Thomas E. Thorsheim, Ph.D.
Incorporated
Licensed Psychologist (SC Lic. # 996)
1326 Haywood Road, Suite 102
Greenville, SC 29615
Tel: 864-421-0098 / Fax: 864-421-0099

Date _____

Patient Information*

***For couple's therapy, please complete two separate intake forms. For children, please complete only applicable information.**

Patient Name: _____ **Referred by:** _____

Address: _____ **Home Phone:** _____

_____ **Date of Birth:** _____

Gender: _____

Marital Status (please circle): Single / Married / Partnered / Divorced / Widowed

If applicable:

School _____ **District** _____ **Grade/Year in School:** _____

Profession/Employer: _____

Please indicate the primary phone number or preferred mode of contact: _____

Are there any special instructions for contacting you? (i.e. for your privacy or convenience) _____

_____

Email Address(es): _____

If you wish, please provide the name/number of an emergency contact: _____

Other Household Members:

Last Name: _____ **First Name:** _____ **Birthdate:** _____ **Relationship:** _____

Last Name: _____ **First Name:** _____ **Birthdate:** _____ **Relationship:** _____

Last Name: _____ **First Name:** _____ **Birthdate:** _____ **Relationship:** _____

Last Name: _____ **First Name:** _____ **Birthdate:** _____ **Relationship:** _____

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A. MEDICAL HISTORY (Y= YES, N= NO, U= UNKNOWN)

Have you ever had any of the following medical conditions?

	Y	N	U			Y	N	U	
1.				**Hearing problems**	**16.**				**Venereal disease**
2.				**Vision problems**	**17.**				**Measles (what type)**
3.				**Headaches**	**18.**				**Mumps**
4.				**Head injury**	**19.**				**Chicken Pox**
5.				**Blackouts / fainting**	**20.**				**Rheumatic Fever**
6.				**Seizures / convulsions**	**21.**				**Tuberculosis**
7.				**EEG / Brain wave test**	**22.**				**Diphtheria**
8.				**Diabetes (or anyone in the family?)**	**23.**				**Enuresis/Encopresis**
9.				**Asthma / breathing problems**	**24.**				**GI Problems**
10.				**Serious accident / injury**	**25.**				**Repeated infections**
11.				**Surgery**	**26.**				**Urinary**
12.				**Hallucinations**	**27.**				**Cardiovascular**
13.				**Congenital defects**	**28.**				**Respiratory**
14.				**Suicide gesture / attempt**	**Date of last pregnancy (if applicable)**				
15.				**Female/Gyn. problems / pregnancy**					

If "yes" to any of the above, please comment: _____

_____

_____

_____

B. Allergies / Type of Reaction:

1. **Medications** _____
2. **Foods** _____
3. **Other** _____

C. Medication History

Are you currently on any medications or supplements? (include both prescription and non-prescription)

NAME DOSAGE REASON EFFECTIVE?

_____

_____

_____

_____

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What medications have you previously taken or been prescribed?

NAME	DOSAGE	REASON	EFFECTIVE?

Adverse side effects? Yes __ No ___
If yes, please explain: _____

_____

Date of last physical exam: _____

Name of family physician: _____

Are you currently under a physician's care for any reason? Yes __ No _____

If yes, please explain: _____

_____

_____

D. DRUGS AND ALCOHOL

Do you: Smoke? Yes _____ No_____ How much? _____

Drink? Yes _____ No _____ How much? _____

Have you ever used "recreational drugs" or "street drugs"? Yes _____ No _____

TYPE	HOW LONG	WHEN

E. PREVIOUS THERAPY, PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT

Are you now or have you previously seen a mental health practitioner? Yes ___ No ___
If so, whom do/did you see? _____
What were your reasons for seeking treatment? _____

_____
Was it helpful? _____
Have you previously had formal psychological testing? Yes _____ No ____
If yes, by whom? _____
Name of Person Completing Form: _____
Date: _____ **Relationship to Patient:** _____

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CONSENT TO MENTAL HEALTH EVALUATION & TREATMENT

Patient Name: _____ Date of Birth: _____ Age: _____

I hereby authorize Dr. Thorsheim to provide mental health services to me (or to my minor child – if the child is the patient being treated).

_____
Printed Name of Client

_____
Signature of Client (or guardian, in the case of a minor) Date

_____
Signature of Child (assent to treatment - if child is primary client) Date

Thomas E. Thorsheim, Ph.D.
Provider

_____
Signature of Provider Date

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NOTICEOFPRIVACYPRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*.

I may use/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.

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.

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

• Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the South Carolina Department of Protective and Regulatory Services (Child Protective Services) or to any local or state law enforcement agency.

• Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services (Adult Protective Services).

• Health Oversight: If a complaint is filed against me with the State Board of Examiners of Psychologists, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

• Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information

is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, 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 the evaluation is court-ordered or is being conducted for a third party.**

• Serious Threat to Health or Safety: If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

• Worker's Compensation: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

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 reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, I am required to abide by the terms currently in effect.
• If I revise my policies and procedures, I will post notice of such revision in a visible location. I may also elect to notify you by mail at the billing address which you have provided to me.

Complaints
If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

_____ _____
Patient Signature (or responsible party) Date

_____
Printed Name of Patient (or responsible party)

_____ _____
Provider Signature Date

Thomas E. Thorsheim, Ph.D.
Printed Name of Provider

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PAYMENT POLICY & FEE RATES

All services rendered are your financial responsibility. You are responsible for full payment at time of service regardless of insurance coverage. Dr. Thorsheim will bill you directly and will not bill your insurance provider. However, you may independently choose to seek reimbursement from your insurance carrier. Dr. Thorsheim will provide you receipts and specific billing codes for you to expedite any reimbursement from your insurance carrier.

If you are issued reimbursement from your insurance, please ask that your insurer send payment directly to you, as my office does not cash third-party checks from insurance.

FEE SCHEDULE

* **PLEASE NOTE:** 48 hours advanced notice is requested to change or cancel an appointment. A minimum of a full 24 hour notice of cancellation is required. Appointments canceled less than 24 hours prior will be billed at the full fee rate.

- Initial Diagnostic Interview (60 min):..... $220
- Individual Psychotherapy (45 min):..... $180
- Individual Psychotherapy (60 min): $220
- Family/Couples Psychotherapy (60min):..... $220
- Group Psychotherapy:..... $70
- Psychological Testing: Fees vary based on testing required. Please call to discuss.
- Executive/Physician Coaching (60 min): Please call to discuss the various offerings.

By signing below, I acknowledge understanding of the above fee schedule. I am aware that Dr. Thorsheim has chosen not to participate in insurance panels and that he does not receive third-party reimbursement from insurers. In addition, I understand that he opts out of Medicare and never seeks or obtains reimbursement from Medicare.

*****I also understand that in the event of a missed appointment or late cancellation (i.e. less than minimum of a full 24 hour notice), I would be charged in full.***
PLEASE INITIAL HERE ___

SIGNED:_____ **DATE:**_____

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Items to consider - and if you'd like, to write about - prior to your first appointment (feel free to add an extra page or two)

Please share a few brief thoughts about what you would like assistance with in our work together (we will discuss at length during your first session).

What has prompted you to get help for these concerns right now?

If you've been to therapy before (or had psychological testing) how was that experience for you? Is there anything in particular that you found especially helpful and/or unhelpful?