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 check all that apply) :

- ☐ Change of Appetite
- ☐ Bingeing/purging food
- ☐ Weight loss/gain
- ☐ Insomnia/hypersomia
- ☐ Withdrawn
- ☐ Mood Swings
- ☐ Anxiety
- ☐ Obsessive Thoughts
- ☐ Compulsive Behaviors
- ☐ Anger Management
- ☐ Cruelty to Animals
- ☐ Fire setting
- ☐ Poor Memory Processing
- ☐ Aggression Lying
- ☐ Stealing
- ☐ Sexual Acting Out
- ☐ Sexual Abuse
- ☐ Nightmares/night terrors
- ☐ 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
- [ ] 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)? _____

Has client ever experienced suicidal ideations? ◯ Yes ◯ No

Has client ever experienced suicidal intentions? ◯ Yes ◯ No

If yes, please explain: _____

_____

Primary Care Giver is:

◯ Biological Parent ◯ Adoptive Parent ◯ Foster Parent ◯ Other

Name of 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
- [ ] Emotional Abuse
- [ ] Sexual Abuse
- [ ] Domestic Violence
- [ ] Abandonment
- [ ] Neglect

Who was perpetrator? _____

Reported to Authorities? _____ Finding/disposition: _____

Did the client witness any of the above types of abuse? ◯ Yes ◯ No

If yes, which type of abuse? _____

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

Substance Use History

☐ Alcohol
☐ Hallucinogens
☐ Narcotics
☐ Marijuana
☐ Inhalants

How long used? _____

Last used? _____

Medical

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

_____

_____

_____

List date and type of any head injuries or seizures:

_____

_____

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List current medications and reason prescribed:

_____

_____

Education:

What school is client enrolled in? _____

Highest grade completed: _____

Any difficulty learning in: Reading: ☐ Writing: ☐ Math: ☐

Favorite subject: _____

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: _____

_____

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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 check 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	☐ DHS Involvement	☐ Trauma	☐ Divorce
☐ New Sibling	☐ Natural Disaster		

Other:_____

Primary Caregiver's signature: _____ Date _____

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:

    - 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

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORM ATION 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.

- 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:_____

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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