Jennifer Ferrell-Hanington, Psy.D., Licensed Psychologist
125 West Pineview Street, Ste. 1005
Altamonte Springs, FL 32714
(407) 347-4188

CLIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname

Address: Street City Zip Code

Home Telephone Number	Mobile Phone Number

Call Back Preference: (Check One) Home ___ Mobile ___ Other _____ No Call Back ___ | May We Leave Message? Y N

Number we may call for same day cancellation: _____

Age	Birth Date	Marital Status	Sex	Race/Ethnicity

Employer	Occupation

Preferred Email

How did you hear about and who may be thanked for referring you to Dr. Ferrell-Hanington?

PERSON TO CONTACT IN CASE OF EMERGENCY

Name Phone Number

Dr. Ferrell-Hanington has permission to speak to the following person(s) other than myself:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

_____ Scheduling and Cancellation of Appointments _____ Scheduling and Cancellation of Appointments

_____ Billing Issues _____ Billing Issues

_____ _____

Signature of Client **Date**

COMPLETE THIS SECTION IF PERSON OTHER THAN CLIENT IS RESPONSIBLE FOR PAYMENTS

Name	Relationship to Client

Address (If different than client): Street City Zip Code

Home Telephone Number	Work Telephone Number

_____ _____

Signature of Client or Responsible Party **Date**

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PRIMARY INSURANCE INFORMATION

Policy Holder's Name (Last) (First) (Middle Initial)		
Policy Holder's Date of Birth	Policy Holder Telephone Number	
Policy Holder Address (Street) (City) (State) (Zip)		Policy Holder's Employer
Insurance Carrier		Policy Number
Claims Address	Group Name and/or Number	Insurance Telephone Number

SECONDARY INSURANCE INFORMATION

Policy Holder's Name (Last) (First) (Middle Initial)		
Policy Holder's Date of Birth	Policy Holder Telephone Number	
Policy Holder Address (Street) (City) (State) (Zip)		Policy Holder's Employer
Insurance Carrier		Policy Number
Claims Address	Group Name and/or Number	Insurance Telephone Number

I certify that the information I have reported with regard to my insurance coverage is correct. I hereby authorize Jennifer J. Ferrell-Hanington, Psy.D. to file insurance on my behalf for covered services rendered. I authorize the direct payment to Jennifer Ferrell-Hanington, Psy.D., P.A. for the benefits allowable and otherwise payable to me under my current insurance policy or policies as payment toward total charges for the services rendered. I further authorize the release of any necessary information to my insurance carrier, (or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) needed for processing my insurance claims. A copy of this authorization may be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges not paid by said insurance.

Signature of Patient, Insured, or Policy Holder: _____

Date: _____

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LIMITS OF CONFIDENTIALITY AND RECEIPT OF NOTICE

This document contains important information about limits of confidentiality. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and 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 Dr. Ferrell-Hanington to make available a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires your signature acknowledging that you are aware of the availability of the Notice for your review.

Limits of Confidentiality

Confidentiality is an ethical concept that prohibits a psychologist from releasing information about the client. Privileged communication is a legal term for a right that belongs to the client that restricts a psychologist from disclosing, in legal proceedings, information that was given with assumed confidentiality. Confidentiality and privileged communication remain the rights of all clients of psychologists according to state law. A psychologist can only release information about a client's treatment with a client's signature on a written Authorization form that meets certain legal requirements imposed by HIPAA.

There are some situations where Dr. Ferrell-Hanington is legally obligated to take actions, which are believed to be necessary to attempt to protect others from harm, and she may have to reveal some information about your treatment:

- If there is clear and immediate probability of physical harm to the client, to other individuals, or to society, information may be disclosed to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the client.

- If there is knowledge or reason to suspect that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires a psychologist to file a report with the Department of Children and Families. Once such a report is filed, a psychologist may be required to provide additional information.

- If there is knowledge or reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that a psychologist file a report with the Department of Children and Families. Once such a report is filed, the psychologist may be required to provide additional information.

Dr. Ferrell-Hanington will not, if at all possible, inform such parties without first sharing that intention with the client. Every effort will be made to resolve the issue before such a breach of confidentiality takes place. Please bear in mind that Dr. Ferrell-Hanington is not able to give you legal advice. If you have special or unusual concerns, she strongly suggest that you talk to a lawyer to protect your interests legally.

There are some situations where Dr. Ferrell-Hanington is permitted or required to disclose information without your consent or Authorization:

- If the client is involved in a court proceeding and a request is made for information concerning diagnosis and treatment, such information is protected by the psychologist-patient privilege law. A psychologist cannot provide any information without the client (your legal representative's) written authorization, or a court order. Clients may want to consult with their attorneys to determine whether a court would be likely to order Dr. Ferrell-Hanington to disclose information.

- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, a psychologist may be required to provide it for them.

- If a client files a complaint or lawsuit against a psychologist, he/she may disclose relevant information about the client in order to defend oneself.

- If a client files a worker's compensation claim and a psychologist is providing necessary treatment related to that claim, the psychologist must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.

Professional Records

Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that are set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that your therapist receives from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

Except in unusual circumstances that disclosure would physically endanger you and/or others, or makes reference to another person (other than a health care provider) and Dr. Ferrell-Hanington believes that access is reasonably likely to cause substantial harm to such other person, 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, Dr. Ferrell-Hanington recommends that you initially review them in her presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, Dr. Ferrell-Hanington may charge a copying fee of $1.00 per page. The exceptions to this policy are contained in the attached Notice Form. If Dr. Ferrell-Hanington refuses your request for access to your Clinical Records, you have a right of review, which she can discuss with you upon request.

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. The Notice explains HIPAA and its application to your personal health information in detail and is available for your review.

Insurance

You should also be aware that your contract with your health insurance company requires that Dr. Ferrell-Hanington provide information relevant to the services that are provided to you. She is required to provide a clinical diagnosis. Sometimes she is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, she 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, she 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. Dr. Ferrell-Hanington will provide you with a copy of any report submitted, per your request. By signing this Agreement, you agree that she can provide requested information to your carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Client Name: _____ DOB: _____

_____ _____ _____

Signature Relationship to client Date

Jennifer Ferrell-Hanington, Psy.D., Licensed Psychologist
125 West Pineview Street, Ste. 1005, Altamonte Springs, FL 32714
(407) 347-4188

CONSENT FOR PSYCHOTHERAPY

Thank you for the trust that you have placed in Dr. Jennifer Ferrell-Hanington. Your first appointment will consist of gathering history about your present problem and background. At the end of your session, she will discuss treatment recommendations with you. Recommendations may include psychotherapy, further assessment, referral to another clinician, etc.

As with all effective treatments, there are many benefits as well as possible risks with psychotherapy. The benefits will depend upon the treatment goals that you and Dr. Ferrell-Hanington establish together. Psychotherapy offers individuals the opportunity to talk things out fully with an objective professional until their feelings are relieved or the problems are solved. People may experience improvement in their mood and coping skills may improve greatly. Their personal goals and values may become more clear. They may grow in many directions as persons and notice an increase in the ability to enjoy life.

There also are risks that may occur for individuals participating in psychotherapy. Risks may be anticipated when people are making important changes in their lives. Sometimes a client's problems may temporarily worsen after the beginning of treatment. The conflict or problem may not be resolved or changed. The emotional experience may be too overwhelming or too intense to deal with at this time. On rare occasions, new and different symptoms may develop during therapy. Even with a psychologist's best efforts, there is a risk that psychotherapy may not work out well for you.

As a condition of providing treatment to you, Dr. Ferrell-Hanington may request your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations. You may revoke this consent at any time by notifying her, *in writing*, except to the extent that she has taken action and reliance on your consent. Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that we may make of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

Dr. Ferrell-Hanington does not provide emergency services. She will return non-emergency calls during normal business hours (9 AM to 5 PM), Monday through Friday. While she is unavailable, you will be able to leave her confidential voicemails. She will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please provide information regarding the best times to return your call. Should you be unable to wait for her to contact you, please go to the nearest emergency room or call 911. You also may call the National Suicide Prevention Lifeline at 800-273-8255 for immediate assistance. Should Dr. Ferrell-Hanington be unavailable for an extended period of time (e.g. vacation), she will provide you with the name of a colleague to contact, if necessary.

PLEASE INITIAL: _____

I, the undersigned, voluntarily agree to participate in psychotherapy with Dr. Jennifer Ferrell-Hanington. I understand that I will be provided with an explanation of any psychotherapy procedures and their purposes. I have read and fully understand the above explanation of benefits that can be expected, and possible risks that may occur. I understand that this consent for services may be withdrawn at any time, and that I have the right to refuse to participate in any procedure which may be suggested, as well as the right to withdraw from counseling at any time.

Client Name: _____ DOB: _____

_____	_____	_____
Signature	Relationship to client	Date

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ACKNOWLEDGEMENT OF NOTICE OF PSYCHOLOGISTS' AND COUNSELORS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

The *Notice of Psychologists' and Counselors' Policies and Practices to Protect the Privacy of Your Health Information* describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. The notice is posted in the waiting room of Dr. Ferrell-Hanington for your review. A copy of the notice is available to you, as well, per your request.

By signing this form, you acknowledge the availability of the *Notice of Psychologists' and Counselors' Policies and Practices to Protect the Privacy of Your Health Information.*

The *Notice of Psychologists' and Counselors' Policies and Practices to Protect the Privacy of Your Health Information* is subject to change. If the notice is changed, you may obtain a copy of the revised notice by accessing our website at www.jfhaningtonpsyd.com or by calling Dr. Ferrell-Hanington at 407-347-4188. If you have any questions about the notice, please ask Dr. Ferrell-Hanington.

I acknowledge the availability of the *Notice of Psychologists' and Counselors' Policies and Practices to Protect the Privacy of Your Health Information.* I may review the posted notice or request a copy of the notice from Dr. Ferrell-Hanington.

Client Name: _____

_____ _____

Signature Relationship to client

_____

Date

Jennifer Ferrell-Hanington, Psy.D., Licensed Psychologist
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General and Financial Policies

Professional Fees

Dr. Ferrell-Hanington is in independent practice and has established her own fee schedule. In addition to regular appointments, other services may be provided to which may have additional fees. Such services include: report writing, extended telephone conversations, consulting with other professionals, preparation of records or treatment summaries, etc. If you become involved in legal proceedings that requires Dr. Ferrell-Hanington's participation, you will be responsible for the fees associated with her professional time, including preparation and transportation costs. Based on the difficulty of legal involvement, Dr. Ferrell-Hanington will charge a fee greater than the usual hourly rate.

Insurance Reimbursement

Dr. Ferrell-Hanington will provide the courtesy of verifying your insurance. However, the initial information provided by your insurance company may not be accurate, and the actual coverage provided by your insurance company cannot be determined until a detailed Explanation of Benefits is received with the insurance payment. As a courtesy, she also will file your insurance but cannot accept responsibility for collecting or for negotiating a settlement of a disputed claim. It is important that you find out exactly what mental health services your insurance policy covers. If you have any questions about the coverage, call your plan administrator.

Please note: ***You are responsible for any balance that your insurance carrier does not pay.***

PLEASE INITIAL: _____

Financial Arrangements

You will be expected to pay for each session at the time that it is rendered, unless Dr. Ferrell-Hanington has agreed to another arrangement. She accepts cash, checks, and credit cards. If your account is overdue and you have not made payments or made a payment arrangement, Dr. Ferrell-Hanington has the option of reporting you to a collection agency or the credit bureau. **Please note the following additional charges that may apply:**

- **A $25.00 fee will be applied to all returned checks**
- **Interest of 1 1/2% per month will be assessed for any outstanding balance greater than 90 days old**

PLEASE INITIAL: _____

Cancellation Policy

Your appointment represents a valuable period of time that obligates the presence of you and Dr. Ferrell-Hanington. Should you need to change an appointment, please notify her at least 24 hours in advance, and please call if there is an emergency or other problem that prevents you from being at your appointment. **If you fail to provide a 24 hour notification of your intent to cancel an appointment or if you miss an appointment without prior notification, other than in times of an emergency, you will be charged a fee of $75.00.** Your insurance will not cover the cost of cancelled or missed appointments.

PLEASE INITIAL: _____

I have read and understand the above information.

Client Name: _____ DOB: _____

_____ _____ _____
Signature Relationship to client Date

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LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to help Dr. Ferrell-Hanington better understand your difficulties that have brought you to her office. This questionnaire should not take longer than fifteen to twenty minutes. However, you are asked to take your time to answer these questions as fully and accurately as possible. It is understandable that you may be concerned about the privacy of this personal information. Please be assured that all of this information will be part of your case record which will be held in strict confidence. Unless required by law, your case record will not be released without your permission.

Name:_____ Age:_____ Date:_____

Presenting Problem:

1.) What are you seeking counseling for? _____

2.) Check any of the following that are *current* or *previous* problems for you:

☐ easily hurt	☐ lonely	☐ aggressive	☐ rejected	☐ misunderstood
☐ suicidal	☐ hallucinating	☐ timid	☐ guilty	☐ bad temper
☐ worthless	☐ agitated	☐ horrible thoughts	☐ full of hate	☐ gambling
☐ women	☐ parents	☐ sex	☐ friends	☐ children
☐ trouble with police	☐ finances	☐ marriage	☐ men	☐ religion
☐ job				

3.) Check any of the following that were significant symptoms during your childhood:

☐ nightmares	☐ scapegoat	☐ bed wetting	☐ lying
☐ cruelty to animals	☐ head banging	☐ thumbsucking	☐ temper tantrums
☐ bullying	☐ stealing	☐ fire setting	☐ loneliness
☐ insomnia	☐ running away	☐ accident prone	

Family of Origin:

4.) Father's age_____ If deceased, what year did he die? _____

5.) Mother's age_____ If deceased, what year did she die? _____

6.) How many brothers do you have? _____ Ages of brothers _____

7.) How many sisters do you have? _____ Ages of sisters _____

8.) Check any of the following that you know have applied to your family members:

☐ Hospitalization for mental illness	family members:_____
☐ Attempted or committed suicide	family members_____
☐ Drinking Problem	family members_____
☐ Drug Abuse	family members_____

Educational History:

9.) What year did you graduate from high school? _____

10.) How many years of college have you completed? _____ Year(s) graduated: _____

Occupational History/Military History:

11.) What is your occupation? _____

12.) How long have you been employed at your present job? _____

13.) What is your longest stay of employment? _____

14.) Have you ever served in the military? ☐ Yes ☐ No What branch? _____

Dates of service: _____ Highest rank achieved: _____

MOS/Duties: _____ Type of discharge: _____

Marital History:

15.) What is your present marital status?

☐ single	☐ divorced	☐ living together, how long? _____
☐ separated	☐ widowed	☐ married, how long? _____

16.) How long did you know your present spouse/partner before marriage? _____

17.) How many times have you married? _____

18.) What are the dates of your marriage(s) and divorce(s)? _____

19.) How many sons do you have? _____ Ages of sons _____

20.) How many daughters do you have? _____ Ages of daughters _____

21.) Check any of the following which describe your marriage or sexual partnership:

☐ not applicable	☐ romantic	☐ indifferent	☐ mutual respect and love
☐ stormy	☐ exciting	☐ mistake	☐ perfect
☐ happy	☐ friendly	☐ good communication	☐ boring
☐ insecure	☐ lack of communication	☐ lack of common interest	☐ secure
☐ average	☐ good sexual adjustment	☐ poor sexual adjustment	☐ sharing of interest

22.)With whom are you living at the present? _____

23.) How well are you getting along with each of the following persons?
(Choose a number between 1 and 10, with 10 being very well and 1 being very poorly).

Mother _____ Father _____ Sister(s) _____ Brother(s) _____

Spouse/Partner _____ Female Child(ren) _____ Male Child(ren) _____

Previous Psychological/Psychiatric Treatment:

24.) List previous *inpatient* psychiatric/mental health hospitalizations:

Dates: *Reason for hospitalization:* *Where:*

1. _____
2. _____
3. _____

25.) List previous *outpatient* counseling/psychological/psychiatric treatment:

Dates: *Type of Treatment (individual, couples, family):* *Who provided treatment?* *Was it beneficial?*

1. _____
2. _____
3. _____

Medical History:

26.) How would you describe your present physical health? ☐ Excellent ☐ Good ☐ Fair

27.) Please check the medical problems that you have experienced and list dates and/or explanations:

- ☐ diabetes _____
- ☐ sexually transmitted disease _____
- ☐ thyroid disease, goiter _____
- ☐ epilepsy _____
- ☐ serious injuries _____
- ☐ meningitis _____
- ☐ encephalitis _____
- ☐ blackouts _____
- ☐ seizures _____
- ☐ coronary heart disease _____
- ☐ cancer _____

28.) Please list any other serious medical conditions:

1. _____ 3. _____

2. _____ 4. _____

29.) Previous surgical history (List operations and dates):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

30.) List allergies to medications:

1. _____ 3. _____

2. _____ 4. _____

31.) List current medications (Name and dosage):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

32.) Describe any sleep changes: _____

33.) Describe any weight changes: _____

34.) Describe any changes in exercise routine: _____

35.) How much caffeine do you consume (coffee, tea, soda, chocolate)? _____

36.) Do you drink alcohol? ☐ Yes ☐ No How much? _____

37.) Do you smoke cigarettes? ☐ Yes ☐ No How many packs per day? _____

38.) Do you use recreational drugs? ☐ Yes ☐ No

Name of drug(s) and describe use: _____

40.) Have you ever had a problem with any of the following?

☐ pep pills, diet pills
☐ tranquilizers, sedatives
☐ marijuana
☐ narcotics
☐ alcohol
☐ LSD, or other hallucinogen (exclude marijuana)
☐ other, please specify
☐ not applicable

41.) List any physicians you see regularly: *(Include name, address, and telephone number)*

_____

_____

Name: _____ Date: _____

Burns Anxiety Inventory

Instructions: Indicate how much each of the following 33 symptoms has been bothering you in the past several days.

	0 - NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 - ALOT
CATEGORY I: ANXIOUS FEELINGS				
1. Anxiety, nervousness, worry, or fear				
2. Feeling things around you are strange or foggy				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stress, "uptight" or on edge				
CATEGORY II: ANXIOUS THOUGHTS				
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening fantasies or daydreams				
10. Feeling on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of illnesses, heart attacks or dying				
14. Fears of looking foolish in front of others				
15. Fears of being alone, isolated or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible will happen				
CATEGORY III: PHYSICAL SYMPTOMS				
18. Skipping, racing or pounding of the heart				
19. Pain, pressure or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations				
31. Headaches or pains the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak or easily exhausted				

Name: _____ Date: _____

Burns Depression Checklist

Instructions: Indicate how much each of the following 15 symptoms has been bothering you in the past several days.

	0 - NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 - ALOT
1. Sadness: Have you been feeling sad or down in the dumps?				
2. Discouragement: Does the future look bleak or hopeless?				
3. Low self-esteem: Do you feel worthless or think of yourself as a loser?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself?				
6. Indecisiveness: Is it hard to make decisions?				
7. Irritability and frustration: Have you been feeling angry or resentful?				
8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends?				
9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10. Poor self-image: Do you think you're looking old or unattractive?				
11. Appetite changes: Have you lost your appetite? Or, do you overeat compulsively?				
12. Sleep changes: Is it hard to get a good night's sleep? Are you tired and sleeping too much?				
13. Loss of libido: Have you lost your interest in sex?				
14. Hypochondriasis: Do you worry a lot about your health?				
15. Suicidal impulses: Do you think life is not worth living or thing you'd be better off dead?				