www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Client Information

Client's Name: _____
(First) (Middle Initial) (Last)
Date of Birth: _____Age: _____ Gender: _____ SS#: _____

Home Address: _____
Email Address: _____
Phone: (Cell) _____(other) _____
Is it okay to leave a message at the above contact options? Y N

Emergency Contact Name: _____ Relationship to Client: _____
Emergency Contact Phone: _____

Who referred you for treatment? Name: _____
What is their contact information? Address: _____
Phone #: _____

Who is your Primary Care Physician? _____
Mailing Address: _____
Phone # _____ Email Contact: _____

Who is your psychiatrist? _____
Mailing Address: _____
Phone # _____ Email Contact: _____

Other mental health provider? _____
Mailing Address: _____
Phone # _____ Email Contact: _____

Who else lives in your home?

Name	DOB	Relationship to client

Marital Status: Total Number of Marriages: _____
___Single ___Married (Length of time: _____) ___Domestic Partnership (Length of time: _____)
___Separated (Length of time: _____) ___Divorced (Length of time: _____)
___Widowed (Length of time: _____)

Assessment of current relationship (if applicable): ___Great ___Good ___Average __Fair ___Poor

www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Client Information

Client Name: _____ DOB: _____

List medications you are **CURRENTLY** taking:

Medication	Dose/Frequency	Prescribing Physician	Start Date	Reason	Effective? Y N

List medications you have taken in the past **FEW YEARS***:*

Medication	Dose/Frequency	Prescribing Physician	Start - End Date	Reason

History of Mental Health Care:

Clinician / Location	Dates of Treatment	Reason / Diagnosis	Effectiveness

Mental Health Concerns in Family Members (Addictions / Suicides / Depression / Anxiety / Other):

What are some of your main concerns for your own wellbeing right now?

Treatment Consent

www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Client Name: _____ DOB: _____

By my signature below, I am providing consent to treatment for myself, or for my child, and I am expressing an understanding and an agreement of the details of this document.

Consent: I consent to treatment for myself, or for my child. I understand that psychotherapy is not easily described in general statements. It varies depending on the personalities of the provider and the client, and the problems I bring forward. I understand that there are many different methods that each therapist may use to deal with the problems that I wish to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on my part. In order for my therapy to be most successful, I will have to work on things we talk about both during sessions and at home.

I understand that psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However, I understand that there are no guarantees of what I will experience.

Contact: I understand that Upturn, LLC clinicians are available by email and telephone. I understand that clinicians are usually in the office at specified periods of time, but they will not answer the phone when with a client. When clinicians are unavailable, their telephone is answered by voicemail. I realize that they will make every effort to return my phone call on the same day that I place it, with the exceptions of weekends and holidays. If I am difficult to reach, I will provide some times when I am most available. I understand that if I am in emergency and an Upturn, LLC clinician is unable to be reached and I feel I cannot wait for a returned phone call I will contact my family physician or the nearest emergency room and ask for the psychologist on call, or I will call 911. If Upturn, LLC clinicians will not be available for an extended period, they will provide me with the name of a colleague to contact if therapeutically necessary.

Emergencies: In an emergency situation in which one's physical safety is in danger or there is a need for hospitalization, I will contact Crisis Intervention for my specific county. These numbers are listed below:

Cumberland County:	717-763-2222	Carlisle Area:	717-243-6005
Dauphin County:	717-232-7511	Lebanon County:	717-274-3363
Lancaster County:	717-394-2631	York County:	1-800-673-2496

Professional Records: I understand that the law and standards of the profession require Upturn, LLC to keep treatment records. I am entitled to receive a copy of my records, or a summary of these records. Because these are professional records, they have the potential to be misinterpreted and / or upsetting to untrained readers. If I wish to see my records, I can review them in an Upturn, LLC clinician's presence so that we can discuss the contents. I understand that I will be charged an appropriate fee for any professional time spent responding to information requests.

Minors: I understand that for clients who are under the age of 14, the law may provide parents the right to examine treatment records. It is Upturn, LLC*'s* policy to request agreement from parents that they give up access to my records. If my parents agree, Upturn, LLC will provide them only with general information about our work together, unless the clinician feels there is a high risk that I will harm myself or someone else. In this case, the clinician will notify my parents of the concern. The clinician will provide my parents with a summary of the treatment plan when it is complete. Prior to giving parents any information, we will discuss the matter together, if possible, and do our best to handle any objections I might have with what we are prepared to discuss.

Treatment Consent

www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Client Name: _____ DOB: _____

Confidentiality: In general, the privacy of all communications between a client and a mental health provider is protected by law, and my clinician can only release information about our work to others with my written permission, but there are a few exceptions.

In most legal proceedings, I have the right to prevent Upturn, LLC from providing any information about my treatment. In some proceedings such as those involving child custody and those in which my emotional condition is an important issue, a judge may order Upturn, LLC's testimony if s/he determines the issues demand it.

There are some situations in which Upturn, LLC is legally obligated to take action to protect others from harm, even if the clinician must reveal some information about a client's treatment. For example, if the clinician believes a child is being abused, the clinician must file a report with the appropriate state agency.

If the clinician believes that a client is threatening serious bodily harm to another, the clinician is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm herself/himself, the clinician may be obligated to seek hospitalization for her/him or to contact family members or others who can help provide protection.

These situations rarely occur in Upturn, LLC's practice. If a similar situation occurs, the clinician will make every effort to fully discuss it with you before taking any action.

Consultation and Coordination: Upturn, LLC clinicians will occasionally find it helpful to consult with other professionals about a case. During a consultation, your Upturn, LLC clinician makes every effort to avoid revealing the identity of the patient. The consultant is also legally bound to keep the information confidential. My clinician will not be required to tell me about these consultations unless s/he feels it is important in our work together.

I understand that, with my consent, Upturn, LLC will likely provide summary updates periodically to my Primary Care Physician.

If there are other concerns that come up for me, I agree to speak with my clinician and/or Dr. Diana Brown, owner, about them directly. S/he will be happy to discuss them with me if I need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and s/he is not an attorney.

☐ I have read the two pages of this document and understand the above information.

_____ _____

Client Signature (age 14 and over) Date

_____ _____

Parent / Legal Guardian Signature (for patients under age 18) Date

Consent to Use and Disclose Protected Health Information

www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Client Name: _____ DOB: _____

This consent form is an agreement between you, _____, and Upturn, LLC. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his/her name here _____.

When we evaluate, diagnose, treat, or refer you to another provider, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to determine which treatment is best for you and to provide the treatment to you. We may also share this information with others who provide treatment to you. We may also use this information to arrange payment for your treatment or for other healthcare operations allowable under HIPAA privacy laws.

By signing this form, you are agreeing to let us use your information here at Upturn, LLC and agreeing to allow us to send your information to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this Consent form. You can find it on our website under the "Forms" tab.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so we may change the Notice of Privacy Practices. If we do change it, you can get a copy from your clinician, from Dr. Diana Brown the Privacy Officer, or from our website www.UpturnToday.com.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we will abide by our agreement.

After you have signed this consent form, you have the right to revoke it by writing a letter to the Privacy Officer, Dr. Diana Brown, and telling her that you no longer consent. We will comply with your wishes about using or sharing your information from that time on but we may have already used or shared some of your information and cannot change that.

_____ _____

Signature of Client / Guardian Date

Symptom Checklist

www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Client Name: _____ DOB: _____

CHECK ALL THE SYMPTOMS THAT APPLY:

Physiological Symptoms: ☐ Headaches ☐ Dizziness ☐ Fainting spells ☐ Racing heart ☐ Shortness of breath ☐ Chest pain ☐ Nausea ☐ Sensation of choking ☐ Stomach trouble ☐ No appetite ☐ Increased appetite ☐ Weight gain / loss in the past month ☐ Fatigue ☐ Tremors ☐ Sweating ☐ Craving alcohol/substances

Thought Symptoms: ☐ Unwanted repetitive thoughts ☐Preoccupied with ongoing thoughts ☐ Suicidal ideas ☐ Difficulty with decision making ☐ Lack of interest in doing things ☐ Memory difficulty ☐ Easily distracted ☐ Racing thoughts ☐ Experienced unaccounted for gaps in time ☐ Ongoing gaps in memory ☐ Suspecting that your partner is unfaithful ☐ Perfectionism ☐ Confused thinking

Behavioral Symptoms: ☐ Avoidance of crowded places ☐ Seeking/craving alcohol / drug use ☐Periods of drinking in excess ☐Using substances not prescribed to you ☐ Unwanted repetitive habits ☐ Difficulty falling / remaining asleep ☐ Difficulty waking up / sleeping for long periods ☐ Past suicide attempts ☐ Sexual problems ☐ Crying spells ☐ Unable to control anger ☐ Money problems ☐ Can't keep a job ☐ Difficulty keeping friends ☐ Difficulty with romantic relationships ☐ Food binging ☐ Food purging ☐ Legal problems ☐ Constantly on guard for anything dangerous that could happen ☐ Hear voices other people don't hear ☐ Disorganized / losing items ☐ Poor time management ☐ Often making careless mistakes ☐ Caffeine having little impact ☐ Difficulty waiting in lines ☐ Starting projects and not finishing ☐ Reading several books at the same time ☐ Difficulty remaining still ☐ Have been told by others that you don't listen well ☐ Difficult to not interrupt others ☐ Tendency to be very talkative ☐ Often "on the go" ☐ risk-taking behaviors ☐ Impulsive behaviors ☐ A history of purposely cutting or physically hurting your body ☐ Need a lot of reassurance from others ☐Always needing to be in a relationship ☐ Like to be the center of attention ☐ Avoiding depth in conversations ☐Passivity towards goal attainment

Emotional Symptoms: ☐Feel tense ☐Anger ☐Irritability ☐ Panicky ☐ Fear of losing control ☐ Fear of going crazy ☐ Fear of dying ☐ Anxious ☐ Trembling ☐ Feel in a "daze" ☐ Depressed ☐ Feel detached from others ☐ Feel void of emotions ☐ Unable to relax ☐ Less interest in pleasant activities ☐ Unable to enjoy self ☐ Don't like weekends or vacations ☐ Feel Inferiority ☐ Feel helpless ☐ Feel hopeless ☐ Feel like there is no future for you ☐ Guilt ☐ Over ambitious ☐ Shy ☐ Feel lonely ☐ Work stress ☐ Paranoia ☐ Impatient ☐ Periods where you feel "on top of the world" and can accomplish anything ☐ Feel empty ☐ Feel life has no meaning ☐ Feel as if people will abandon you ☐ Mood swings

Situational Happenings: ☐ Experienced or witnessed unwanted sexual contact ☐ Experienced or witnessed physical assault, abuse, trauma ☐ Experienced or witnessed a life threatening event or serious injury ☐ Experienced fear, hopelessness or horror during the event ☐ Distressing recollections of the event ☐ Distressing dreams of the event ☐ Act or feel as if the event is recurring ☐ Difficulty talking about the event ☐ Difficulty seeing anything that reminds you about the event ☐As a child, often sworn at, ridiculed, or insulted ☐As a child, often pushed, grabbed, or slapped ☐As a child, often felt no one in your family loved you or thought you were special ☐As a child, often felt hunger, had dirty clothing, no one protecting you ☐As a child, lost a parent through divorce or abandonment ☐As a child, often witnessed caregivers getting pushed, grabbed, slapped ☐As a child, lived with someone who was a problem drinker, drug user ☐As child, lived with someone with mental illness ☐As a child, a household member went to prison ☐Other people or groups have discriminated against you because of how they view you

Other struggles (please describe): _____

Authorization for Insurance Release

www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Client Name: _____ DOB: _____

Primary Insurance Company: ☐ Highmark/BCBS ☐Capital Blue Cross ☐Tricare ☐Medicare ☐Out of Network

Subscriber Name: _____ Subscriber DOB: _____

Policy Number: _____

Group Number: _____

Employer of Subscriber: _____

Plan Type: ☐PPO ☐POS ☐HMO ☐Other

Secondary Insurance Company: ☐ Highmark/BCBS ☐Capital Blue Cross ☐Tricare ☐Medicare ☐Out of Network

Subscriber Name: _____ Subscriber DOB: _____

Policy Number: _____

Group Number: _____

Employer of Subscriber: _____

Plan Type: ☐PPO ☐POS ☐HMO ☐Other

☐ I authorize the release of any information necessary to process claims with my insurance company.
This information could include a diagnosis, presenting problems, current symptoms, and treatment dates.

☐ I authorize my insurance company to make payments for my treatment directly to Upturn, LLC.

☐ I understand that I am responsible for paying my deductible and / or co-payments.

☐ I understand that it is my responsibility for payment of services if my insurance company does not provide reimbursement.

Client Signature: _____ Date: _____

Guardian Signature*: _____ Date: _____
*(If Client is under 14 years of age)

I authorize Upturn, LLC to release information to Office Ally, LLC for the purposes of billing.

Client Signature: _____ Date: _____

Guardian Signature*: _____ Date: _____
*(If Client is under 14 years of age)

www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Treatment Fees & Financial Responsibility

Client Name: _____ DOB: _____

It is very important that you understand basic information about benefits for outpatient mental health services covered through your health insurance policy.

Insurance Reimbursement

For us to set realistic treatment goals and priorities, it is important to evaluate which resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, you (not your insurance company) are responsible for the full payment of fees for services rendered. It is very important that you find out exactly which mental health services your insurance policy covers.

Your insurance company has set your co-payments and deductible amounts and these fees are not subject to negotiation with your therapist. If you would like additional information on these fees, please call your health insurance company or consult your insurance member handbook for additional information on exactly which mental health services your insurance policy covers. We will be happy to assist you with whatever information we can based on our experiences and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, Upturn, LLC will be willing to call the company on your behalf.

Co-payments for your treatment may change without notice by your insurance company. You will be held responsible for any co-payments due. You are responsible for informing us about changes to your policy that may affect your mental health treatment coverage. Insurance companies do not allow us to retroactively bill for services rendered beyond certain time frames.

I understand that I am obligated to pay co-payments and deductibles as required by my health insurance company's policy. I also understand that I will be financially responsible for all treatment fees incurred by myself or by my child. I understand that payments are due at the time of service. I understand that any outstanding balance for services rendered will be turned over to collections if not paid promptly.

I understand that most insurance companies will require me to authorize Upturn, LLC to provide them with a clinical diagnosis. Sometimes Upturn, LLC will have to provide additional clinical information such as treatment plans or summaries, or in rare cases, copies of the entire record. This information will become part of your insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, Upturn, LLC has no control over what they do with your information once the information leaves Upturn, LLC. In some cases, your insurance company may share your information with a national medical information database. Upturn, LLC will provide me a copy of any report they submit, if I request it.

☐ I do understand that I always have the right to pay for Upturn, LLC's services myself to avoid the problems described above.

☐ I authorize my insurance benefits be paid directly to Upturn, LLC. I authorize the release of pertinent medical information to insurance carriers.

By my signature below, I acknowledge that I have read, understand, and agree to the above financial conditions.

_____ _____

Signature of Client / Guardian Date

www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Client Name: _____ DOB: _____

Non-covered services

I accept responsibility for payment for all non-covered services. Non-covered services include, but are not limited to, telephone conversations lasting longer than 10 minutes, writing letters, attendance at meetings with other professionals I have authorized, preparation of records or treatment summaries, and time spent performing any other service I may request of my provider. If I become involved in legal proceedings that require my provider's participation, I will be expected to pay for my provider's professional time even if my provider is called to testify by another party. Because of the difficulty of legal involvement, I understand my provider will charge $250 per hour for preparation and attendance of any legal proceeding. Payment for these services will be agreed to when they are requested.

I give permission for Upturn, LLC to send periodic financial account summaries and billing statements to my email address and / or my home. I understand that the information sent to my email address will require a password for retrieval.

I understand that I will be charged for appointments which are not canceled at least 24 hours prior to the appointment time. I understand that I will be billed for that session at the rate of $50 for the first offense, $100 for the second offense, and $160 for the third offense, barring emergency situations, or severely inclement weather. I also understand that my insurance company will not cover such a claim, and I agree to be responsible for payment of that session. Non-payment after 30 days will be considered late. I understand and agree to a $5 or 1.5% monthly interest rate and / or collection procedures and necessary costs if payment is greater than 30 days late. If my account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Upturn, LLC has the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If legal action is necessary, those costs will be included in the claim. In most collection situations, the only information released regarding a patient's treatment is his / her name, the nature of the service provided, and the amount due.

I will be assumed to withdraw from treatment if I fail to keep my account up to date. Should my account be deemed delinquent, all future appointments will be cancelled. I understand that treatment with Upturn, LLC clinicians will be terminated if regular appointments with a therapist are not maintained.

I give permission for all persons acting on behalf of Upturn, LLC to contact me and leave a message at the following address, email account, and phone numbers. To change this permission, I must contact my Upturn, LLC clinician in writing.

Mailing Address: _____

_____

Email Address: _____

Phone number: (H)_____(C)_____

If I have additional questions and / or concerns, I understand I may contact the company that manages my mental health care benefits directly. The health insurance phone number is usually on the back of my insurance card.

I will make personal checks payable to **Upturn, LLC** or pay with exact cash. I understand that Upturn, LLC does not accept credit cards or debit cards as payment.

I understand there will be a $25 charge for all returned checks. I agree to pay this charge.

☐ I have read both pages of this document and understand the above information.

_____ _____

Client Signature (age 14 and over) Date

_____ _____

Parent / Legal Guardian Signature (for clients under age 18) Date

www.UpturnToday.com
2405 North Front Street
Harrisburg, PA 17110
Phone: (717) 745-7463

Authorization for Release of Protected Health Information (PHI)

Client Name: _____ DOB: _____

Address: _____ Phone: _____
_____

I, _____, authorize Upturn, LLC to send / receive the following records to / from:

Medical Provider: _____
Company Name: _____
Address: _____
Email: _____
Phone: _____
Fax: _____

(*A separate authorization, as defined by HIPAA, is required for psychotherapy notes.)

____ Service Plans ____Summary Reports _____Therapy Notes

____ Psychological Reports ____ Entire Record, Except Therapy Notes

The above information will be used for the following purposes:

____ Planning appropriate treatment or program
____ Continuing appropriate treatment or program
____ Determining eligibility for benefits or program
____ Case review
____ Updating files
____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by the same state or federal rules.

I understand that this authorization is voluntary, I may revoke this consent at any time by providing written notice, and after treatment termination this consent automatically expires. I have been informed which information will be given, its purpose, and who will receive the information. I understand that I have the right to receive a copy of this authorization. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Upturn, LLC, nor will it affect my eligibility for benefits.

☐ I understand that I may inspect and have a copy of the information described in this authorization. There may be a cost for this copy or for other services.

☐ I have read this form or had it explained to me and I understand its contents.

_____ _____ _____
Client or Guardian Signature Relationship Date