Brian Griswold, LCPC
Pyschotherapist

744 Dulaney Valley Road ◆ Towson, MD 21204 ◆ 3rd Floor, Suite 7 ◆ 410 305 9246
www.briangriswold.com

CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Today's Date: _____

Address_____ City_____

State_____ Zip_____ Email_____

Home phone: _____ May we leave a message Y/N

Work phone: _____ May we leave a Message Y/N

Cell phone: _____ May we leave a message Y/N

Any number you do not want to be contacted at: _____

Sex: □ Male □ Female Date of Birth: _____ Age: _____

Check here if you want Christian counseling ☐

Do you regularly attend a church, synagogue, or other religious institution? □ Yes □ No

If yes, which one? _____

RELATIONAL INFORMATION

Current marital status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed
If engaged, married, separated, divorced, or widowed, for how long? _____
Number of previous marriages for you. _____ For your spouse. _____
If married, spouse's name: _____ Age: _____
Is your spouse supportive of you seeking counseling? □ Yes □ No □ Unsure □ Spouse doesn't know

Please provide a brief description of your spouse (e.g., angry and controlling; outgoing and supportive):

_____

What is your current occupation? _____

What is your level of satisfaction with your occupation?

_____

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Please list your children (including step, adopted, foster) below:				
Name	Sex	Age or yr. of death	Relationship to you	Living with whom?

Who else lives with you? _____

Please list your father, mother, sisters, brothers, stepfamily relations, or other family members who had a significant effect on your life (either positive or negative). (Use the back of this sheet if necessary.)

Name	Sex	Age or yr. Of death	Relationship to you	Describe him/her (e.g. angry, outgoing, supportive, controlling)

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs. (Use the back if necessary.)

Therapist's Name or Program	Major Issue	Dates

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Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions?
□ Yes □ No
If yes, please describe: _____

Have any of your family members or friends ever attempted or committed suicide?
□ Yes □ No
If yes, who and when: _____

MEDICAL HISTORY
Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling: _____

Are you currently receiving any medical treatment? □ Yes □ No If yes, please describe: _____

Please list all current medications you are taking and the reasons for taking them. (List even if you seldom use, or take only as needed.)		
Name of medications	Dose	Reason for taking

Are you taking these medications according to the doctor's recommendations?
□ Yes □ No

If no, please explain: _____

Date and outcome of last physical exam: _____

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PRESENT ISSUES AND GOALS

Please describe why you are coming to counseling. (i.e. what are your issues, problems, symptoms, how long, etc. Use the back if necessary.)

_____

_____

Check any of the following symptoms or problems that you currently are or recently have experienced:

List 1	List 2	List 3
□ Stress	□ Marital Problems	□ Compulsive Behaviors
□ Anxiety	□ Other Relational Problems	□ Seeing Things Others Don't
□ Panic	□ Physical Abuse	□ Hearing Voices
□ Depression	□ Emotional Abuse	□ Racing Thoughts
□ Apathy	□ Verbal Abuse	□ Eating Problems
□ Fatigue/Lack of Energy	□ Sexual Abuse	□ Drug Use
□ Loss of Appetite/Overeating	□ Sexual Problems	□ Alcohol Use
□ Trouble Sleeping	□ Gender Identity Issues	□ Pregnancy
□ Poor Concentration	□ Anger	□ Abortion
□ Feeling Worthless	□ Aggressive Behavior	□ Legal Matters
□ Recent Death	□ Bad Dreams	□ Work Stress
□ Grief	□ Unwanted Memories	□ Career Choices
□ Chronic Pain	□ Loss of Control	□ Indecisiveness
□ Loneliness	□ Impulsive Behavior	□ Parenting Problems
□ Fears	□ Controlling	□ Financial Problems
□ Shyness	□ Controlled by Others	□ Spiritual Problems
□ Low Self-Esteem	□ Obsessive Thoughts	□ Other _____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

[----------]

Very Minimally Distressed | Moderately Distressed | Very Extremely Distressed

Are you currently experiencing any suicidal thoughts? □ Yes □ No
Have you experienced suicidal thoughts in the past? □ Yes □ No
Have you attempted suicide in the past? □ Yes □ No
Are you currently experiencing any violent or homicidal thoughts? □ Yes □ No

What do you hope to gain from this counseling experience?

_____

_____

Client's Signature_____ Date_____

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LIMITS OF CONFIDENTIALITY

All information obtained/derived by the course of treatment is fully confidential; disclosures you share with your therapist are confidential unless you have SIGNED a consent form to release part or all of the information.

Therefore, to either release or obtain information from a specific individual or agency, a Release of Information must be obtained. Exceptions to this guideline include instances when 1. The patient is a clear danger to (a) themselves or (b) others and, 2. Instances when the patient is a minor (under the age of 18) and reports that he or she is or has been a victim of physical or sexual abuse, and 3. There is any suspected abuse to a child or adult.

Please sign and date all Release of Information documents. Please print a copy for yourself as the copies you sign will be given to your therapist.

In addition, cases are occasionally discussed by the clinic's professional staff to obtain feedback and provide alternative treatment plans and continuity of care (e.g. your therapist, if unlicensed, will discuss your case with his or her Clinical Supervisor). Your signature on this form will allow this process to proceed smoothly.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

A**buse of Children and Vulnerable Adults**
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Confidentiality of E-mail, Chat, and Cell Phone Communication
Therapeutic email and chat exchanges are delivered via HushMail. You agree to work with me online using HushMail or another encrypted email/chat service determined to be suitable by Brian Griswold. If you choose to email me form your personal email account, please limit the contents to housekeeping issues such as cancellation or change in contact information. I will not respond to personal and clinical concerns via regular email. If you call me, please be aware that unless we are both on landline phones, the conversation is not confidential. Likewise, text messages are not confidential. Any computer files referencing our communication are maintained using secure and encrypted measures. If you wish to use email as a way to "journal" information between sessions, you understand that I may not have the opportunity to review your journal emails until our next scheduled session. You understand that emails between sessions that contain confidential information will be sent utilizing encryption.

I make every effort to keep all information confidential. Likewise, if we are working online together, I ask that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors, and friends. I encourage you to only communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured. Be sure to fully exit all online counseling sessions and emails. If we are unable to connect or aer disconnected during a session due to a technological breakdown, please try to reconnect within 1- minutes. If reconnection is not possible, email to schedule a new session time.

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POLICIES AND PROCEDURES

Telephone Calls
If you need to speak with me between sessions to alert me of an emergency or to schedule an appointment, please call 410. 305.9246. Your call will be returned as soon as possible. Messages are checked daily (but never during the night time). Messages are checked less frequently on weekends and holidays. If an emergency situation arises that requires immediate attention, you may call the emergency National Suicide Hotline at 800.784.2433 or dial 911. If a life-threatening crisis should occur, you agree to contact a crisis hotline, call 911 or go to a hospital emergency room.

Length of Sessions
The psychotherapy session is about 45-50 minutes in length beginning at our appointed time and concluding 45-50 minutes after (75 minutes sessions may be prearranged with your therapist). Therefore, it is to your benefit to arrive a few minutes in advance of the appointment time. Since your therapist has sessions scheduled after yours, the sessions must end 45-50 minutes after the appointment time regardless of your arrival time (full fee for the session will be charged).

Fees and Payment
All payments are due at the time of service. We accept cash or check made payable to Brian Griswold. A $25.00 service charge will be levied on all checks returned by a bank for insufficient funds. Our current fee per session is $100. If all outstanding balances are not paid, Brian Griswold reserves the right to release a client's name and address to a collection agency. Also, a monthly interest fee of 2% will be charged for these balances until they are paid in full. Online sessions must be paid in advance of session by credit card via PayPal.

Insurance
We do not bill insurance companies. We do ask each client to pay in full at the time of service.

Cancellations and Missed Appointments
When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, the therapist is unable to make use of that time. Therefore, sessions must be cancelled 24 hours in advance or a cancellation fee of $100 will be charged.

Online and Email Therapy
You as the client understand that phone and email sessions have limitations compared to in-person sessions, among those being the lack of "personal" face-to-face interactions, and the lack of visual and audio cues in the therapy process. You understand that telephone/online psychotherapy with me is not a substitute for medication under the care of a psychiatrist or doctor. You understand that online and telephone therapy is not appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts. As stated previously, if a life-threatening crisis should occur, you agree to contact a crisis hotline, call 911, or go to a hospital emergency room. You also understand that I follow the laws and professional regulations of the State of Maryland (USA) and the psychotherapy treatment will be considered to take place in the state of Maryland (USA).
We will discuss this informed consent during our first session. If our sessions are scheduled online please fax or mail this form with your signature FAX: 877.860.6241 MAIL: 744 Dulaney Valley Rd Suite 7, Towson, MD 21204.

I agree to the above limits of confidentiality, polices and procedures and understand their meaning and ramifications.

_____ _____
Client Signature (Client's Parent/Guardian if under 18) Date

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PRIVACY NOTICE FOR THE PRACTICE OF BRIAN GRISWOLD

This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice gives you information required by the health insurance portability and accountability act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of your individual identifiable health information; this is, *Protected Health Information (PHI)*, as that term is defined in the HIPAA under *Information*.

The effective date of this notice is april 14, 2003. BRIAN GRISWOLD is required to follow the terms of this Notice until it is replaced. BRIAN GRISWOLD may make changes to the terms of this Notice at any time. **Upon your request**, we will provide you with a copy of the current Notice. BRIAN GRISWOLD reserves the right to make the changes apply to your *Information* maintained in my files before and after the effective date of the new Notice. The following is a general description of how Federal and State law permits me to use and disclose your *Information*.

Purposes for which BRIAN GRISWOLD May Use or Disclose Your Mental Health Information with your Consent
BRIAN GRISWOLD may request your consent for the use and/or disclosure of your *Information* for *treatment*, *payment* or *health care operations* as described below:

- *Treatment*. BRIAN GRISWOLD with use and disclose your *Information* to provide, coordinate, or manage your mental health care and any related services. BRIAN GRISWOLD may disclose your *Information* to physicians, therapists, other mental health providers, or other health care providers who are treating you or assisting in your diagnosis, treatment, or recovery.

- *Payment*. Your *Information* will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one, third party payer is responsible for payment for your health care, BRIAN GRISWOLD may disclose your *Information* to more than one health plan and those health plans may share your *Information* with each other. Your *Information* may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.

- *Mental Health Care Operations*. BRIAN GRISWOLD may use or disclose, as needed, your *Information* in order to support my delivery of mental health care services. BRIAN GRISWOLD may call you by name in the waiting room area. BRIAN GRISWOLD may use or disclose your *Information*, as necessary, to contact you to schedule an appointment or remind you of your appointment.

  BRIAN GRISWOLD may share your *Information* with third party Business Associates who perform various administrative services. For example, those within BRIAN GRISWOLD, or with whom BRIAN GRISWOLD contracts, who perform billing services, transcription services, record retention, or other professional consultants. Whenever an arrangement between a Business Associate and me involves the use or disclosure of your *Information*, we will have a written contract that contains terms that will protect the privacy of your *Information*.

- *Health Care Services*. Your *Information* may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures With Your Verbal Consent
Your *Information* may be disclosed to a family member, friend, or other person designated by you or as designated by the law, if you verbally agree.

Uses and Disclosures with Your Written Authorization
Except as provided below, your *Information* will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your *Information* for a purpose that is not described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the *Information* BRIAN GRISWOLD maintains, unless BRIAN GRISWOLD has taken action in reliance on your authorization.

Uses and Disclosures Without Your Consent
- As required by law;
- To comply with legal proceedings, such as a court or administrative order or subpoena;
- To law enforcement officials for limited law enforcement purposes;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To avert a serious threat to your health or safety or the health or safety of others;
- To a governmental agency authorized to oversee the mental health care system or government programs;
- To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and
- To public mental health authorities for public health purposes.

Your Rights
- You may make a written request to me to do one or more of the following concerning your *Information*:
- Put additional restrictions on use and disclosure of your *Information*.
- Communicate with you in confidence about your *Information* by a different means than BRIAN GRISWOLD is currently doing.
- See and get copies of your *Information*.
- Receive a list of disclosures of your *Information* that BRIAN GRISWOLD has made for certain purposes for six (6) years prior to your request (after April 14, 2003), with certain exceptions permitted by law, which includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact me at the address below. In certain instances, BRIAN GRISWOLD is not required to agree to your request. BRIAN GRISWOLD will give you the necessary information and forms for you to complete and return to request your *Information*. BRIAN GRISWOLD is permitted, by law, to charge you a fee for copying any documents requested in accordance with your rights as listed above. (Fee $1.00 per page.)

Complaints
If you believe that BRIAN GRISWOLD violated your privacy rights, you have the right to complain to me or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with me at the address below. An individual must file a complaint within 180 days of when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS.

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Contact Address:
Brian Griswold, LGPC
744 Dulaney Valley Rd Suite 7
Towson, MD 21204

As a client of Brian Griswold, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Brian Griswold.

Client Name_____

Client Signature _____ Date_____

Clear Form Print Form