Erik Mutén, MFA, PsyD
Kailo Consulting & Coaching
90 Conz Street Suite 101
Northampton, MA 01060
(413) 384-3615

Patient Information (Please Print)

Patient's Name: ____**DOB:** ______________ **Gender:** □ **M** □ **F** □ **O**

Street Address: ____

City: ________________________________**State:**____________________________ **Zip Code:** ___________________

Mailing Address (if different)____

City: ________________________________**State:**____________________________ **Zip Code:** ___________________

Home Phone: _____________________**Work Phone:** ________________________**Cell Phone:** __________________

Employer: _______________________**Full or Part-time**_________ **email:**___________________________________

<u>Primary Insurance Information</u>

Policy Holder (if not the same as above): ____

DOB: ________________ **Gender:** □ **M** □ **F** **Relationship to Patient (self, spouse, parent)**______________________

Insurance Company:_________________________________ **Insurance Phone;**___________________________________

ID Number: _______________________________________ **Group Number:**__________________________________

Annual Deductable _________________ **Co-payment:** _______________ **Medical Savings Account:** □ **Yes** □ **No**

<u>Secondary Insurance Information</u>

Insurance Company: ________________________________ **Insurance Phone:** ___________________________________

ID Number: ____**Group Number:** ____________________________________

<u>Authorization for Release of Information and Assignment of Benefits for Insurance</u>

I authorize the use or disclosure of my health insurance information necessary to submit and process insurance claims. I understand that the service authorized to receive the information is not a health plan or healthcare provider. I authorize payment of medical benefits to my provider for services rendered.

Signed ____ **Date** ________________

Revised 06/19/16

This questionnaire is designed to help Erik Mutén, PsyD develop a comprehensive understanding of the strengths, problems, and symptoms that bring you to our office. Please answer the questions to the best of your ability. All information recorded on this form is confidential and is not released without your permission.

Physical Information:

Who is your Primary Care Physician? ____

When was your last complete physical exam? ____________ By whom? ____________________

Were there any unusual findings? □ Yes □ No If yes, please explain:

Do you have any diseases, symptoms, or problems? □ Yes □ No If yes, please list and explain:

Are you currently taking any medications: □ Yes □ No If Yes, please list medication and dosage:

Do you smoke? □ Yes □ No If yes, # per day and brand:

Would you like to stop smoking? □ Yes □ No

Do you exercise? □ Yes □ No If yes, # of times per week and type:

Cholesterol Level __________LDL ______ HDL _______ Height ________ Weight __________

Do you pay attention to the foods you eat? □ Yes □ No If yes, in what ways:

What is your blood pressure when you go to the doctor's office? ____________________________

Are you allergic to anything? ____

Do you use alcoholic beverages? □ Yes □ No If yes, how much?

Are you, your family, your friends or your doctor concerned that you may have an addiction? □ Yes □ No (Examples include: prescription or non-prescription drugs, street drugs, gambling, sex, relationships, computers, work, food, Internet, and video games). If Yes, please describe:

How many hours of television/Internet surfing/video game playing do you do per week? What is your screentime?

Have you ever had any physical problems which caused you to be hospitalized or under the treatment of a physician for an extended period of time? □ Y □ N If yes, please explain:

Have you ever had an indication of or been treated for: (check where appropriate and underline specific symptoms)

□ **Visual disturbances, dizziness, severe headaches, weakness or paralysis of the arms or legs, strokes?**

□ **Disorder of the eyes, ears, or throat?**

□ **Persistent cough, coughing blood, shortness of breath, asthma, hayfever, pneumonia, bronchitis, or emphysema?**

□ **Chest pain during or after exertion, rheumatic fever, heart murmur, high blood pressure, diabetes, palpitations?**

□ **Have you ever been hospitalized for any nervous or mental disorder?**

□ **Frequent or persistent nausea or vomiting, vomiting blood, or passing blood in stool, abdominal pain, frequent diarrhea, constipation, history of ulcers, hepatitis, jaundice, intestinal bleeding, colitis, appendicitis, hemorrhoids, recent weight loss?**

□ **Increased urinary frequency, pain or burning on urination, passing of blood?**

□ **Any rashes, chronic skin disorders, arthritis, or gout?**

□ **Blackouts, convulsions, or seizures?**

Please use the space below to explain any symptoms underlined above as specifically as possible:

Emotional

Do you find yourself worrying a great deal? □ Yes □ No If yes, about what?

Do you have trouble sleeping? □ Yes □ No If yes, how long has this been happening?

Are you critical or judgmental of yourself? □ Yes □ No If yes, what are you critical/judgmental of?

Are you "in control" of your feelings? □ Yes □ No If yes or no, please explain:

What do you do to have fun and relax?

Have you been seen by a counselor, therapist, or psychiatrist for "emotional problems" in the past? □ Yes □ No
If yes, □ within the last 6 months, □ within the past 5 years, □ more than 5 years ago.

Please list the professionals you have seen and the reason for seeing them:

Have you ever been prescribed medications for "nerves" or "emotional problems" □ Yes □ No
If yes, please list the medication name, dosage, and the name of the prescribing physician:

Did you have any negative side effects to this medication? □ Yes □ No If yes, please explain:

Have you ever thought of or tried to commit suicide? □ Yes □ No If yes, please explain:

Have you ever been physically, emotionally, sexually, or spiritually abused? □ Yes □ No If yes, please explain:

Are you being abused now? □ Yes □ No

Have you ever been incarcerated or have you had any legal problems? □ Yes □ No If yes, please explain:

Cognitive/Vocational

What do you like to learn about?

What "skills" have you mastered or begun to master?

Education

What is your highest level of education?

How would you describe your school experience?

Why did you end school? ◻ **Graduated** ◻ **Needed to earn a living** ◻ **Expelled** ◻ **Uninterested/Unable to do the work**
◻ **Marriage/Pregnancy** ◻ **Other**

Comments:

Military

Did you serve in the Armed Forces? ◻ **Yes** ◻ **No**

Branch of Service: __________________________ **Combat:** ____

Type of discharge: __________________________**Date of discharge:** _______________________________________

Comments:

Employment

What is your current occupation and job title? ____

How long have you worked at this job? ____

Please list your employers and job positions over the last 5 years:

If you could do any type of work that you wanted, what would it be?

Social

Were you raised by both of your natural parents? ◻ **Yes** ◻ **No** **If no, who raised you?**

Comments:

If yes, are your parents still living together? ◻ **Yes** ◻ **No**
If no, what happened?

If your parents are still alive:

What is your mother's state of health and what is your relationship with her like?

What is your father's state of health and what is your relationship with him like?

Where were you raised?

What is your family's ethnic/cultural background?

Please list the names and ages of your brothers and sisters:

Are they living and healthy? If no, please explain:

Were your parents, grandparents, or any of your brothers/sisters treated or hospitalized for "emotional problems", "mental illness", or physical problems for which there was no explanation, alcoholism, or drug abuse? □ Yes □ No

If yes, please explain:

Do you have current concerns about any of your family members (parents, brothers, sisters, children, spouse)?
□ Yes □ No If yes, please explain:

<u>Current Relationships</u>:

Present Status: □ Married □ Widowed □ Divorced □ Separated □ Committed Relationship □ No relationship □ Other

Comments:

How many times have you been married? ________ Please list dates of marriage and divorce:

How many children do you have? _______ Please list their names and ages:

Are any of your children adopted? □ **Yes** □ **No**

How many of your children are currently living with you? ____

Has anything out of the ordinary happened to any of your children? □ **Yes** □ **No** **If yes, please explain:**

How would you describe your social behavior? □ **Outgoing, I enjoy being with and sought out by others**
□ **Prefer to be alone** □ **Both like being with others and being alone**

Do you have: □ **Friends** □ **A few friends** □ **One or Two Friends** □ **No Friends**

Do you wish you had more friends? □ **Yes** □ **No**

How do you prefer to spend your free time?

Are you currently involved in community activity or work? □ **Yes** □ **No** **If yes or no, please explain:**

Are you involved with any "teams" or groups that you enjoy or help to give you a sense of purpose? □ **Yes** □ **No**

If yes, please explain:

<u>Ideological/Religious/Spiritual</u>:

What are your most important values?

Do you feel that your life allows you to practice these values? □ **Yes** □ **No** **If yes or no, please explain:**

Do you have a regular religious or spiritual practice? □ **Yes** □ **No**

Comments:

What outcome would like in coming to see Erik Mutén and what is your primary reason for seeking *treatment* at this time?

Thank you for taking the time to complete this questionnaire.

Signature of person served ____________________ **Date** ____________

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Cancellation/Missed Appointment Policy

Unlike appointments with other doctors, your therapy requires keeping regularly scheduled appointments. If you do not come to your appointments, it is usually not possible for me to "squeeze in" or schedule another patient. I reserve that time for you. Appointments that are cancelled within less than one business day (Mon-Fri) are considered a *late cancellation*.

If you cannot come to a scheduled appointment, if you have a late cancellation, or fail to show for your appointment I may charge my usual fee. This fee is $150. Cancellation fees are not covered by any insurance.

I will not schedule further appointments with you if you miss two or more appointments without canceling with at least one business day notice.

***Please note* that appointments may be cancelled after hours by calling (413) 384-3615.**

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I, ____have read and understand this cancellation/ missed appointment policy.

____________________________________	________________________
Signature of Person Treated	**Date**
____________________________________	________________________
Signature of Parent of a Minor	**Date**

Revised 06/19/16

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Notice of Privacy Practices for Protected Health Information
Effective January 1st, 2013

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. "Protected Health Information" (PHI), discussed in this notice, is information about you that may identify you and that relates to your past, present, and future health care services. At Kailo Consulting & Coaching, we are committed to the highest possible standards of care and access to your information is given only to other health care professionals who need it to fulfill their jobs. We invite you to review this information carefully and contact us with any questions. This notice is effective January 1st 2013.

1. **Uses and Disclosures of Protected Health Information**
   There are two categories for the use and disclosure of our patients' PHI: (1) information that we can use and disclose without the patient's prior consent; and (2) information that we cannot use or disclose without the patient's prior authorization.

   A. **Patient's Prior Consent Not Required**
      1. **Treatment: We may use and disclose your health information to provide, coordinate, and manage your health care and any related services. For example, your medical information may be shared among health care professionals providing you treatment. This is especially the case with health care professionals at Atkinson Family Practice where some of your healthcare information will be shared on their electronic medical record.**

      2. **Payment: We may use and disclose your health information to obtain payment for services we provide you.**

      3. **Health Care operations: We may use and disclose your health information for our routine operations. This may include quality assessment activities, employee review activities and licensing.**

      4. **Other Permitted Uses and Disclosures: There are a number of other specified purposes for which we may disclose a patient's PHI without the patient's prior consent (but with certain restrictions) Examples include public health activities; situations where there may be abuse, neglect or domestic violence; in connection with health oversight activities; in the course of judicial or administrative proceedings; in response to law enforcement inquiries; in the event of death; where organ donations are involved; in support of research studies; where there is a serious threat to health and safety; in cases of military or veterans activities where national security is involved; for determinations of medical suitability; for government programs for public benefit; for worker' compensation proceedings; when our records are being audited; when medical emergencies occur.**

   B. **Patient's Prior Authorization Required**
      For purposes other than those mentioned above, we are required to ask for our patients' written authorizations before using or disclosing any of their PHI. If we request an authorization, any of our patients may decline to agree; and if a patient gives us an authorization, the patient has the right to revoke the authorization and by doing so, stop future uses and disclosures of the patient's PHI that the authorization covered. An example of a situation where the patient's prior authorization would be required is: if we wish to conduct a marketing program that would involve the use of PHI.

2. **Your Rights**

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

A. You have the right to inspect and copy your protected health information . This means you, in the presence of Erik Muten, PsyD (or a proxy), may inspect and obtain a copy of Protected Health Information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice used for making decisions about you. We may deny your request only in very limited circumstances. If you are denied access to your medical or billing records, you may request that the denial be reviewed.

B. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Please discuss any restriction you wish with your physician. Your physician is not required to agree to a restriction that you may request.

C. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. Please contact our Safety Officer to determine if you have questions about amending your medical record.

D. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in the Notice of Privacy Practices. It excludes disclosures we have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after September 1st, 2012. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

E. You have the right to obtain a paper copy of this notice from us, even if you have agreed to accept this notice electronically.

3. **Complaints**

If a patient believes that we have violated the patient's rights as to the patient's PHI under HIPAA and the regulations, or if a patient disagrees with a decision we made about access to the patient's PHI, the patient has the right to complain HCHC for filing a complaint.

4. **Our Responsibilities**

We are required by law to protect the privacy of our patients' PHI, to provide this notice about our privacy practices, and follow the privacy practices that are described in this notice. We reserve the right to make changes to our privacy practices that will apply to all the PHI we maintain. A new notice will be available on request before any significant change is made.

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Notice of Privacy Practice Acknowledgement Form

Patient's Name: ____DOB: ______________________

By signing this, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature of Person Served: ____

If the signature above is not the Person Served, please specify your relationship to the patient:

____

Date: _______________________

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Informed Consent Regarding Limitations on Confidential Communications

I understand that information about my treatment and communication with Erik Mutén, PsyD may not be released without written authorization. However, these communications or this information may have to be revealed without my permission, as explained below:

1. **If necessary to protect my safety or the safety of others.**
   A. **If I am clearly dangerous to myself, my psychologist may take steps to seek involuntary Hospitalization and may also contact members of my family.**
   B. **If I threaten to kill or seriously hurt someone and Erik Mutén, PsyD believes I may carry out my threat, or if he believes I will attempt to kill or seriously hurt someone, he may:**
      - **Tell any reasonably identified victim**
      - **Notify the police**
      - **Arrange for me to be hospitalized**

2. **If necessary for me to be hospitalized for psychiatric care.**

3. **If a judge thinks Erik Mutén, PsyD has evidence about my ability to provide care or custody in a child custody or adoption case.**

4. **In court proceedings involving the care and protection of children or to dispense the need for parental consent to adoption.**

5. **If Erik Mutén, PsyD believes a child, a disabled person, or an elderly person in my care is suffering abuse and/or neglect.**

6. **To provide information regarding my diagnosis, prognosis, and course of treatment, or for purposes of utilization review or quality assurance to a third party payer.**

7. **In a legal proceeding where I introduce my mental or emotional condition.**

8. **If I bring action against Erik Mutén, PsyD and disclosure is necessary or relevant to a defense.**

9. **If necessary to use a collection agency or other process to collect amounts I owe for services.**

10. **If a court orders access to my records in a sexual assault or other criminal case.**

I additionally authorize Erik Mutén, PsyD to consult professional colleagues, if needed to enhance the clinical services I receive. He may do this through email, telephone, and face to face consultation.

I have had the opportunity to discuss this informed consent statement with Erik Mutén, PsyD, I understand its meaning and consent that I am receiving services based on this understanding.

____________________________________ __________________________
Signature of person being served **Date**

Revised 06/19/16

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Agreements for Treatment Engagement at Kailo Consulting & Coaching

Listed below are my expectations of you as we work together. Your signature at the bottom of this page constitutes an agreement that you have read, understand, and will abide by these policies.

- **I agree to show up on time.**
- **I agree to not show up for session (family, individual, group, or intake) under the influence of alcohol or illegal drugs. I understand that the therapist reserves the right to terminate patients from a session if, in his/her opinion said person is under the influence.**
- **I agree that if I must cancel I will call at least 24 hours (1 full business day) ahead of time. Note: If I am canceling a Monday morning appointment then I need to call by Friday morning as weekend hours are not considered business days.**
- **I agree that if I do not show up for an appointment or call within the 24 hour time period two times I may be asked to discontinue treatment.**
- **I agree to accompany each child under the age of 18 to their session.**
- **I agree to talk with Erik Mutén, PsyD or my primary care provider about any parts of the treatment that I am uncomfortable with in our work together.**

____
Signature of Person Served **Date**

____
Erik Mutén, PsyD **Date**

Revised 06/19/16