

## BACKGROUND INFORMATION FORM

Please provide the following information about yourself. What you write is confidential. It will help me to understand your situation better when we first meet.

Full Name \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender: \_\_\_\_\_

Age: \_\_\_\_\_

Best phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Can I leave a voice message on this number? Y/N

Education Level: \_\_\_\_\_

Occupation: \_\_\_\_\_

Email \_\_\_\_\_

Marital Status: \_\_\_\_\_

Would you like appointment reminders? (circle) Text/Email/None

*[Please note that exchanging texts, emails, or other forms of digital communications with Dr. Hamilton indicates that you voluntarily waive confidentiality protections from that medium, as your device cannot be assumed to be secure]*

Person Dr. Hamilton may contact in case of an emergency:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please list names and ages of family members and circle whom you presently live with:

\_\_\_\_\_

Who were you referred to this office by? \_\_\_\_\_

Please list all medications, including vitamins/supplements you are currently taking:

MEDICATION	DOSAGE	DESIRED EFFECT

Do you smoke or use other tobacco products?	Yes	No
Do you drink two or more coffees, teas, or caffeinated sodas per day?	Yes	No
Do you drink more than two alcoholic beverages per week?	Yes	No
Do you use other recreational substances?	Yes	No
Do you exercise at least twice a week?	Yes	No
Please rate your sleep quality 0 (very poor) – 9 (excellent)	_____	

~~~Please Continue On The Next Page~~~

In your own words, please describe why you are being evaluated/seeking treatment:

How willing are you to attempt to make changes? 0 (not) – 9 (very)

Below is a list of diseases and symptoms that you may have experienced. Please circle all that apply to you.

|                     |                    |                    |                  |
|---------------------|--------------------|--------------------|------------------|
| Auto-Immune Disease | Coma               | HIV/AIDS           | Paralysis        |
| Alcoholism          | Depression         | Hormone Diff.      | Polio            |
| Anxiety             | Diabetes           | Hypertension       | Rheumatic fever  |
| Arteriosclerosis    | Dizziness          | High Cholesterol   | Seizure/Epilepsy |
| Arthritis/Gout      | Drug Addiction     | Hypoxia            | Sensory Loss     |
| Asthma              | Encephalitis       | Kidney Disease     | Sleep Apnea      |
| Attention Deficit   | Fibromyalgia       | Liver Disease      | Stroke/TIAs      |
| Blood Disease       | Food Intolerance   | Loss of Smell      | Syphilis         |
| Brain Tumor         | GI Issues          | Memory Loss        | Thyroid Disease  |
| Cancer              | Head Injury        | Meningitis         | Tourette's       |
| Chemical Exp        | Headaches          | Migraines          | Tremor           |
| Chronic Fatigue     | Heart/Lung Disease | Multiple Sclerosis | Vit D Deficiency |
| Chronic Pain        | Heat Exhaustion    | Numbness           | Unconsciousness  |
|                     |                    | Parkinson's        |                  |

Please Describe Any Other Medical or Psychiatric Conditions You May Have:

What is your surgical history? (procedure/approximate year)

What major medical/psychiatric conditions have your family members had? (e.g. dementia, psychosis, etc).

In the past two weeks, have you been sad most or days and/or less interested in doing things you used to enjoy?

Yes No

Have you felt sad or depressed most days for the past two years?

Yes No

Have you ever had a sudden episode where you felt remarkably anxious, scared, or nervous, felt you might die, or other symptoms of panic?

Yes No

In the past month, have you avoided social situations due to fear of embarrassment, humiliation, or shyness?

Yes No

Do you repetitive or recurrent unwanted thoughts or impulses (e.g. fear of harming others or contamination, collecting, unwanted sexual imagery, etc)?

Yes No

Have you ever experienced a traumatic event in which the life or physical integrity of yourself or someone close to you was threatened (e.g. assaults, accidents, abuse, etc)?

Yes No

Do you have pain that has persisted longer than three months?

Yes No

Are you extremely concerned about your body image?

Yes No

In the past month, have you thought about suicide?

Yes No

Have you ever made a suicide attempt?

Yes No

Have you ever been psychiatrically hospitalized?

Yes No

Have you ever previously participated in psychotherapy?

Yes No

~~~Please Continue On The Next Page~~~



Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all - NEVER
- 1 Applied to me to some degree, or some of the time - SOMETIMES
- 2 Applied to me to a considerable degree, or a good part of time - OFTEN
- 3 Applied to me very much, or most of the time - ALMOST ALWAYS

FOR OFFICE USE

|   | N | S | O | AA | D | A | S |
|---|---|---|---|----|---|---|---|
| 1 I found it hard to wind down  | 0 | 1 | 2 | 3  |   |   |   |
| 2 I was aware of dryness of my mouth  | 0 | 1 | 2 | 3  |   |   |   |
| 3 I couldn't seem to experience any positive feeling at all   | 0 | 1 | 2 | 3  |   |   |   |
| 4 I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)            | 0 | 1 | 2 | 3  |   |   |   |
| 5 I found it difficult to work up the initiative to do things   | 0 | 1 | 2 | 3  |   |   |   |
| 6 I tended to over-react to situations  | 0 | 1 | 2 | 3  |   |   |   |
| 7 I experienced trembling (eg, in the hands)  | 0 | 1 | 2 | 3  |   |   |   |
| 8 I felt that I was using a lot of nervous energy   | 0 | 1 | 2 | 3  |   |   |   |
| 9 I was worried about situations in which I might panic and make a fool of myself   | 0 | 1 | 2 | 3  |   |   |   |
| 10 I felt that I had nothing to look forward to   | 0 | 1 | 2 | 3  |   |   |   |
| 11 I found myself getting agitated  | 0 | 1 | 2 | 3  |   |   |   |
| 12 I found it difficult to relax  | 0 | 1 | 2 | 3  |   |   |   |
| 13 I felt down-hearted and blue   | 0 | 1 | 2 | 3  |   |   |   |
| 14 I was intolerant of anything that kept me from getting on with what I was doing  | 0 | 1 | 2 | 3  |   |   |   |
| 15 I felt I was close to panic  | 0 | 1 | 2 | 3  |   |   |   |
| 16 I was unable to become enthusiastic about anything   | 0 | 1 | 2 | 3  |   |   |   |
| 17 I felt I wasn't worth much as a person   | 0 | 1 | 2 | 3  |   |   |   |
| 18 I felt that I was rather touchy  | 0 | 1 | 2 | 3  |   |   |   |
| 19 I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat) | 0 | 1 | 2 | 3  |   |   |   |
| 20 I felt scared without any good reason  | 0 | 1 | 2 | 3  |   |   |   |
| 21 I felt that life was meaningless   | 0 | 1 | 2 | 3  |   |   |   |

## NORTH CAROLINA NOTICE FORM

### **Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information**

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:

- “**PHI**” refers to information in your health record that could identify you.
- “**Treatment, Payment and Health Care Operations**”
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician, psychiatrist or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “**Use**” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “**Disclosure**” applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

#### **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. I will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information (PHI) for marketing purposes, and disclosures that constitute a sale of PHI require patient authorization;

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. 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.

#### **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 you give me information which leads me to suspect child abuse, neglect, or death due to maltreatment, I must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, I must do so.

**Adult and Domestic Abuse:** If information you give me gives me reasonable cause to believe that a disabled adult is in need of protective services, I must report this to the Director of Social Services.

**Health Oversight:** The North Carolina Psychology Board has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding, and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order.

This 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:** I may disclose your confidential information to protect you or others from a serious threat of harm by you.

**Worker's Compensation:** If you file a workers' compensation claim, I am required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.

#### **IV. Patient's Rights and Psychologist's Duties**

##### **Patient's Rights:**

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process. You will be notified if there is ever a breach of your unsecured PHI for any reason.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically
- Right to Restrict PHI Disclosure- You have the right to restrict certain disclosures of PHI to health plans/insurance companies if you pay out of pocket in full for the health care service

##### **Psychologist's Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I am required by law to take reasonable steps to protect unintentional disclosure through breaches of security, such as computer viruses and electronic transmission of data.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide individuals with a revised notice in our next session or by US mail.

#### **V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me in writing. We will then set up a meeting to discuss these concerns with the intent to seek a mutual resolution. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

#### **VI. Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on September 27, 2013.

I will limit the uses or disclosures that I will make as follows: Your written consent is obtained, except where disclosure is required by law. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice during our next session or by US mail.

END OF NOTICE FORM

**Authorization to Release Protected Information**  
(APA HIPAA Compliant: 4/03)

I, \_\_\_\_\_ hereby authorize:

Name and contact details for people (such as healthcare provider, family member, etc):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To **exchange** (two-way share)  
Or (circle): release to Dr. Hamilton or receive from Dr. Hamilton

My confidential medical records and protected health information involving assessment or treatment with:

Asheville Integrated Behavioral Health, PC  
William Hamilton, PhD  
30 Clayton Street  
Asheville, NC 28801  
FAX (828) 333-4362 [secure FAX]

**Without Exclusions**

Or limited to or specifically excluding: \_\_\_\_\_

**For the purpose of: to help with diagnosis and treatment planning**

Or specify other purpose: \_\_\_\_\_

I have the right to revoke this authorization, in writing, at any time by sending such written notification to William Hamilton's office address. Any such revocation will not be effective to the extent that the releasing parties have taken action in reliance on the authorization, and that this authorization was obtained as a condition for obtaining insurance coverage, and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of this information, and may no longer be protected by the HIPAA Privacy Rule.

**Today's date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

This authorization shall remain in effect until one year from today's date, or ending \_\_\_\_/\_\_\_\_/\_\_\_\_ per my specification. I also acknowledge that I have the right NOT to authorize this release of my health information, and I do so freely of my own accord.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Printed Name**

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
(Witness/Guardian Signature and Printed Name)