**Melinda Moore, Ph.D.**

**Licensed Psychologist**

**2365 Harrodsburg Rd, Suite B225 Lexington, KY 40504**

**(859) 457-1210**

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**PERSONAL INFORMATION**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

first initial last

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ >> OK to mail? Y N

street apt. city state zip

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_>> OK to call? Y N Voice Msg? Y N Text Msg? Y N

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ >> OK to call? Y N OK to leave message? Y N

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to send email? Y N

Gender \_\_F \_\_M Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status: \_\_ single \_\_ married/partnered \_\_ separated \_\_ divorced \_\_ remarried

Living With: \_\_ spouse/partner \_\_ parent[s] \_\_ roommate[s] \_\_ children \_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education: Highest grade completed or highest degree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:** Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to You \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who Referred You?**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do I have permission to thank this person for referring you? \_\_\_ Yes \_\_\_ No

**SYMPTOM CHECKLIST** (check all that apply)

\_\_\_ Work/Career problems

\_\_\_ Sleep pattern disturbances

\_\_\_ Nervous or anxious feelings

\_\_\_ Sadness

\_\_\_ Repetitive/ intrusive thoughts

\_\_\_ Motivation problems

\_\_\_ Concentration problems

\_\_\_ Loneliness or isolation

\_\_\_ Panic attacks

\_\_\_ Alcohol/drug use or abuse

\_\_\_ Eating/ body image issues

\_\_\_ Sexual problems

\_\_\_ Guilt/shame

\_\_\_ Anger management

\_\_\_ Dealing with conflict

\_\_\_ Legal problems

\_\_\_ Health/physical illness

\_\_\_ Aging

\_\_\_ Identity

\_\_\_ Concerns about family

\_\_\_ Physical/sexual abuse or assault

\_\_\_ Other trauma

\_\_\_ Cultural/ethnic/racial issues

\_\_\_ Pregnancy-related problems

\_\_\_ Sexual orientation issues

\_\_\_ Grief or loss

\_\_\_ Impulsiveness

\_\_\_ Trouble saying no/setting

limits

\_\_\_ I have used illegal drugs (pot, coke, pills, etc.) within the past year.

\_\_\_ I have on average \_\_\_\_\_\_\_alcoholic drinks on days I chose to drink.

\_\_\_ I have been arrested in the past year.

\_\_\_ I often go on eating binges.

\_\_\_ I vomit, take laxatives, or exercise a great deal to control my calorie intake.

\_\_\_ In the past I have made a suicide attempt.

\_\_\_ I have been thinking about harming or killing myself:

\_\_\_\_\_\_today \_\_\_\_\_\_\_this week \_\_\_\_\_\_\_ in the last month \_\_\_\_\_\_ in the last 6 months

\_\_\_ I have periods where I need very little sleep, think fast, work fast, and feel much happier than usual.

\_\_\_ I have thoughts about harming others.

**PREVIOUS COUNSELING**  \_\_\_ No \_\_\_ Yes

If yes, please give dates and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Ever been hospitalized for a mental health concern? \_\_\_ No \_\_\_ Yes

If yes, please give dates and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL HISTORY**

Past health problems or illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current health problems or illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr.’s name who is treating you for above problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to coordinate care with your doctor? \_\_\_ yes \_\_\_ no \_\_\_ N/A because no MD

I am currently taking medication prescribed by a doctor. (Please list)

Medication Reason Medication Reason

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Reason Medication Reason

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I take the following herbal supplements, teas, or over the counter medications on a regular basis: \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Parents Marital Status: \_\_ Married (to each other) \_\_ Separated \_\_ Divorced \_\_ Widowed \_\_ Never Married

Members of Immediate Family:

Name Age Relationship Education Occupation

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there any history of mental illness in your family? \_\_ No \_\_ Yes If yes, please describe: \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Consent to the Use and Disclosure of Health Information

for Treatment, Payment or Healthcare Operations

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that as part of my health care, Melinda Moore, Ph.D. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment,
* A means of communication among the many health care professionals who contribute to my care,
* A source of information for applying my diagnosis and service information to my bill
* A means by which a third-party payer can verify that services billed were actually provided, and
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practi*ces that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the *Notice of Privacy Practices* prior to signing this consent,
* The right to object to the use of my health information for directory purposes, and
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Melinda Moore, Ph.D. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that action has already been taken based on my initial signing of this consent. I also understand that by refusing to sign this consent or revoking this consent, Dr. Moore may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Melinda Moore, Ph.D. reserves the right to change her notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dr. Moore change her *Notice of Privacy Practices* she will send a copy of any revised notice to the address I’ve provided.

I wish to have the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures by fax.

By my signature below, I attest that I fully understand and accept the terms of this consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature Date

Consent to Treatment

Welcome. I am a psychologist licensed by the Commonwealth of Kentucky Board of Psychology. I provide individual and group therapy. My practice is independent, meaning that I am not associated with any other provider of psychological services in this building. I have prepared this contract to provide you with information about your rights and responsibilities as a client, fees, scheduling and other details related to my practice. Please read this information and ask any questions you have to clarify your understanding. When you sign this sheet, it will represent an agreement between us.

**Emergencies:** I am not available for emergency appointments. In the event of a crisis you may leave a message for me on my phone at 859-457-1210. I will attempt to call you back as soon as I can after I hear your message or at least within 24 hours of your call, and if I can help with a brief talk on the phone, I will. If you cannot wait 24 hours to be contacted, or if you are in an emergency situation or need immediate help, you should call 911 or go to the nearest hospital emergency room. If there is an emergency during or after our work together where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the police, hospital, or the person whose name you have provided on the information sheet.

**Confidentiality:** Information regarding the content of your sessions is confidential and protected by law. This means that I cannot share any information about you without your written permission. There are times, however, when I am legally and ethically required to disclose information with or without your permission: (1) in the event that I believe there is clear and imminent danger to either yourself or another person; (2) when you disclose evidence or raise suspicion of threats of violence, harm, abuse, or neglect of an individual, and (3) when the court issues a legitimate subpoena requiring records or testimony, and attempts to block such a motion have failed. Administrative information may be released to a collection agency, if necessary.I may occasionally find it helpful to consult with other professionals regarding your treatment, diagnosis, or other pertinent issues. In these consultations, I make every effort to keep identifying information confidential. The consultant is legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together.

**Email/Text:** If you give permission for email and/or text messaging contact, please be aware that these are not confidential modes of communication, and that, due to quirks of technology, sometimes messages are delayed for days or simply never arrive. As such, please do not send personal information to me this way unless you are willing to take the risk that it might be intercepted or read by an unintended party. Emails with therapeutic content will be printed and treated as part of your clinical records and then deleted from my account. Because of risks to confidentiality, responses from me will be brief, and possibly vague. Unless you and I have a separate agreement, email/text messages that I initiate will be limited to scheduling and payment issues, or if I cannot reach you by phone and am concerned about your safety.

**Cancellations**: Therapy involves a collaborative relationship and requires an active effort on your part in order to be successful. It is important that you are consistent with your attendance. If you must miss or reschedule an appointment, please contact me as soon as possible, and at minimum 48 hours in advance by calling 859-457-1210. Since scheduling an appointment involves the reservation of time specifically for you, a $90 fee will be charged for sessions missed without 48 hours notification. Insurance companies do not reimburse for missed sessions so you will be personally responsible for paying this fee. Please notify me if you will be late for a session.

**Referrals:** Your participation in therapy with me is voluntary. You have the right to discontinue and/or request a referral to another therapist at any time. I may make a referral if I do not feel qualified to address your concern, or if I don’t believe I have been helpful to you, or if I believe additional help is needed for your treatment to be successful. You may decline the referral or decline the recommendations of a consulting professional. If I believe that my services are not productive or sufficient for you, I may decide to end counseling with you. If this occurs, I will discuss the reasons for the decision with you and give you a list of referrals for continued treatment. You may later return for a reevaluation if you think my services can be productive for you.

**Benefits and Risks**: Therapy often leads to more satisfying relationships, a resolution of specific problems, and a significant reduction of feelings of distress. Risks may include experiencing uncomfortable feelings, recalling unpleasant aspects of your past, an increase in conflict in your relationships or even the dissolution of a relationship. It is possible that your problems may worsen immediately after beginning therapy. Most of these risks are to be expected when people are making important changes in their lives. Finally, it is important to note that even with the best effort on the part of both of us, therapy may not work out well for you. For individuals that have chronic problems involving suicidal behavior (e.g. repeated suicide attempts), one of the risks of outpatient psychotherapy is death, although this is infrequent in outpatient care. There are no guarantees about the outcome of therapy. However, your satisfaction will likely be increased by your commitment to the process, including a willingness to continue through difficult or uncomfortable feelings, and to participate fully and honestly. Please let me know if you feel therapy is not helping or is making things worse.

**Payment Requirements:** Full payment, or co-payment if you are using insurance, is expected at each session. Payment is accepted by cash, check, or credit card. You will be billed personally for any missed appointments. If you have difficulty making payments, please discuss this with me.

I have read the above information and agree to participate in therapy under the stated conditions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Name (please print) Date

**CREDIT CARD AUTHORIZATION**

**Even if you do not plan to pay by credit card, please provide this information.**

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holder’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

□ Visa □ MasterCard

Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code: \_\_\_\_\_\_\_\_\_\_ (3 digits found on the back of the card in the signature line)

***Unless I pay by other means, I authorize Melinda Moore, Ph.D., PLLC to charge my credit card for any fees due, including missed appointments and late cancellations.***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_