IPCI
INTEGRATED PSYCHOLOGICAL CENTER OF INDIANA

50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317-550-3221
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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 _____

Reason individual or parent/legal guardian did not sign this form:
☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

Signature: _____ Date: _____

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Consent to Treatment-Couples Therapy

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 **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 with collecting this bill.

_____ _____
Initial **Initial**

(*For out-of-network patients)* I understand that my clinician is not an in-network provider with my insurance company, _____. As a result, I understand that I am responsible for payment up front, and my clinician will provide me with the necessary documentation for me to file a claim with my health insurance company, if applicable. The cost of the session is _____.

_____ _____
Initial **Initial**
I understand that both partners are legally holders of the medical record, even though the record is in one individual's name.

_____ _____
Initial **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 **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 numbers):

_____ _____
Partner 1 Partner 2

☐ Voicemail Messages:

_____ _____
Partner 1 Partner 2

☐ Text Messages (if different than above):

_____ _____
Partner 1 Partner 2

☐ Emails:

_____ _____
Partner 1 Partner 2

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

_____ _____
Partner 1 Partner 2

_____ _____
Patient Signature Date

_____ _____
Printed Name Date

_____ _____
Patient Signature Date

_____ _____
Printed Name Date

_____ _____
Witness Signature Date

_____ _____
Witness Printed Name Date

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Adult Patient Information Form: Couples

Today's Date: _____

Name/Partner 1: _____ **Date of Birth:** _____ **Age:** _____

Gender: _____ **Gender Pronouns:** _____

Sexual Orientation: _____ **Race/Ethnicity:** _____

Partner/Relationship Status:_____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

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

Secondary Phone Number (home/work/cell): _____

Current Medications: _____

Previous Mental Health Services: _____

Name/Partner 2: _____ **Date of Birth:** _____ **Age:** _____

Gender: _____ **Gender Pronouns:** _____

Sexual Orientation: _____ **Race/Ethnicity:** _____

Partner/Relationship Status:_____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

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

Secondary Phone Number (home/work/cell): _____

Current Medications: _____

Previous Mental Health Services: _____

Referral Source: _____

Presenting Problems: _____

_____

Contact Information in Case of Emergency

Name:_____ **Relationship to Patient:** _____ **Phone:** _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name:_____ **Phone#:**_____

Insurance Company Address: _____

_____

Policy Holder's Name:_____**Date of Birth:**_____

Relationship to Patient:_____**SS#:**_____

ID#:_____**Group#:**_____

Name of Policy Holder's Employer:_____

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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 Integrated Psychological Center of Indiana 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: _____

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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
___ Progress Notes
___ Psychological Evaluation
___ Other: _____

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

_____ Patient/Guardian Signature
_____ Witness Signature

_____ Printed Patient/Guardian Name
_____ Witness Printed Name

_____ Date
_____ Date

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

TO RECEIVE from _____
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
___ Progress Notes
___ Psychological Evaluation
___ Other: _____

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

_____ Patient/Guardian Signature
_____ Witness Signature

_____ Printed Patient/Guardian Name
_____ Witness Printed Name

_____ Date
_____ Date

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Couple History Form
(Each partner to complete separately)

Name: _____ **Today's Date:** _____

This form, along with your partner's Couple History Form, will be used during your intake session to guide the initial assessment process and make the most of our first session together.

Presenting Problem:
What brings you in for couples therapy at this point?:

How do you see the problem(s) in the relationship?:

Current Relationship Dynamics:
What are your relationship strengths?:

How the two of you communicate about the following:
Day to day information (i.e. work, household tasks, plans)

When there is disagreement:

Issues related to your children/parenting (if applicable):

Sex:

Please describe any current stressors that may be affecting your relationship:

Relationship History:
How did you meet your partner?:

How long were you together before you first became seriously committed to each other?:

What first attracted you about your partner and are those qualities still present?:

What did you like best/least about your partner?:

When did your relationship change and what occurred around that time?:

Have there been any relationship betrayals? If so, please explain:

Please describe any past stressors that could have affected your relationship:

Sexual Orientation:
Please describe your sexual orientation:

Please describe your coming out history (if applicable):

Sexual Relationship History:
When was your first sexual encounter with each other? Please describe this experience:

What is your sex life like now? Please describe frequency ***and*** quality of sex:

Please circle/highlight any specific sexual difficulties that are occurring:
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)

INDIVIDUAL HISTORY

This section includes information about you, individually, that may contribute to some struggles you are experiencing as a couple.

Mental Health History:
Please list any current mental health symptoms you may be experiencing:

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/Discharge Status/Reason for discharge/Tours of duty completed

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

What do you do for fun?:
As a couple *As an individual*

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:

Please describe your parents' relationship (connected/loving/conflictual/violent). How did they handle conflict?

Please list any other significant attachment figures in your life growing up:

How was sex communicated about in your family of origin?:

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:

Wrap-Up:
What are you strengths as a couple?:
1.

2.

3.

What are your vulnerabilities or challenges as a couple?:
1.

2.

3.

What are 3 changes you would ask of and/or want from your partner?
1.

2.

3.

Other Important Information Your Clinician Should Know About:

Goals for couples therapy:

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