Finch Finch
Consulting Group, LLC

Individual, Marriage & Family Therapy
Kenneth A. Finch, Ph.D., LMHC License # MH0004869
Dallas A. Finch, LCSW License # SW13235

CLIENT INFORMATION

Who referred you to this office?_____ Today's Date: _____

Name: _____ DOB: _____ Age:_____

Address: _____

City: _____State: _____ Zip: _____

Email Address: _____

Employer: _____Occupation: _____

Number of Years: _____ Enjoy Job? Yes ☐ No ☐

PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT FROM ABOVE

Name:_____ Relationship:_____

Address:_____ City:_____State:_____Zip:_____

Cell Phone:_____ Work Phone: _____

GENERAL CONTACT AND EMERGENCY CONTACT INFORMATION

Provider can call me at the following phone number: _____

☐ Provider can leave their name and phone number only when they call.
☐ Provider can leave a detailed message when they call.

Provider can mail me information such as billing.
☐ Provider can mail information to my home address.
☐ Provider cannot mail information to my home address.

Provider can email me with information.
☐ Provider can email me.
☐ Provider cannot email me.

If you would like to receive an appointment reminder via text, please check the box below:

☐ Text: Phone number: _____

The appointment reminder will include only the date and time of your appointment and your service provider's name. We will not encrypt messages. Health care information sent by regular email or text could be lost, delayed, intercepted, delivered to the wrong address or number, or arrive incomplete or corrupted. If you understand these risks and would like to receive any appointment reminder by email or text, I need you to confirm you accept responsibility for these risks and will not hold us responsible for any event that occurs after we send the message.

Patient Name (Print): _____ Signature: _____

In case of emergency, I authorize Provider to contact: _____

at (__)_____ Relationship to patient: _____

Patient Name (Print):_____Signature:_____

Acknowledgement of HIPAA Notice of Privacy Practice

I, _____ , acknowledge receipt of the HIPAA Notice of Privacy Practice.

_____ _____

Signature of client or legal guardian/representative Date

Acknowledgement of Payment Policy & Release of Information

I, _____, acknowledge receipt of payment policy regarding fees and payment for services. I understand that I am financially responsible for all charges. I hereby authorize Kenneth A. Finch, Ph.D., orDallas A. Finch, LCSW to release all information necessary to secure their payment or my reimbursement and my information may be made available for retrieval by my insurance company or person responsible for payment.

_____ _____

Signature of client or legal guardian/representative Date

Acknowledgement of Exceptions Therapist-Client Relationship

I, _____, acknowledge that there are circumstances that create exceptions to the therapist-client confidentiality, as follows:

1. Any reasonable suspicion of child abuse, physical or sexual is required by the State of Florida to be reported to the Department of Health and Rehabilitative Services.
2. If you disclose to me that you intend to harm someone, I am required to warn the intended victim of the possible danger.
3. If you disclose to me that you intend to harm yourself in a suicidal situation, confidentiality will be broken.
4. In some cases, consultation during peer supervision will be sought on behalf of client's treatment.
5. If outside referral is deemed necessary, you will be asked to sign a release form for me to provide information about your case. NO information is released without your permission.
6. Records may be subpoenaed in some court cases.
7. If you utilize third-party payment to reimburse yourself: information you have authorized for release may be available for retrieval by your insurance company.

_____ _____

Signature of client or legal guardian/representative Date

AUTHORIZATION FOR RELEASE / REQUEST OF INFORMATION

CLIENT NAME: _____**DOB:** _____

AUTHORIZATION FOR (check as appropriate):

____Request for information ____ Release of information

I authorize Finch & Finch Consulting Group, LLC to request/release information and/or records of the individual name above.
This information may be released to / requested from the following:

FACILITY/PERSON: _____

ADDRESS: _____

THE INFORMATION & RECORDS ARE FOR THE PURPOSE OF: _____

INFORMATION TO BE RELEASED INCLUDES: (check one)

_____ Specific information (such as billing, treatment summary, referral): _____

_____ All information

I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed again and no longer protected by those regulations.

I understand that I have the right to inspect or copy any information I have authorized to be used. I understand that if I agree to sign this authorization, I have a right to receive a copy of the signed form.

I understand that I have a right to cancel this authorization at any time by presenting my written notice of cancellation. I understand that the cancellation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of the information is voluntary. I understand that I may refuse to sign this authorization and that this refusal will not affect my ability to obtain treatment, payment, or healthcare options. I understand that the above information may be disclosed by the recipient of the information. Most healthcare providers must follow federal rule protecting the privacy of health information. However, Finch & Finch Consulting Group, LLC, cannot guarantee that others receiving the information will protect it.

_____ _____

Signature of client or legal guardian/representative Date

Consent for Treatment of Minor Child

I/We, _____, and
(parent or guardian)

_____,
(parent or guardian),

agree for minor child, _____, DOB: _____
(first and last name)

to receive a mental health assessment and mental health care, treatment, or services and that I/We authorize Finch & Finch Consulting Group, LLC to provide such assessment and care, treatment of services as we consider necessary and advisable. That you understand and agree that you will participate in the planning of care, treatment, or services and at any time you may stop such care, treatment or services that you receive.

Confidentiality Notice

Parents or legal guardians provide consent for a child's mental health treatment and may have access to records. To support effective therapy, children are given a private space to speak openly during sessions. Information shared in therapy is kept confidential **unless** there is a concern about safety. This includes risk of harm to the child or others, suspected abuse or neglect, or a legal requirement such as a court order. Finch & Finch Consulting Group, LLC follows all laws and rules surrounding confidentiality, while also including parents in the treatment process in a collaborative way.

Signature: Date:

_____

(Parent or Guardian)

Signature: Date:

_____

(Parent or Guardian)

Credit Card Authorization Form

A completed credit card authorization form is necessary when someone other than the client is responsible for payment.

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information:

Card Type:

Mastercard: _____ Visa: _____ Discover: _____ Other: _____

(We do not accept American Express)

Cardholder Name (as shown on card): _____

Patient Name (to apply charge): _____

Card Number (last 4 digits only): _____

Expiration Date(mm/yy): _____

Cardholder ZIP Code (billing address): _____

I, _____, hereby authorize Finch & Finch Consulting Group, LLC to charge the credit card indicated above for services rendered. I understand and consent to my payment information being securely stored for future authorized charges to this account.

_____
Signature

_____
Date

Consent to Treatment: Treatment may include assessment, diagnosis, and therapeutic interventions consistent with professional standards. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment or services at any time.

Signature: _____Date: _____

Court Policy & Fee's

Please be advised that the therapists of Finch & Finch Consulting Group, LLC do not participate in person, by phone or in writing in any court-related matter that the client of Finch & Finch Consulting Group, LLC may be a party to or become a party to in any way. The therapists of Finch & Finch Consulting Group, LLC do not write letters regarding their client's treatment to any entity, including court. The therapists of Finch & Finch Consulting Group, LLC at no time will offer an opinion or recommendation in any court matter, especially as it relates to custody.

If a court order is served and is requesting that a therapist of Finch & Finch Consulting Group, LLC be present in person and or there is a request for records, the client's consent will be requested before turning over confidential information. When obtaining this consent, the client will be told exactly what has been requested by the court and there is no guarantee that the information will be kept confidential. This includes a client's mental health history; current status and inclusive records and may not be in the best interests of the client. The therapist client relationship does not render the therapist as an advocate. The therapist will withhold any opportunity to engage in a dual relationship with the client.

Please be advised that should a therapist from Finch & Finch Consulting Group, LLC be ordered by court to write a letter to the court, the time shall be billed at $200 per hour.

Please be advised that should a therapist from Finch & Finch Consulting Group, LLC be court ordered to appear in court, the fee stipulation is as follows:

- $2,000 per day plus $200 per hour for travel to and from the court.
- $200 per hour for preparation

All therapists of Finch & Finch Consulting Group, LLC will **NOT** be ON-CALL at any time. Should a case be trialed, the therapist will be paid in full for each day as well as an additional $1,000 per day as it hinders the therapist's or intern's ability to be available to their other clients.

All court fees must be received prior to the court date. Should the court calendar the hearing for another date, the therapist or intern must be re-issued a court order with the new court hearing date.

Should the therapists or interns be on vacation, the party initiating the court order must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena.

Signature: _____Date: _____

REASON FOR SEEKING PROFESSIONAL HELP:
MY PROBLEM BEGAN (Date): _____ **WHAT HAPPENED?** _____

_____

_____

I HOPE TO CHANGE: _____

_____

PROBLEM LIST: (check if applies to you)

Environment:	Relationship:	Mood:	Self-perception:
___social	___father	___anxious/panic	___poor self-esteem
___emotional	___mother	___depression	___lack personal hygiene
___behavior	___siblings	___poor concentration	___being held back
___relationships	___spouse	___lack energy	___hypersexual
___school	___girl/boyfriend	___withdrawal	___decreased libido
___work	___boss	___sleep problems	___suicidal thoughts
___church	___coworker	___lack interest to do	___homicidal thoughts

Emotions:	Behaviors:	Other:
___excess anger	___aggressive/violent	___fear of dying
___fear of harm	___inappropriate sexual	___fear of going crazy
___fear of being watched	___antisocial	___feeling that you are not real
___grief	___substance abuse	___feeling things around you are not real
___hopeless	___self-mutilation	___loss of time
___helpless	___self-induced vomiting	___flashbacks
___low frustration	___poor impulse control	___difficulty trusting self/others
___up and down	___over/under eating	___compulsive/obsessive

AS A CHILD:

___temper outbursts	___problems with authority/school	___strange behavior
___unhappy	___problems with authority/home	___strange thoughts
___daydreaming	___problems with the law	___school performance change
___clumsy	___lying	___fearful
___overactive	___truancy	___shy
___slow	___drug/alcohol use	___soiling pants/bed wetting
___short attention span	___sexual trouble/problems	___conflict with siblings
___undependable	___disobedient	
___peer conflict	___mean to others	
___stubborn	___lacks initiative	

Do you desire to explain any of the above or note further symptoms that you are currently experiencing?

_____

_____

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MEDICAL HISTORY: (if you need more writing space for history, notebook paper is fine)

Past mental health Outpatient treatment (date)_____ Provider_____
Duration_____ diagnosis/problem _____
Past Inpatient/Hospitalization treatment for mental health (date)_____ Provider_____
Duration_____ diagnosis/problem_____
Past suicide attempt(s) and date_____
Current Medication(s) dosage_____

Serious Illness/Surgery & date_____

_____

Used the following for # of years: ____cigarettes ____alcohol ____marijuana ____cocaine/crack
(Female only) Year & #:_____pregnancy _____miscarriage(s) _____abortion(s)

FAMILY OF ORIGIN HISTORY:

Diabetes: M/F/Bro/Sis	Depression: M/F/Bro/Sis	Downs Syndrome: M/F/Bro/Sis
Epilepsy: M/F/Bro/Sis	Migraines: M/F/Bro/Sis	Alcoholism/Drugs: M/F Bro/Sis
Allergies: M/F/Bro/Sis	Thyroid: M/F/Bro/Sis	Sleep Disorder: M/F/Bro/Sis
Seizures: M/F/Bro/Sis	Hearing: M/F/Bro/Sis	Mental Retardation: M/F/Bro/Sis
Anxiety: M/F/Bro/Sis	Vision: M/F/Bro/Sis	Panic Attacks: M/F/Bro/Sis
Eating Disorder: M/F/Bro/Sis	Cerebral Palsy: M/F/Bro/Sis	Hydrocephalus: M/F/Bro/Sis

Parents married at age M___ F___# of BRO___# of SIS___ My order in family 1,2,3,4,5,6,7,8,9
Current age of siblings _____
Describe M as you remember her growing up _____
Describe F as you remember him growing up _____
Describe relationship with BRO/SIS growing up _____

MILITARY HISTORY: M F Years? _____Branch? _____Retired? _____
CLIENT MILITARY HISTORY: Years? _____Branch? _____Retired? _____

PAST/CURRENT CLIENT LEGAL HISTORY (dates) court charges _____
pending_____ probation_____ jail_____ car accident(s) _____
divorce_____ bankruptcy _____

CHILDHOOD DEVELOPMENT: Did you experience any of the following and at what age?

nail biting_____	thumb sucking_____	bedwetting_____	soiling_____
truancy_____	stealing_____	fire setting_____	animal cruelty_____
alcohol use_____	drug use_____	running away_____	fighting_____
juvenile court_____	foster home_____		

By whom & what age(s)? Emotional neglect_____ Physical abuse? _____
Sexual abuse_____ Rape_____
Acts of Nature or witness to trauma or violence? _____
Mother's pregnancy, any complications? _____
Was anger expressed in the family explosive? Y N by M F other OR anger was repressed? Y N by M F other
Explain_____

Was discipline expressed in family harsh? Y N by M F other OR discipline was fair? Y N by M F other
Explain_____

Received emotional support from M? Y N F? Y N Other? _____
Explain_____

Love was expressed by and whom? Hugging M F Kissing M F Kidding M F Verbally M F
Gifts M F Explain_____
Was there a shortage of the following? Money Food Clothes Shelter
Explain_____

SCHOOL HISTORY: Home town_____ repeated grade_____
learning disabilities_____ behavior problems_____
I enjoyed Jr. High: Y N I enjoyed High School: Y N I enjoyed college: Y N
School activities _____
Major/Special Training _____

FINANCIAL/WORK HISTORY: list any age & order of first job _____
_____
_____
Current financial status: poor_____ adequate _____ good_____
Explain: _____

RELIGION/FAITH HISTORY: Attended church as a child? Y N What denomination? _____
With whom and how often? _____
When did you stop attending or change? _____

LEISURE/SOCIAL: How did you spend time taking care of you during childhood and now?

_____

RELATIONSHIP HISTORY: Age of first date ___ Did you date much prior to marriage Y N
Age of first marriage ____ # of years dated prior to marriage ____ # of years married ____
Reasons for divorce_____
Age of second marriage ____ # of years dated prior to marriage ____ # of years married ____
Reasons for divorce_____
Age of third marriage ____ # of years dated prior to marriage ____ # of years married ____
Reasons for divorce_____
Age of fourth marriage ____ # of years dated prior to marriage ____ # of years married ____
Reasons for divorce_____
Current relationship is ____ good ____satisfactory ____ poor Explain_____
Sexual satisfaction is _____ good _____satisfactory _____ poor
Explain _____
Past or current extra-marital affairs (when and how long)? _____
Explain_____
Domestic violence problems? Y N
Explain_____
CURRENT HOUSEHOLD INCLUDES: (name, age and relationship to you)_____
_____
_____

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Zung Self-Rating Depression Scale (SDS)

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days

Place check mark (✓) in correct column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue.				
2. Morning is when I feel the best.				
3. I have crying spells or feel like it.				
4. I have trouble sleeping at night.				
5. I eat as much as I used to.				
6. I still enjoy sex.				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beats faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to.				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable than usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful and needed.				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

Zung WW. (1965). A self-rating depression scale. *Archives of General Psychiatry* 12: 63-70.

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Zung Self-Rating Anxiety Scale (SAS)

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days. Bring the completed form with you to the office for scoring and assessment during your office visit.

Place check mark (✓) in correct column.	A little of the time	Some of the time	Good part of the time	Most of the time
1 I feel more nervous and anxious than usual.				
2 I feel afraid for no reason at all.				
3 I get upset easily or feel panicky.				
4 I feel like I'm falling apart and going to pieces.				
5 I feel that everything is all right and nothing bad will happen.				
6 My arms and legs shake and tremble.				
7 I am bothered by headaches neck and back pain.				
8 I feel weak and get tired easily.				
9 I feel calm and can sit still easily.				
10 I can feel my heart beating fast.				
11 I am bothered by dizzy spells.				
12 I have fainting spells or feel like it.				
13 I can breathe in and out easily.				
14 I get feelings of numbness and tingling in my fingers & toes.				
15 I am bothered by stomach aches or indigestion.				
16 I have to empty my bladder often.				
17 My hands are usually dry and warm.				
18 My face gets hot and blushes.				
19 I fall asleep easily and get a good night's rest.				
20 I have nightmares.				

Source: William W.K. Zung. A rating instrument for anxiety disorders. Psychosomatics. 1971

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Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check {✓} the answer that best applies to you. Please answer each question as best you can.	Yes	No
1. Has there ever been a period of time when you were not your usual self and…		
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
…you were so irritable that you shouted at people or started fights or arguments?	○	○
…you felt much more self-confident than usual?	○	○
…you got much less sleep than usual and found you didn't really miss it?	○	○
…you were much more talkative or spoke faster than usual?	○	○
…thoughts raced through your head, or you couldn't slow your mind down?	○	○
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
…you had much more energy than usual?	○	○
…you were much more active or did many more things than usual?	○	○
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
…you were much more interested in sex than usual?	○	○
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
…spending money got your or your family in trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check one response only*	○	○
3. How much of a problem did any of these cause you – like being able to work; having family, money, or legal troubles, getting into arguments or fights? Please check 1 response only. ○No problem ○Minor problem ○Moderate problem ○Serious problem		
4. Have any of your blood relatives [i.e. children, siblings, parents, grandparents, aunts, uncles] had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○