Thomas E. Thorsheim, Ph.D.
Incorporated
Licensed Psychologist (SC Lic. # 996)
45 Greenland Drive
Greenville, SC 29615
Tel: 864-421-0098 / Fax: 864-421-0099

Date ___________

Patient Information*

***For couple's therapy, please complete two separate intake forms. For children, please complete only applicable information.**

Patient Name: ____________________ **Referred by:** ____________________
Address: ____________________ **Home Phone:** ____________________
____________________ **Date of Birth:** ____________________
Gender: ________ **Soc. Sec. #:** ____________________

Marital Status (please circle): Single / Married / Partnered / Divorced / Widowed

If applicable:

School ____________ **District** ____________ **Grade/Year in School:** ____________

Profession/Employer: ____________________

Please indicate the primary phone number or preferred mode of contact: ____________________

Are there any special instructions for contacting you? (i.e. for your privacy or convenience) ____________________

____

Email Address(es): ____________________

If you wish, please provide the name/number of an emergency contact: ____________________

Other Household Members:

Last Name: ________ **First Name:** ________ **Birthdate:** ________ **Relationship:** ________

Last Name: ________ **First Name:** ________ **Birthdate:** ________ **Relationship:** ________

Last Name: ________ **First Name:** ________ **Birthdate:** ________ **Relationship:** ________

Last Name: ________ **First Name:** ________ **Birthdate:** ________ **Relationship:** ________

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A. MEDICAL HISTORY (Y= YES, N= NO, U= UNKNOWN)

Have you ever had any of the following medical conditions?

	Y	N	U			Y	N	U	
1.				Hearing problems	16.				Venereal disease
2.				Vision problems	17.				Measles (what type)
3.				Headaches	18.				Mumps
4.				Head injury	19.				Chicken Pox
5.				Blackouts / fainting	20.				Rheumatic Fever
6.				Seizures / convulsions	21.				Tuberculosis
7.				EEG / Brain wave test	22.				Diphtheria
8.				Diabetes (or anyone in the family?)	23.				Enuresis/Encopresis
9.				Asthma / breathing problems	24.				GI Problems
10.				Serious accident / injury	25.				Repeated infections
11.				Surgery	26.				Urinary
12.				Hallucinations	27.				Cardiovascular
13.				Congenital defects	28.				Respiratory
14.				Suicide gesture / attempt	Date of last pregnancy (if applicable)				
15.				Female/Gyn. problems / pregnancy					

If "yes" to any of the above, please comment: ____

____

____

____

B. Allergies / Type of Reaction:

1. Medications ____
2. Foods ____
3. Other ____

C. Medication History

Are you currently on any medications or supplements? (include both prescription and non-prescription)

NAME DOSAGE REASON EFFECTIVE?

____

____

____

____

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What medications have you previously taken or been prescribed?

NAME	DOSAGE	REASON	EFFECTIVE?

Adverse side effects? Yes __ No ___
If yes, please explain: ______________________________

____

Date of last physical exam: ____________________

Name of family physician: ____________________

Are you currently under a physician's care for any reason? Yes __ No _____

If yes, please explain: ______________________________

____

____

D. DRUGS AND ALCOHOL

Do you: Smoke? Yes _____ No_______ How much? ______________

Drink? Yes ______ No ______ How much? ______________________________

Have you ever used "recreational drugs" or "street drugs"? Yes _____ No _____

TYPE	HOW LONG	WHEN

E. PREVIOUS THERAPY, PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT

Are you now or have you previously seen a mental health practitioner? Yes ____ No ____
If so, whom do/did you see? ______________________________
What were your reasons for seeking treatment?______________________________

____

Was it helpful?______________________________
Have you previously had formal psychological testing? Yes _____ No ____
If yes, by whom?______________________________
Name of Person Completing Form: ______________________________
Date: ________________ Relationship to Patient: ______________________________

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CONSENT TO MENTAL HEALTH EVALUATION & TREATMENT

Patient Name: ________________________________ Date of Birth: __________ Age: ______

I hereby authorize Dr. Thorsheim to provide mental health services to me (or to my minor child – if the child is the patient being treated).

____
Printed Name of Client

____
Signature of Client (or guardian, in the case of a minor) Date

____
Signature of Child (assent to treatment - if child is primary client) Date

Thomas E. Thorsheim, Ph.D.
Provider

____
Signature of Provider Date

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- Incorporated -
Licensed Psychologist
45 Greenland Drive
Greenville, South Carolina
Tel. 864-421-0098

NOTICEOFPRIVACYPRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*.

I may use/disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the South Carolina Department of Protective and Regulatory Services (Child Protective Services) or to any local or state law enforcement agency.

- Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services (Adult Protective Services).

- Health Oversight: If a complaint is filed against me with the State Board of Examiners of Psychologists, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information

is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. **The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if the evaluation is court-ordered or is being conducted for a third party.**

• Serious Threat to Health or Safety: If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

• Worker's Compensation: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

Psychologist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my policies and procedures, I will post notice of such revision in a visible location. I may also elect to notify you by mail at the billing address which you have provided to me.

Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

____________________________________ _______________

Patient Signature (or responsible party) Date

____

Printed Name of Patient (or responsible party)

____________________________________ _______________

Provider Signature Date

Thomas E. Thorsheim, Ph.D.

Printed Name of Provider

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PAYMENT POLICY & FEE RATES

All services rendered are your financial responsibility. You are responsible for full payment at time of service regardless of insurance coverage. Dr. Thorsheim will bill you directly and will not bill your insurance provider. However, you may independently choose to seek reimbursement from your insurance carrier. Dr. Thorsheim will provide you receipts and specific billing codes for you to expedite any reimbursement from your insurance carrier.

If you are issued reimbursement from your insurance, please ask that your insurer send payment directly to you, as my office does not cash third-party checks from insurance.

FEE SCHEDULE (effective July 1, 2014)*

* Please note that late cancellations (less than 24 hr notice) and appointments missed for any reason are billed at the full fee.

- Initial Diagnostic Interview (60 min):............... $200
- Individual Psychotherapy (45 min):.................. $170
- Individual Psychotherapy (60 min): $200
- Family/Couples Psychotherapy (60min):......... $200
- Group Psychotherapy:...................................... $70
- Psychological Testing: Fees vary based on testing required. Please call to discuss.
- Executive/Physician Coaching (60 min): Please call to discuss the various offerings.

By signing below, I acknowledge understanding of the above fee schedule. I am aware that Dr. Thorsheim has chosen not to participate in insurance panels and that he does not receive third-party reimbursement from insurers. In addition, I understand that he opts out of Medicare and never seeks or obtains reimbursement from Medicare.

*****I also understand that in the event of a missed appointment or late cancellation (i.e. less than minimum of a full 24 hour notice), I would be charged in full.***

PLEASE INITIAL HERE ___

SIGNED:____ **DATE:**____________

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Web address: www.clarityforwellness.com

Items to consider - and if you'd like, to write about - prior to your first appointment (feel free to add an extra page or two)

Please share a few brief thoughts about what you would like assistance with in our work together (we will discuss at length during your first session).

____

____

____

____

____

____

What has prompted you to get help for these concerns right now?

____

____

____

____

____

____

If you've been to therapy before (or had psychological testing) how was that experience for you? Is there anything in particular that you found especially helpful and/or unhelpful?

____

____

____

____

____