

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

Client Name: _____ **DOB:** _____ **Gender:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code** _____
Date completed: _____

Name of person completing this form and relationship to client: _____

Reason for seeking counseling (please circle all that apply) :

Change of Appetite Bingeing/purging food Weight loss/gain Insomnia/hypersomnia
Withdrawn
Mood Swings
Anxiety
Obsessive Thoughts Compulsive Behaviors Anger Management Cruelty to Animals Poor
Memory Processing: Difficulty, Fire setting
Aggression Lying
Stealing
Sexual Acting Out
Sexual Abuse
Nightmares/night terrors
Vivid dreams
Fears
Abuse/neglect
Grief/loss
Stress
Flash Backs
Financial difficulties
Addictive Behavior
Impulsivity
Hyperactivity
Lethargic
Poor Concentration
Short Attention Span
Poor Family Relations
School Attendance Problems
Poor Relations with Peers Hallucinations/delusions Difficulty with Authority
Spiritual Issues

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

Feeling inadequate/Low self worth

Mental Health History: (Past out patient services and hospitalizations, include dates)

How did it help? _____

What was your diagnosis (es)? _____

Have you ever experienced suicidal/homicidal ideations? Yes/No Intentions? Yes/No

If yes, please explain: _____

Are you willing to sign a release of information for previous mental health providers? Yes/No

Primary Care Giver is (Circle One): Biological Parent Adoptive Parent Foster Parent Other

Primary Care Giver is (Circle One): Married Single Divorced Widowed Other

Name siblings and ages:

Legal Issues: (List any past & present legal issues: i.e., arrests, convictions, etc. include dates)

Abuse History (has client been victim of any type of abuse?):

Physical abuse Yes No Emotional Abuse Yes No Sexual Abuse Yes No Domestic Violence Yes

No Abandonment Yes No Neglect Yes No

Age(s) at time of abuse: _____

Who was perpetrator? _____

Reported to Authorities? _____ Finding/disposition: _____

Did client witness any types of abuse listed above: Yes No

If yes, which type of abuse? _____

Who was the victim? _____ Who was the perpetrator? _____

Has client been the perpetrator of any abuse? Yes No Who was the victim? _____ If

yes, which type of abuse? _____

Treatment received: _____

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

Substance Use History (If you need more space use back of page):

Substance: Alcohol Tranquilizers Sleeping Pills Hallucinogens Gambling (Circle please)

Substance: Pain Pills Stimulants Narcotics Heroin/Meth Pornography. (Circle please)

Substance: Marijuana Inhalants Food. Sex Tobacco. (Circle please)

Drug of preference: _____

Treatment program: _____ When? _____ How long? _____ How long clean/sober?

How long used? _____

Last used? _____

Medical History (If you need more space use back of page):

List any major accidents, illnesses, operations with date of occurrence:

List date and type of any head injuries or seizures:

List current medications and reason prescribed:

Education:

What school is client enrolled in? _____ Highest grade completed:

_____ Any difficulty learning to Read: _____ Write: _____ Math: _____

Did you ever repeat a grade? Yes/No For what reason: _____

Favorite subject: _____ Most accomplished subject: _____

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

Describe any difficulties client is having related to their education:

Family History (Please list those family members with a history of mental illness, learning disabilities, mental retardation or addictions) (If you need more space use back of page)

Parents: _____

Siblings: _____

Maternal Grandparents: _____

Paternal Grandparents: _____

Maternal Aunts and Uncles: _____

Paternal Aunts and Uncles: _____

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

Developmental History:

Prenatal health issues:

Birth Trauma (C-section, birth injuries, complications):

Developmental Milestones: Describe any problems with the following:

Attachment/bonding:

Motor skills:

Toileting: _____

Speech/language:

_____ Social Skills:

Temperament:

Stressors: Please circle all following which the client has experienced in the last year:

Death of a loved one New School New Home Loss of Pet Serious Illness Care Givers
Absence Dept of Children and Families Involvement Divorce New Sibling Trauma
Natural Disaster Other:

Primary Caregiver's signature: _____ Date _____

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

Therapist-Client Agreement & Informed Consent Form

You may revoke this agreement in writing and discontinue therapy at any time. That revocation will be immediately binding on me, unless I have already taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

Confidentiality Statement

All information shared in this treatment is confidential except in circumstances governed by law. If you would like me to confer with another healthcare professional, you will need to sign a "Release of Information" form. This permission can be revoked by you at any time. Both parties agree to take all reasonable measures to ensure confidentiality with any communication over the phone, electronic mail, and/or the Internet.

Limits of Confidentiality

The law protects the privacy of all communications between a client and therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and/or treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without 1) your (or your legal representative's) written authorization; 2) a court order; or 3) you informing me that you are seeking a protective order against my compliance with a subpoena that has been properly served on me and of which you have been notified in a timely manner. If you are involved in or contemplating litigation, you should consult with your attorney about likely required court disclosures.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and the services I am providing are relevant to the injury for which the claim was made, I must, upon appropriate request, provide a copy of the patient's record to the patient's employer, the insurance carrier.
- There are some situations in which I am legally obligated to take actions and reveal some information about your treatment. These exceptions to confidentiality include the following:

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

- If I believe a minor, elderly person, or disabled person is being abused, neglected, or living in a home where there is domestic violence, I am legally required to file a report with the appropriate state agency.
- If I believe that a client is threatening serious bodily harm to another or to themselves I am legally required to take protective actions, which may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- If you are involved in a court case and/or your records are subpoenaed by the court. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

Minors and Parents

Clients under 18 years of age (who are not emancipated) and their parents should be aware that the law may allow parents to examine their child's Clinical Record. Privacy in psychotherapy is often crucial to successful progress, particularly with teenagers; therefore, it is usually my policy to request that parents allow for confidentiality between the minor and their therapist. However, parental involvement is also very important; therefore, during treatment it is helpful and important to periodically talk or meet with parents (either with or without the client) and provide parents with general information about the progress of the minor's treatment and attendance at scheduled sessions. Any other communication will require the minor's

authorization, unless I feel that they are in danger or is a danger to someone else, in which case, I will notify the parents and/or appropriate others of my concern (please refer to the Limits of Confidentiality section). Before giving parents any information, I will discuss the matter with the minor, if possible, and do my best to handle any objections they may have. I am happy to discuss my procedures for treatment with minors further with parents.

Statement of Understanding

Your signature below indicates that you have read this agreement and agree to abide by its terms during our professional relationship. Your signature also serves as your informed consent for treatment.

_____/_____/_____
Child/Adolescent Signature Date

_____/_____/_____
Parent Signature Date

Therapist _____/_____/_____
Kevin Tutty, LPC Date

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

HIPAA Notice of Privacy Practices

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 consent. To help clarify these terms, here are some definitions:

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "Authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy (As of now, not relevant to my practice).

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's Welfare, the law requires that I report such knowledge or suspicion to the Oklahoma Department of Child and Family Services.

Adult and Domestic Abuse: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order.

•

The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

Printed Name: _____

Signature: _____

Date Received: _____

Kevin Tutty, LPC
1401 NW 150th Street, Ste A
Edmond, OK 73013

Insurance Consent

I authorize Kevin Tutty, LPC to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me, and includes authorization to release information about mental health, substance use, or HIV diagnoses as required. In consideration of the services provided to me, I assign all benefits to Kevin Tutty, LPC if accepted, and authorize my insurance companies, Medicare, or other third-party payers to make payments directly to Kevin Tutty, LPC and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.

Parent signature

Date ____/____/____