondence via the following ways (check all that apply):

☐ Telephone (please provide preferred number): ________________________________

☐ Voicemail Message ________________________

☐ Text Message (if different than above):_____________________________

☐ Email: _____________________________________

☐ Postal Mail (include address if other than provided): _________________________________

_________________________________ _____________________
Patient Signature Date

_________________________________ _____________________
Printed Name Date

_________________________________ _____________________
Witness Signature Date

_________________________________ _____________________
Witness Printed Name Date

50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317-550-3221
Fax: 317:550-3228
info@ipci.hush.com

Maria P. Hanzlik, PsyD, HSPP-Clinical Psychologist
Jessicah D. Walker, PhD, HSPP-Counseling Psychologist
Josie Gronbach, PsyD-Post-Doctoral Resident

Adult Patient Information Form

Name: ________________________ Date of Birth: ___________ Today's Date: _______________________

Gender: _______________ Gender Pronouns: ________ Sexual Orientation: __________________

Age: _________ Partner/Relationship Status:__________ Race/Ethnicity: _____________________

Other Important Demographic Information/Identities: ____

Street Address: ____

City: ________________ State: ________ Zip Code: ___________

Preferred Phone Number (home/work/cell): ____

Referring Provider: ____

Current Medications: ____

Previous Mental Health Services: ____

Presenting Problems: ____

Contact Information in Case of Emergency

Name:_________________________ Relationship to Patient: _____________ Phone: _________________

PRIMARY INSURANCE INFORMATION

Insurance Company Name:__________________________ Phone#:__________________________________

Policy Holder's Name:________________________________Date of Birth:___________________________

Relationship to Patient:____________________________ Name of Policy Holder's Employer:___________

ID#:___________________________________ Group#:________________________________

SECONDARY INSURANCE INFORMATION

Insurance Company Name:__________________________ Phone#:__________________________________

Policy Holder's Name:________________________________Date of Birth:___________________________

Relationship to Patient:______________________ Name of Policy Holder's Employer: ___________

ID#:___________________________________ Group#:__________________________________

IPCI
INTEGRATED PSYCHOLOGICAL
CENTER OF INDIANA

50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317-550-3221
Fax: 317:550-3228
info@ipci.hush.com

Maria P. Hanzlik, PsyD, HSPP-Clinical Psychologist
Jessicah D. Walker, PhD, HSPP-Counseling Psychologist
Josie Gronbach, PsyD-Post-Doctoral Resident

CREDIT CARD AUTHORIZATION FORM

NAME OF PATIENT: ____
NAME ON CARD:____
BILLING
ADDRESS:____
____

Circle one: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

ACCOUNT #: ____

EXPIRATION DATE: ______________________

CVC # (ON BACK OF CARD): ______________

By signing this form, I authorize IPCI and my clinician to charge this card. I may choose to use other forms of payment such as cash, check or an HSA account. I understand that, should my account be **30 days overdue**, I authorize IPCI and my clinician to automatically charge this card.

I hereby grant permission to charge my credit card after every ____ session(s) _______ (initials)

or

I hereby grant permission to charge my credit card if my balance reaches $100 without further authorization.

AUTHORIZED
SIGNATURE:____

DATE: ________________________

AUTHORIZED
SIGNATURE:____

DATE: ________________________

50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317-550-3221
Fax: 317:550-3228
info@ipci.hush.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________do hereby consent and authorize my provider and/or IPCI,

TO DISCLOSE to: ____

Name/Address/Telephone Number

The following specific information regarding (self/child's name): __________________________________

___ Admission
___ Attendance in Treatment
___ Progress in Treatment
___ Prognosis/Diagnosis
___ Discharge Summary
___ Patient Demographic Information
___ Treatment Plans
___ Other: ____
___ Progress Notes
___ Psychological Evaluation

I understand that this information is to be used for the purpose of: _______________________________

____
Patient/Guardian Signature

____
Printed Patient/Guardian Name

____
Date

____
Witness Signature

____
Witness Printed Name

____
Date

I, ___________________________do hereby consent and authorize my provider and/or IPCI, **TO DISCLOSE to:**

____

Name/Address/Telephone Number

The following specific information regarding (self/child's name): __________________________________

___ Admission
___ Attendance in Treatment
___ Progress in Treatment
___ Prognosis/Diagnosis
___ Discharge Summary
___ Patient Demographic Information
___ Treatment Plans
__ Other: ____
___ Progress Notes
___ Psychological Evaluation

I understand that this information is to be used for the purpose of: ____

____
Patient/Guardian Signature

____
Printed Patient/Guardian Name

____
Date

____
Witness Signature

____
Witness Printed Name

____
Date

Patients may revoke releases at any time by informing my clinician verbally or in writing. Unless otherwise specified by this patient, this release will remain valid for **1 year** from the time of signing.

50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317-550-3221
Fax: 317:550-3228
info@ipci.hush.com

Maria P. Hanzlik, PsyD, HSPP-Clinical Psychologist
Jessicah D. Walker, PhD, HSPP-Counseling Psychologist
Josie Gronbach, PsyD-Post-Doctoral Resident

Adult History Form

Name: ________________________ **Date of Birth:** ___________ **Today's Date:** _______________________

Gender: _______________ **Gender Pronouns:** ________ **Sexual Orientation:** __________________

Age: _________ **Partner/Relationship Status:**__________ **Race/Ethnicity:** _____________________

Religious/Spiritual Affiliation (if applicable): ____

Other Important Cultural/Identity Information: ____

Presenting Problem:
Reasons for seeking services:

Please list current symptoms:

Mental Health History:
How long have you been dealing with these concerns?:

Please list past outpatient therapy you may have received:
(Name of therapist/length of time in therapy/type of work completed/past diagnoses)

Please list past inpatient mental health hospitalization you may have received:
(Name of hospital/location/length of stay/age of hospitalization/reason for hospitalization)

Please list past and current medications you have been prescribed/are using:

Medication name	Dosage	Reason for med.	Taking as prescribed? (Y/N)

Educational History:
Highest level of education/name of school:

Please list/describe any trouble you may have experienced in school (academic or behavioral)?:

Employment History:
Occupation:
Place of employment:
Have you ever been fired from a position? Y/N
If Yes, what were the circumstances?

Military Status (circle all that apply)
Branch of military served:
Currently enlisted
Reserves
Veteran-Discharge Status/Reason for discharge: Honorable/Other Than Honorable Conditions/Bad Conduct/Dishonorable/Officer/Entry-level separation/Medical/Administrative
Tours of duty completed:

Social Functioning:
Who do you rely on for support?:

What do you do for fun?:

Medical History:
Please list any medical conditions you have, and rate how well managed they are (good, fair, poor):

Please list any surgeries you may have had:

Please list any hospitalizations you may have had for a medical condition/length of stay:

Family of Origin History:
Place of birth:

By whom were you raised?:

Relationships with family members (e.g. good, fair, poor, abusive, no contact):

(QoR=Quality of Relationship)

Name	Relationship	Past QoR	Current QoR	Mental Health Symptoms/Diagnoses

Please list other family members not listed above who may have had diagnosed or undiagnosed mental health conditions:

Current Family & Living Conditions:

Please list who currently lives with you and the quality of those relationships:

Sexual History:

Please indicate the last time you were sexually active (with a partner and alone):

Age at first sexual encounter:

Attracted to males/females/both/other:

Please circle/highlight any of the following sexual concerns:

Low desire *Low arousal* *Difficulty reaching orgasm* *Premature/rapid ejaculation*

Delayed ejaculation *Pain with vaginal penetration* *Pain with anal penetration*

Discrepancies in level of sexual desire with your partner *Sexual avoidance*

Feelings of embarrassment talking about sex with a partner

Are there any other sexual concerns you might want to discuss with your clinician? Y/N

(Feel free to write those below or wait until face-to-face session to discuss

Trauma History

The purpose of this section is for me to have a better understanding if there have been past experiences of trauma on your part that may be affecting you in the present. We can discuss this section in more detail when we meet in person.

Please circle/highlight any of the following you may have experienced:

Physical abuse *Emotional/verbal abuse* *Sexual abuse*

Witnessing violence (including domestic violence) *Bullying*

Confusing experiences/boundary violations *Peer rejection*

Natural disasters *Loss of a parent or other important caregiver*

Substance Use:

Please check the following substances you have used in the past and currently:

	Past	Current
Alcohol		
Wine		
Liquor		
Beer		
Marijuana (any form)		
Cocaine		
Crack Cocaine		
Hallucinogens		
Inhalants		
"Club Drugs" (i.e. Ecstasy)		
Heroin		
Prescription Drugs (not as prescribed)		
Stimulants		
Tobacco		
Caffeine		
Other		

Has anyone ever expressed concern that you might need to cut back on your use?
(Y/N/Who/Circumstances):

If so, have you felt annoyed/irritated and has it caused conflict?:

Please list any prior treatment for drug or alcohol use:
(Inpatient/Intensive Outpatient/Educational/Detox/Date/Location):

Legal History:

Charge	Date of Arrest	Incarcerated (Y/N)	Pending Case (Y/N)

Other Important Information Your Clinician Should Know About:

Goals for therapy (*if applicable*):

Short Term	Long Term
1.	1.
2.	2.
3.	3.