JESSICA A. GOLUB, PH.D.
LICENSED CLINICAL PSYCHOLOGIST
847-772-6600

333 N. MICHIGAN AVE., SUITE 1801
CHICAGO IL 60601
JG@JESSICAGOLUB.COM

Name: _____ Date: _____

Address: _____
Street and # *City* *State* *Zip*

Phone- home:(____)_____ work:(____)_____ cell:(____)_____

Email address: _____

OK to leave messages for you at home? _____work? _____cell? _____ email? _____ SMS?_____

Date of Birth: _____ Age: ____ Gender: ____ Marital Status: _____

Emergency contact- Name: _____Phone : (____)_____

Relationship to you: _____ Referred by: _____

May I thank you referral source for referring you? _____

Name of Primary Care Physician (PCP): _____ Phone: (____) _____

May I inform your Primary Care Physician of your receiving services from me? _____ Yes / _____ No

What is your occupation? _____ Employer: _____

How did you first hear about my practice? _____

Would you be open to taking an anonymous survey about my services in the future? _____

Primary Insurance Information
Name of insurance policyholder if not yourself: _____ Relation to you:_____

Subscriber DOB: _____Subscriber ID #:_____ Group #: _____

Insurance Name: _____ Insurance Phone #: (_____)_____

Insurance Address:_____
POB or Street *City* *State* *Zip*

Secondary Insurance Information (if applicable)
Name of insurance policyholder if not yourself: _____ Relation to you:_____

Subscriber DOB: _____Subscriber ID #:_____ Group #: _____

Insurance Name: _____ Insurance Phone #: (_____)_____

Insurance Address:_____
POB or Street *City* *State* *Zip*

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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

This document (the Agreement) contains important information about the therapist's professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that the therapist provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is included in your intake packet, explains HIPAA and its application to your personal health information in greater detail. The law requires that the therapist obtain your signature acknowledging that the therapist has provided you with this information by the end of our first session. We can discuss any questions you have about this agreement. When you sign this document, it will also represent an agreement between us.

CONSENT FOR SERVICES

I request and consent to a comprehensive assessment to determine the need for mental health services, to the development of a treatment plan, and to the provision of those services. _____ (initial and date)

PSYCHOLOGICAL SERVICES

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, the therapist will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with the therapist. Therapy may involve a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about his/her procedures, we should discuss them whenever they arise. If your doubts persist, the therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

During our initial meeting(s), the therapist will be getting a better understanding of your concerns, condition, and goals. We can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, the therapist will usually schedule one session per week at a time we agree on (and will

usually be 45 minutes in duration), although some sessions may be longer or more frequent.

SCHEDULING / CANCELLATION POLICY

If you need to re-schedule an appointment, please let the therapist know as soon as possible, so that we have a better chance of finding an alternate time to meet. A fee will not be charged for cancellation as long as you notify the therapist **24 hours in advance** of your scheduled appointment. If a session is cancelled with less than 24 hours notice or if you fail a scheduled appointment, you will be responsible for the **full session fee** as indicated in the PAYMENT section below, as insurance would not cover such occurrences.

***I understand and consent to this cancellation policy*: _____ (initial and date)**

PAYMENT

Your fee for service is payable by cash or check *at each session*. The current full fee schedule is as follows: $300 for the initial assessment, $200 for individual sessions, and $240 for couple/family sessions. If for some reason it is easier for you to pay on a different schedule, please let the therapist know so that we can discuss this. If you have a co-pay agreement in your insurance policy, you will be responsible for the co-pay at each session. Depending on your insurance plan, The therapist or a designated billing representative may be submitting claims to your insurance company on your behalf, and your signature below authorizes this to occur, as well as assignment of payment to the provider. Information that is released to insurance includes dates of service, procedure, and diagnosis.Your insurance company also reserves the right to request further information to support necessity of services, and can request treatment plans, session notes, or other information about treatment. *You will be responsible for any payment of services not covered by your insurance carrier*. Any insurance payments will be reflected on your account. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the therapist has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require the therapist to disclose otherwise confidential information. In most collection situations, the only information the therapist release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

***I understand and consent to this payment policy*: _____ (initial and date)**

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EMERGENCIES
If you believe you are having an emergency, call 911. After you are being take care of by emergency personnel, call the therapist at the phone number listed on this letterhead.

CONTACTING ME
If you need to reach the therapist between sessions, please call the therapist at the number listed on this letterhead, and leave the number where you will be, as well as good times to reach you, and the therapist will return your call as soon as possible. The therapist will make every effort to return calls as soon as possible. If the therapist is on extended leave, and feels you may need additional support in his/her absence, the therapist will offer you the name of another mental health provider covering for the therapist.

LIMITS ON CONFIDENTIALITY
The law protects the privacy of all communications between a patient and a psychologist. In most situations, the therapist can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Illinois law. However, in the following situations, no authorization is required:

The therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, the therapist will make every effort to avoid revealing the identity of his/her patient. The other professionals are also legally bound to keep the information confidential.

- From time to time, the therapist may have contracts with other vendors to assist with his/her practice, such as a billing service. As required by HIPAA, the therapist will have a formal business associate contract with this/these business(es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, the therapist can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law, but the therapist may be required to disclose information in the case of a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order the therapist to disclose information.

- If a government agency is requesting the information for health oversight activities, the therapist may be required to provide it for them.

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- If a patient files a complaint or lawsuit against the therapist, the therapist may disclose relevant information regarding that patient in order to defend himself/herself.

- If you file a worker's compensation claim, and the therapist is rendering treatment or services in accordance with the provisions of Illinois Workers' Compensation law, the therapist must, upon appropriate request, provide a copy of your record to your employer or his/her appropriate designee.

There are some situations in which the therapist is legally obligated to take actions that the therapist believe are necessary to attempt to protect others from harm. The therapist may have to reveal some information about a patient's treatment. These situations are unusual in his/her practice.

- If the therapist has reasonable cause to believe that a child under 18 known to the therapist in his/her professional capacity may be an abused child or a neglected child, the law requires that the therapist file a report with the local office of the Department of Children and Family Services. Once such a report is filed, the therapist may be required to provide additional information.

- If the therapist has reason to believe that an adult over the age of 60 living in a domestic situation has been abused or neglected in the preceding 12 months, the law requires that the therapist file a report with the agency designated to receive such reports by the Department of Aging. Once such a report is filed, the therapist may be required to provide additional information.

- If you have made a specific threat of violence against another or if the therapist believes that you present a clear, imminent risk of serious physical harm to another, the therapist may be required disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking your hospitalization.

- If the therapist believes that you present a clear, imminent risk of serious physical or mental injury or death to yourself, the therapist may be required to disclose information in order to take protective actions. These actions may include your hospitalization or contacting family members or others who can assist in protecting you.

If such a situation arises, the therapist will make every effort to fully discuss it with you before taking any action and the therapist will limit his/her disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and the therapist is not an attorney. In situations where specific advice is required, formal legal advice may be needed.

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PROFESSIONAL RECORDS

The laws and standards of his/her profession require that the therapist keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, the therapist recommends that you initially review them in his/her presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, the therapist is allowed to charge a copying fee of $0.25 per page.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that the therapist amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about his/her policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and his/her privacy policies and procedures. the therapist is happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 17 cannot examine their child's records unless the child consents and unless the therapist finds that there are no compelling reasons for denying the access. Parents are entitled to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Since parental involvement is often crucial to successful treatment, in most cases, the therapist requires that patients between **12** and **17** years of age and their parents enter into an agreement that allows parents access to certain additional treatment information. If everyone agrees, during treatment, the therapist will provide parents with general information about the progress of their child's treatment, and his/her attendance at scheduled sessions. The therapist will also provide parents with a verbal summary of treatment when it is complete. Any other communication will require the child's Authorization, unless the therapist feels that the child is in danger or is a danger to someone else, in which case, the therapist will notify the parents of his/her concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and do his/her best to handle any objections he/she may have.

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INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what 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. The therapist will fill out forms and provide you with whatever assistance the therapist can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of his/her fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, the therapist will provide you with whatever information the therapist can based on his/her experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that your contract with your health insurance company requires that you authorize the therapist to provide it with information relevant to the services that the therapist provides to you. If you are seeking reimbursement for services under your health insurance policy, you will be required to sign an authorization form that allows the therapist to provide such information. The therapist is required to provide a clinical diagnosis. Sometimes the therapist is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, the therapist will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, the therapist has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. The therapist will provide you with a copy of any report the therapist submits, if you request it. It is important to remember that you always have the right to pay for his/her services yourself to avoid the problems described above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, INCLUDING YOUR CONSENT FOR MENTAL HEALTH SERVICES. YOUR SIGNATURE BELOW ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE READ AND BEEN OFFERED A COPY OF THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I have read and agree to all these arrangements,

_____ _____
Patient/Client Signature Date

_____
Print Name

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ILLINOIS NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. I may also disclose PHI for *payment* purposes with your *general consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
  – *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

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II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or 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 if I keep them. "*Psychotherapy Notes*" are notes I may have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your 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, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

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

- *Child Abuse* – If I have reasonable cause to believe a child known to me in my professional capacity may be an abused child or a neglected child, I must report this belief to the appropriate authorities.

- *Adult and Domestic Abuse* – If I have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.

- *Health Oversight Activities* – I may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

- *Judicial and Administrative Proceedings* If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release such information without a court order. I can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization 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 must be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, I will discuss with you the details of the request for access process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

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- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

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 I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will notify you via phone or in person.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please talk with me about your concerns. You may also contact the Illinois Department of Professional and Financial Regulation.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on the date you sign it as indicated below.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by notifying you either in person or via telephone call.

_____ _____
Patient/Client Signature Date

_____
Print Name

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CHECKLIST OF CONCERNS AND HISTORY FORM

Name:_____ Date: _____
Please mark any items that apply to you.

PROBLEM AREAS--CAREER, SCHOOL
___Career concerns, goals, and choices
___Unemployment
___Job stress
___School problems
___Learning problems
___Work performance issues such as procrastination
___Work life balance issues (workaholism/overworking)
___Difficulty maintaining employment

PROBLEM AREAS--RELATIONSHIPS
___Communication problems
___Dating issues
___Detachment or estrangement from others
___Divorce, separation
___Friendships
___Feeling physically unsafe with my partner
___Infidelity, affairs
___Interpersonal conflicts
___Parenting issues
___Sexual issues with partner
___Social problems
___Physical fights with relationship partner
___Physical fights with others
___Relationship conflict
___Other Relationship problems (specify:
_____)
___Withdrawal, isolating

PROBLEM AREAS--LIFE EVENTS
___Childhood issues (your own childhood)
___Financial or money troubles, debt, impulsive spending, low income
___Grieving, mourning, deaths, losses
___Legal matters, charges, suits
___Other (Please specify: _____)

PROBLEM AREAS--PHYSICAL WELL-BEING
___Headaches, neck or back pain (Please specify: _____)
___Health, illness, medical concerns, physical problems
___Menstrual problems, PMS
___Pains, chronic (Please specify: _____)
___Sexual functioning problem (e.g. erectile dysfunction, painful intercourse)

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PROBLEM AREAS--SELF
___Identity issues
___Sexual identity issues
___Suicidal ideas
___Thoughts that life may not be worth living
___Self-esteem problems

EMOTIONAL CONCERNS
___Alert for danger, even in safe locations
___Anger, hostility
___Distressing memories of the past
___Suspiciousness
___Anxiety, nervousness
___Agitated
___Fear of leaving my home
___Fear of specific locations, such as elevators or planes (Please specify: _____)
___Fear of specific situations, such as heights or snakes (Please specify:_____)
___Fear of social situations
___Fear of abandonment
___Obsessive thoughts
___Panic or anxiety attacks
___Feeling hyper or wound up
___Shyness
___Tension—can't relax
___Attention, concentration
___Confusion
___Distractibility
___Memory problems
___Loneliness
___Depression, low mood, sadness, crying
___More depressed in the morning, with mood better later in the day
___More depressed in the winter, mood better in the summer
___Emptiness feelings
___Failure feelings
___Fatigue, tiredness, low energy
___Guilt
___Inferiority feelings
___Motivation problems
___Oversensitivity to rejection
___Oversensitivity to criticism
___Lack of interest in my usual activities
___Hopelessness
___Mood swings
___Overly high energy level for my age
___Perfectionism
___Sexual drive—lack of
___Feeling that others are out to get me
___Feeling that others are watching me
___Hearing voices

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BEHAVIORAL ISSUES
___I drink alcohol more than 2 nights per week
___At least one day a week, I have 4 drinks or more (if female) or 5 drinks or more (if male)
___I have used an illegal drug in the last month
___I smoke at least one cigarette per week
___At least once a week, I drink more than 2 cups of coffee, OR more than 4 colas or cups of tea
___I have had a DUI (When? _____)
___I have been charged with a crime in the past (other than parking, speeding or DUI)
___Aggressive or violent thoughts or behaviors
___Arguing
___Compulsive behaviors (Please specify: _____)
___Repetitive behaviors (e.g. hand washing, checking doors, checking stove)
___Cutting or otherwise injuring self
___Other self-harm in past (Describe: _____)
___Decision making problems, indecision, mixed feelings, putting off decisions
___Disorganization
___Gambling
___Irritability
___Impulsiveness
___Irresponsibility
___Judgment problems, risk taking
___Self-neglect, poor self-care
___Suicide attempt in past (When? _____)
___Temper problems, self-control, low frustration tolerance

EATING/WEIGHT ISSUES
___Lack of appetite
___Weight loss (How much? _____ Over what time? _____)
___Overeating
___Weight gain (How much? _____ Over what time? _____)
___Vomiting
___Taking laxatives, enemas or diuretics to lose weight
___Bingeing on food
___Diet issues
___Fear of becoming fat

SLEEP ISSUES
___Sleeping too much
___Insomnia
___Difficulty going back to sleep upon awakening during night
___Too much worrying or thinking keeps me from getting to sleep
___Waking at least 2 hours too early in the morning
___Feeling extremely restless or squirmy prior to bedtime
___I have taken a sleeping pill or drank alcohol to sleep at least once in the past month
___Nightmares or upsetting dreams
___Suddenly falling asleep in inappropriate locations
___Snoring
___Grinding teeth during sleep
___Stopping breathing briefly during sleep (noticed by you OR partner)
___Sleepwalking

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ANY OTHER CONCERNS OR ISSUES THAT MAY BE A FOCUS FOR PSYCHOTHERAPY?:

_____

_____

_____

_____

WHICH CONCERNS DO YOU MOST WANT HELP WITH?
1.

2.

3.

INFORMATION CHECKLIST
Please review the following list of treatments you may have had in the past. Please put a check next to any that apply to you and indicate the dates, to the best of your recollection.

			Dates:
Inpatient psychiatric hospitalization	___ No	___Yes	_____
Intensive outpatient treatment (e.g. at least 2-3 days per week)	___ No	___Yes	_____
Psychotherapy	___ No	___Yes	_____
Outpatient Substance Abuse counseling	___ No	___Yes	_____
Attending AA/NA/CA meetings	___ No	___Yes	_____
Taking medication for emotional difficulty	___ No	___Yes	_____
Taking medication for sleep	___ No	___Yes	_____

PSYCHOTROPIC MEDICATIONS
_____ I do not take psychotropic medications
Psychiatrist _____ Phone _____ Fax _____
Address _____
If you enter treatment with me for psychological problems, I strongly recommend that treatment be coordinated between your psychiatrist and me. Do you have any problems with this? ___ No ___Yes

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847-772-6600

333 N. MICHIGAN AVE
SUITE 1801, CHICAGO, IL 60601
JG@JESSICAGOLUB.COM

EDUCATION

Did you graduate from HIGH SCHOOL? ____ Yes ____ No
Year of graduation _____

COLLEGE OR VOCATIONAL SCHOOL Attendance and Degrees/Certificates:

From	To	School	Degree Program	Did you graduate?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYMENT for the last 5 years

Dates From	To	Name of military or employers	Job title or duties	Reason for leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HISTORY OF EVENTS

Please indicate any of the following events that may have occurred to you in the past:

____ My parents/caretakers punished me physically as a child or teenager
____ My parents/caretakers were verbally harsh and critical of me as a child or teenager
____ My parents/caretakers did not provide appropriate supervision, food, shelter or other protection.
____ My parents/caretakers were unaware of my difficulties when I was a child or teenager.
____ There was violence in my home growing up.
____ I experienced inappropriate sexual contact as a child or teenager
____ I experienced sexual harassment as an adult
____ I experienced other upsetting sexual experience(s) as an adult
____ As an adult, I experienced a physical injury intentionally caused by another adult.
____ Someone has hit, kicked, punched or otherwise hurt me during the last 12 months.
____ Someone has threatened me verbally with bodily harm.
____ I experienced any other upsetting experience(s) as noted below:

_____
_____

PRESENT RELATIONSHIP

____ I do not have a partner at present
How would you characterize your relationship with your partner? _____
_____

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USE OF CAFFEINE, ALCOHOL, TOBACCO AND STREET DRUGS

How much coffee, cola, tea, or other sources of caffeine do you consume each day?

_____

_____

ALCOHOL

1. Have you ever felt the need to cut down on your drinking? ___ No ___Yes
2. Have you ever felt annoyed by criticism of your drinking? ___ No ___Yes
3. Have you ever felt guilty about your drinking? ___ No ___Yes
4. Have you ever taken a morning "eye-opener"? ___ No ___Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average?

_____

6. How much TOBACCO do you smoke or chew each week?

_____

7. Which STREET DRUGS have you used in the last 3 years?

_____

LEGAL ISSUES

1. Are you presently suing anyone or thinking of suing anyone? ___ No ___Yes
If yes, please explain:

_____

2. Is your reason for coming to see me related to an accident or injury? ___ No ___Yes
If yes, please explain:

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?
___ No ___Yes If yes, please explain

_____

4. Have you had any contacts with the police, courts, and jails/prisons regarding a crime that you were charged with? ___ No ___Yes
5. Were you ever locked up in jail or prison--even if just overnight? ___ No ___Yes
6. Are there any other legal involvements I should know about? ___ No ___Yes
If yes, please describe:

_____

MEDICAL HISTORY

1. Please list all CURRENT MEDICAL PROBLEMS that you have (Be sure to include chronic conditions such as asthma, seizure disorder, arthritis, diabetes, etc.).

_____

_____

_____

2. Please rate your current level of PHYSICAL PAIN on a scale of 0-10, with 0 being no pain and 10 being the worse pain you have ever had _____
Rate the most severe pain you have had in the past month ____
Why were you experiencing pain? _____

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3. List all MEDICATIONS, HERBAL SUPPLEMENTS, VITAMINS, AND OVER-THE-COUNTER DRUGS you have taken in the last month.

Medication/drug	Dose (how much?)	Taken for	Prescribed by

4. Have you had any SURGERIES, including any plastic surgery? If so, please list briefly:

_____
_____

5. Have you ever been hit or injured on the HEAD? ___ No ___Yes
Have you ever been knocked UNCONSCIOUS? ___ No ___Yes
Please describe:

_____
_____

HEALTH HABITS

1. What kinds of physical exercise do you get?

_____
_____

2. How many times per week do you typically exercise for 20 minutes or more? _____

3. Do you try to restrict your eating in any way? How? Why?

_____
_____

4. Do you have any problems getting enough sleep?

_____
_____

5. What is your average number of hours of sleep per night? _____

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PATIENT ELECTRONIC COMMUNICATION CONSENT FORM

Patient Name: _____
Patient Address: _____ _____
_____
E-mail: _____
Cell/SMS: _____

DEFINITIONS

"Provider" shall refer to Jessica A. Golub, Ph.D.
"Practice" shall refer to all affiliates, shareholders, officers, directors, physicians, providers, agents and employees affiliated with the practice of the Provider.
"Electronic communication" shall refer to e-mail, SMS (text messaging), teletherapy, video conferencing, facsimile transmissions, and/or all other forms of communication transmitted and/or received electronically.

1. RISK OF USING E-MAIL, SMS ("TEXT MESSAGING"), VIDEO-CONFERENCING, AND OTHER FORMS OF ELECTRONIC COMMUNICATION

Transmitting patient information by E-mail, SMS, and/or other forms of electronic communication has a number of risks that patients should consider before using these forms of communication. These include, but are not limited to, the following risks:

a) **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails and SMS messages sent from this Provider and the Practice may not be encrypted, so they may not be secure.** Therefore it is possible that the confidentiality of such communications may be breached by a third party.
b) E-mail and SMS messages can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) E-mail and SMS senders can easily mis-assign an E-mail or SMS.
d) E-mail and SMS is easier to falsify than handwritten or signed documents.
e) Backup copies of E-mail and SMS messages may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect E-mail and SMS messages transmitted through their systems.
g) E-mail and SMS messages can be intercepted, altered, forwarded, or used without authorization or detection.
h) E-mail (and possibly SMS messages) can be used to introduce viruses into computer systems. The Practice server and/or computer system could go down and E-mail and/or SMS message may not be received until the server is back on-line.
i) E-mail and SMS messages can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL, SMS ("TEXT MESSAGING"), AND OTHER FORMS OF ELECTRONIC COMMUNICATION

The Practice cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail, SMS, and other forms of electronic communication information sent and received. Practice and Provider are not liable for improper disclosure of confidential information that is not caused by Practice's or Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) **E-mail, SMS messaging, and other forms of electronic communication are not appropriate for urgent or emergency situations. Practice and Provider cannot guarantee that any particular electronic communication will be read and responded to within any particular period of time.**
b) **If the patient's E-mail, SMS message, or other form of electronic communication requires or invites a response from**

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Practice or Provider, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the electronic communication and when the recipient will respond.

c) The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail or SMS messages.
d) **E-mail, SMS messages, and other forms of electronic communication may be printed and filed in the patient's medical record.**
e) Although unlikely, office staff (if applicable) may receive and read your messages.
f) Practice will not forward patient identifiable electronic communications outside of the Practice without the patient's prior written consent, except as authorized or required by law.
g) The patient should not use E-mail, SMS messages, or other forms of electronic communication for communicating sensitive information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Practice is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i) This consent will remain in effect until terminated in writing by either the patient or Practice.
j) My decision to allow the Provider to communicate with me by e-mail, SMS, or other electronic means is voluntary, and that treatment is not conditioned upon my election to do so.
k) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by E-mail, SMS, or other forms of electronic communication with Practice.

3. INSTRUCTIONS

To communicate by E-mail, SMS messaging, or other forms of electronic communication, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the E-mail.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Practice of changes in his/her E-mail address or SMS phone number.
e) Acknowledge any E-mail, SMS message, or other electronic communication received from the Practice and/or Provider.
f) Take precautions to preserve the confidentiality of all electronic communications.
g) Protect his/her password or other means of access to E-mail, SMS, and other forms of electronic communication.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and **fully** understand this consent form. I understand the risks associated with the communication of E-mail, SMS messages, and other forms of electronic communication between the Practice, Provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by E-mail, SMS, and/or other forms of electronic communication. If I have any questions, I may inquire with the Practice Privacy Officer, who is also the Provider.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release the Provider and affiliates, shareholders, officers, directors, physicians, providers, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail, SMS messages, and/or other forms of electronic communication.

Patient Signature _____

Date _____

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Credit/Debit Card Payment Consent Form

Patient Full Name _____

Full Name on credit card (if different) _____

I authorize Jessica A. Golub Ph.D. and/or her billing associate(s) to charge my credit card for professional services for the balance of fees not paid by me or my insurance company.

Credit Card Number _____ - _____ - _____ - _____
(Unable to accept DEBIT cards at this time)

Exp. Date _____/_____

CVV Number _____ (3 digit # from back of card, or AMEX then 4 digit # on front right of card)

Card Holder's complete Billing Address for Monthly Card Statements

_____ _____ ____ _____
Street *City* *State* *Zip*

Card Holder E-mail Address (*to send receipt*) _____

A credit card receipt that does not contain the full credit card number may be e-mailed to you at the e- mail address above

Card Holder Signature _____ Date ____ /____ /____

Charges will appear on your card statement as Professional Services Rendered or similar iteration.