



CONFIDENTIAL CLIENT INFORMATION

Welcome to the Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal law, any information you provide is strictly confidential.

Demographic Information:

Name _____ SSN _____ Date _____

Mailing Address: _____

City: _____ State _____ Zip Code _____

Email Address: _____

Home Phone: _____ Work Phone _____ Cell Phone: _____

What is the best way to contact you? _____ Is it okay to leave a message? Yes No

Date of Birth	Age	Sex	Ethnic Group	Religious Preference
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Relationship Status:

Single ___ Cohabiting ___ Married ___ Separated ___ Divorced ___ Widowed ___

Emergency Contact: _____ Telephone: (____) _____

Parent/Guardian (if relevant): Name: _____

Address: _____ Telephone: (____) _____

Referral Information:

How did you find out about our services? _____

Employment Information:

Are you currently employed? Yes No

If yes, where are you employed? _____

What is your job title? _____

For Office Use Only: Date of Last Information Update and Initials of Staff Member Completing

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Education Information:

Highest Level of Education Completed:

Grade School ____ High School ____ College ____ Graduate School ____

Are you currently a student? Yes No

If yes, where? _____ Year _____ Major _____

Family/Significant Others:

Does anyone in your family have a history of the following? (please check all that apply)

Mental Illness ____ Substance Abuse ____ Eating Disorder ____ Obesity ____ Dieting ____

Please specify on the chart below:

Please provide the following information about your family members (include parents, stepparents, all siblings, spouse/partner, children, etc.) and significant others.

Name	Relationship to You	Age	Job/ Highest Education Completed	Where He/She Lives	Mental/Medical Conditions

Health Information:

Please list any chronic illnesses, injuries, physical conditions or disabilities: _____

Allergies/Adverse Reactions to Treatment: _____

Primary Care Physician Name: _____

Address: _____ Telephone: (____) _____

Current Medications

Supplements & Vitamins Daily Dose Start Date Name of Prescriber

Supplements & Vitamins	Daily Dose	Start Date	Name of Prescriber

Mental Health History:

Have you received counseling before? Yes No

If yes, when, where, and with whom? _____

Please list any hospitalizations for psychological, psychiatric, or chemical dependency treatment, including location and dates: _____

Have you ever experienced any of the following (check all that apply)?

Physical Abuse___ Sexual Abuse ___ Sexual Assault ___ Verbal/Emotional Abuse ___

Have you experienced any recent and/or important loss? Yes No

If "yes", please specify _____

Is there any other relevant information that we have not asked about?

Clinical Information:

What type of services are you seeking/expecting? (Please check all that apply to you)

Individual Counseling ___ Group Counseling ___ Couples/Family Counseling ___

Bariatric Evaluation___ Assessment___ Nutritional Counseling ___

How well are you getting along psychologically at this time?

- ___ Very well, the way I want to. ___ So-so, can keep going with effort.
- ___ Quite well, no important complaints. ___ Quite poorly, can barely manage.
- ___ Fairly well, but have ups and downs. ___ Very poorly, don't think I can manage.

Current Issues (Please check all that apply to you):

- | | |
|---------------------------------|-----------------------------------|
| ___ Romantic Relationships | ___ Self-Confidence/Self-Esteem |
| ___ Family Relationships | ___ Body Image |
| ___ Peer Relationships | ___ Eating Disorder/Eating Issues |
| ___ Divorce/Separation | ___ Drug/Alcohol Abuse |
| ___ Stress | ___ Physical Abuse |
| ___ Depression | ___ Sexual Abuse/Molestation |
| ___ Loneliness/Social Isolation | ___ Sexual Assault |
| ___ Sleep Problems | ___ Sexual Identity Issues |
| ___ Anxiety | ___ Anger Management |
| ___ Fears/Phobia | ___ Homicidal Feelings |
| ___ Unwanted Habits | ___ Suicidal Feelings |
| ___ Legal Problems | ___ Racial/Cultural Issues |
| ___ Financial Problems | ___ Grief/Loss |
| ___ Career Planning | ___ Physical Health |
| ___ Unemployment | ___ Pregnancy (past, present) |
| ___ Academic Performance | ___ Spirituality |
| ___ Learning Disabilities | ___ Decision Making |
| ___ Attention Problems | ___ Other _____ |

SYMPTOM CHECKLIST

Client Name: _____ Age: _____ Date: _____

Instructions: *Please answer the following questions by putting a check in the appropriate column or writing in a response where indicated.*

Symptom Experienced	Y	N	N/A
1. Has heavy drug or alcohol use ever caused problems in your life?			
Has anyone ever remarked on or expressed concern about your use of alcohol or drugs?			
Has heavy drug or alcohol use been a problem for you in the past year?			
Have you ever used marijuana, coke, heroin, or any other drug to make yourself feel good?			
2. Have you ever felt unusually high, charged up, excited or restless?			
Have other people ever said that you were too high, charged up, excitable, or talkative?			
How long have these moods usually last?			
What is the longest they have lasted?			
3. Have you ever felt depressed, sad, empty, or hopeless for several days or weeks at a time?			
Have you ever felt very irritable or tired for a period of time for no particular reason?			
How long do these feelings usually last?			
What is the longest they have ever lasted?			
4. Have you ever had sudden spells of nervousness, panic, or fear come over you for no particular reason?			
Did you see a doctor because of this?			
What did the doctor tell you about these symptoms?			
5. Have you ever very afraid of certain things, like heights, animals, needles, the sight of blood, lightning, etc?			
What were you afraid of?			
Have you ever been so afraid to leave home by yourself that you wouldn't go out?			
Have you ever been afraid to go to supermarkets, go into tunnels, or use elevators?			
Have you ever been so afraid of embarrassing yourself in public that you would not do certain things like eating in a restaurant, using a public restroom, or speaking out in a room full of people?			
6. Have you ever been bothered by certain embarrassing, scary, or ridiculous thoughts that came into your mind over and over again, even if you tried to ignore or stop them?			
Please describe them:			
7. Have you ever felt compelled to repeat a certain act (such as checking, counting, cleaning, ordering), follow particular routines or rituals, or do things in an exact way or order even if it didn't make sense?			
8. Have you ever experienced flashbacks, in which you found yourself reliving some terrible experience over and over?			
9. Have there ever been days at a time when you felt extremely nervous, anxious, or tense for no particular reason?			
Have you sometimes felt this way even if you had nothing special to do?			
Have these feelings ever bothered you on and off for six months or more at a time?			

SYMPTOM CHECKLIST

Symptom Experienced	Y	N	N/A
10. Have you consistently had difficulty focusing and paying attention?			
Do you frequently feel impatient, restless, and have difficulty sitting still?			
Would others describe you as impulsive and/or hyper (e.g. do you tend to blurt out comments, interrupt others, say or do things you regret later)?			
11. Have you had a lot of physical problems that have forced you to see different doctors?			
Have doctors had difficulty finding what caused the problems?			
Did you start having any of these problems before you were 30 years old?			
12. Have you ever deliberately lost so much weight that people expressed concern?			
Have you ever been afraid of getting fat even when other people said you were thin enough or too thin?			
13. Have you ever eaten so much that you felt sick?			
Have you ever eaten to comfort, soothe, reward, or punish yourself?			
Have you ever felt that your eating was excessive and/or not really normal?			
Have you ever felt out of control while eating?			
Have you ever felt depressed, ashamed, or disgusted after eating?			
Have you ever vomited, used laxatives or diuretics, or exercised excessively to try to make up for eating too much?			
14. In the past couple of months, have you been very worried or upset about something that happened to you, such as the death of a loved one, losing a job, getting separated or divorced, having a bad accident, getting a serious illness, etc?			
Do you feel that you've had more trouble handling this situation than most people would?			

15. Have any of these symptoms -- drinking, drug use, moods, anxiety, etc – ever interfered with school, work, or your job? What concerns, if any, have family and friends expressed? Please explain.

16. Have any of these symptoms ever gotten you into trouble with the authorities and/or caused legal problems? If yes, please explain.

17. Has your health ever suffered as a result of any of these symptoms? If yes, please explain.

18. Have you ever received medication or treatment for any of these symptoms? If yes, please explain.

19. Were you ever hospitalized for any of these symptoms? If yes, please explain.

EATING AND BODY IMAGE CHECK SHEET

Client Name: _____ Date: _____

Weight History:

Current Height _____ Current Weight _____ Desired Weight _____
 Lowest Weight _____ Highest Weight _____ How often do you weigh yourself? _____

Food History:

Restrictive Eating/Dieting (please check all that apply)

	Past	Current		Past	Current
skipping meals	_____	_____	fasting	_____	_____
reducing portions	_____	_____	reducing calories	_____	_____
restricting carbs	_____	_____	restricting fats	_____	_____
restricting protein	_____	_____	restricting dairy	_____	_____
chewing & spitting	_____	_____	throwing away food	_____	_____

Binging/Compulsive Eating (please check all that apply)

	Past	Current		Past	Current
eating sweets	_____	_____	eating a lot in a short period of time	_____	_____
eating carbs	_____	_____	feeling out of control when eating	_____	_____
eating dairy	_____	_____	eating until uncomfortably full	_____	_____
eating to soothe self	_____	_____	guilt/shame after eating	_____	_____
eating to punish self	_____	_____	eating for emotional reasons	_____	_____

Specify binge foods _____

Purging/Weight Control Measures:

<u>Behaviors</u>	<u># of times per day</u>	<u># of days per week</u>	<u>Past or Present?</u>
Vomiting	_____	_____	_____
	<u># of pills per day</u>	<u># of days per week</u>	<u>Past or Present?</u>
Diet Pills	_____	_____	_____
Laxatives	_____	_____	_____
Diuretics	_____	_____	_____
	<u># of mins per day</u>	<u># of days per week</u>	<u>Type & Duration</u>
Current Exercise	_____	_____	_____
Past Exercise	_____	_____	_____

Possible contributors to eating & body image issues (check all that apply):

_____ teasing about appearance	_____ divorce
_____ problems at school/work	_____ difficulty coping with stress
_____ media influences	_____ relationship issues
_____ family problems	_____ leaving home/separation
_____ puberty	_____ difficult sexual experience
_____ medical reasons (illness/operation)	_____ prolonged period of dieting
_____ depression	_____ body image dissatisfaction
_____ death/loss	_____ problems w/friends
recommendation of weight loss by: _____ parent _____ friend _____ physician _____ coach	
other (please explain) _____	

EATING AND BODY IMAGE CHECK SHEET

Physical Symptoms:

Which of the following are you currently experiencing?

- | | | |
|---|--|---|
| <input type="checkbox"/> loss of period | <input type="checkbox"/> bloating | <input type="checkbox"/> brittle hair |
| <input type="checkbox"/> irregular period | <input type="checkbox"/> diarrhea | <input type="checkbox"/> hair loss |
| <input type="checkbox"/> nausea | <input type="checkbox"/> sore throat | <input type="checkbox"/> dry skin |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> swollen glands | <input type="checkbox"/> yellowish skin |
| <input type="checkbox"/> light-headedness | <input type="checkbox"/> ulcers | <input type="checkbox"/> coldness |
| <input type="checkbox"/> fainting spells | <input type="checkbox"/> dental problems | <input type="checkbox"/> muscle cramps |
| <input type="checkbox"/> weakness | <input type="checkbox"/> irritated gums | <input type="checkbox"/> muscle weakness |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> chest pain | <input type="checkbox"/> loss of muscle |
| <input type="checkbox"/> lack of energy | <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> tingling |
| <input type="checkbox"/> sleep problems | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> numbness |
| <input type="checkbox"/> acid reflux | <input type="checkbox"/> frequent urination | <input type="checkbox"/> swelling of ankles |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> dehydration | <input type="checkbox"/> swelling of hands |
| <input type="checkbox"/> gas | <input type="checkbox"/> water retention | <input type="checkbox"/> fractures |
| <input type="checkbox"/> cramps | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> injuries |

other: _____

Last physical exam: when, where & with whom? _____

Psychological Symptoms:

Which of the following have you experienced?

- | | |
|--|--|
| <input type="checkbox"/> irritability | <input type="checkbox"/> difficulty making decisions |
| <input type="checkbox"/> depression | <input type="checkbox"/> impaired concentration |
| <input type="checkbox"/> mood swings | <input type="checkbox"/> memory problems |
| <input type="checkbox"/> mania/high mood | <input type="checkbox"/> phobias |
| <input type="checkbox"/> guilt | <input type="checkbox"/> panic attacks |
| <input type="checkbox"/> worthlessness | <input type="checkbox"/> avoidance of social situations |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> fear of sex |
| <input type="checkbox"/> perfectionism | <input type="checkbox"/> promiscuous sexual behavior |
| <input type="checkbox"/> obsessive thoughts | <input type="checkbox"/> risky sexual behaviors |
| <input type="checkbox"/> following strict routines/rigid rules | <input type="checkbox"/> thoughts of suicide |
| <input type="checkbox"/> engaging in rituals | <input type="checkbox"/> self-mutilation (cutting, burning, hurting) |

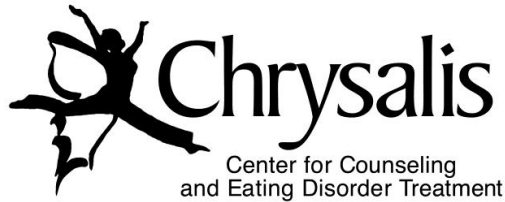
Substance Use:

Which of the following substances do you use? Specify amount & frequency of use.

- caffeine _____
- cigarettes _____
- alcohol _____
- drugs (what kind?) _____

Who knows about your eating disorder? _____

Other questions or concerns that have not been specifically addressed:



RIGHTS & CONSENT TO TREATMENT

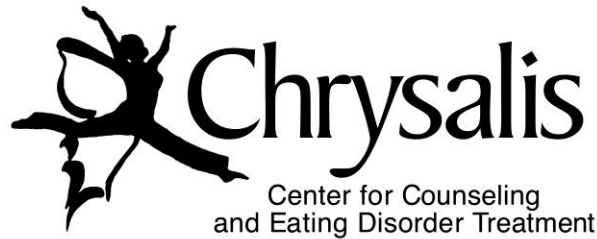
- You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- You have the right to be treated in accordance with professional and ethical standards of conduct.
- You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Clinical records will be maintained in a secure, locked environment. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order.
- You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- I understand that sessions run for 45-50 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- I understand that there is no guarantee that any particular outcome will result from treatment.
- I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians, Kelly Broadwater, LPA, LPC, Kim Longbottom, LCSW, LCAS, Annmarie Miller, LCSW, Ashley Swinson, LCSW, and Kendra Wilson, LCSW and the nutritionists, Chaundra Klein, RD, LDN and Terri Mozingo, RD, LDN actively collaborate and consult about mutual cases, as well as share clinical notes.
- I understand that my therapist may consult and share clinical information with their supervisor and/or clinical board in order to provide legal and ethical treatment. They may also do so to meet the requirements set forth for their licensure or certification.

I have read and understood this document and will address any concerns or questions with my therapist and/or the office manager.

Client/Representative Signature _____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature _____ **Date** _____



Office Procedures and Financial Agreement

Please read, initial, and sign below. You may request a copy for your records.

Chrysalis is a business facility where a number of mental health professionals practice. Your contract for services is with our facility and applies to any and all providers you may see here.

APPOINTMENTS:

All office visits are by appointment and may be scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. The usual length of an appointment is 45-50 minutes. If you arrive more than 15 minutes late, you may be asked to reschedule your appointment, which will result in a *late cancellation* charge.

Payment: Payment is required at the time services are rendered, whether you are a self-pay client or have insurance benefits. Please note: if you are unable to provide payment at the time of service, you will not be seen and your appointment will be considered a *late cancellation*. You will be charged for the appointment time. Acceptable methods of payment include cash, check, and credit card. *The fee for returned checks is \$35. If a second check is returned, you will be asked to arrange another method of payment.*

Late cancellations/No shows: For a missed or late cancelled clinical or nutritional appointment, you will be charged the *self-pay* rate for the appointment (unless otherwise specified by your insurance carrier). Please note: both clinical and nutritional appointments must be cancelled by 9:00am the business day before. Please be advised that reminder calls are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

INSURANCE:

Insurance co-payments are due at the time of service. If your insurance deductible has not yet been met, you will be billed the full charge for services. As a courtesy to you, we will bill rendered services to your insurance carrier. We cannot guarantee insurance coverage, nor that the information provided by your carrier is accurate. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. *It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility.*

Please note: treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers, may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

Medicaid/Medicare: Co-payments are due at the time of service. You are also required to present your Medicaid or Medicare Card at each visit. Failure to present your card may result in your not receiving services. If your Medicaid or Medicare coverage has lapsed or terminated, please be advised that you will be responsible for payment in full for services rendered during that time.

OUTSTANDING BALANCE:

You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued.

If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from

treatment, and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with the Office Manager or Accounts Receivable Manager.

Late Fees: A late fee of \$25 will be charged to accounts that are not paid within 30 days of receipt of the first bill. If payment is not received by the third billing cycle, your delinquent account may be referred to collections and you will be responsible for all associated collections and fees.

ADDITIONAL SERVICES

In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring for psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment.

Phone Calls: Typically there is no charge for phone calls. However, phone calls that are extended and/or that constitute therapy may be billed at our self-pay rate.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do not reimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Case Management Fee: Extensive services that involve clinical coordination and continuity of care may constitute an additional fee that is separate of therapeutic services.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____ I have read, understand, and agree to the above policies.

_____ I have discussed these policies and addressed concerns and questions with the Office Manager or AR Manager.

_____ I have been offered a copy of these policies to take with me if I desire.

_____ I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.

_____ I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

Signature of Client

Date

Signature of parent or Legal Guardian

Date

Signature of Office or AR Manager

Date



**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): _____

Address: _____

Telephone: _____

Birth Date: _____

Social Security Number: _____

Relationship to Policy Holder: _____

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

* Please see reverse side for secondary insurance information and consenting signature.

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

Name of Client (printed)

Date

Signature



**ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES
& CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION**

This form is an agreement between you, _____ and Chrysalis Center. When we use the word “you” below, it can mean you, your child, a relative or other person if you have written his or her name(s) here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form you are agreeing to let us use your information and send it to others. Please read the Notice of Privacy Practices dated 05.25.2010 before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.chrysaliscenter-nc.com, or by calling us at 910-790-9500. If you have any questions regarding the Notice or your privacy rights, you can also contact Kendra Wilson, LCSW, Privacy Officer, at kendra@chrysaliscenter-nc.com or at the address listed below.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to our Privacy Officer at Chrysalis Center about these concerns. (Although we will try to respect your wishes, we are not required to agree to these limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter to the Privacy Officer). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Chrysalis Center’s Notice of Privacy Practices. My signature indicates that I have reviewed this notice and understand its content.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Relationship to Client (if guardian or representative): _____

** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).*

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

Client Refuses to Acknowledge Receipt:

Signature of authorized representative of this office or practice: _____



CONTRACT FOR BARIATRIC SURGERY EVALUATION & FOLLOW-UP

- I am aware that a pre-operative psychological evaluation is required. This evaluation will consist of an extended clinical interview and psychological assessments. Due to the extensive nature of the evaluation, 2 or more office visits may be required to complete the process.
- The cost for the evaluation includes a clinical interview, psychological testing, scoring the testing, and preparing the psychological report. The cost of the evaluation will be determined at your initial appointment, based on your insurance coverage. Payment in full is expected at the time of the initial appointment. *If full payment is not received by the completion of psychological testing, the psychological report will not be submitted to the surgeon until payment is remitted.*
- It is extremely important that I am completely honest with my evaluator so that she can make an informed decision and provide me with the optimal level of care as I go through this process. I understand that my evaluator wants to ensure my success with surgery.
- I understand that I will need to sign a release of information to allow the clinician who meets with me for the evaluation, and the doctor who will be performing the surgery, to communicate with each other. They will be sharing treatment recommendations. I am aware that the result of this evaluation is a recommendation regarding my appropriateness for surgery and the level of support I may need in order to optimize my success with the surgery. Typical recommendations include: patient seems appropriate for surgery; patient would benefit from additional support prior to and/or following surgery; patient does not seem appropriate for surgery at this time.
- I understand that my psychological evaluation report will be released to my doctor and to my insurance company for further review, and that they will ultimately determine whether or not I am approved for surgery.
- I understand that neither raw test data nor the psychological report will be released directly to me. I am aware that if I desire feedback or an interpretation of my testing, I will need to schedule an additional session with the clinician who performed the evaluation.
- I am aware that the Kelly Broadwater, MA, LPA, LPC and Kendra Wilson, MSW, LCSW, may consult with each other in order to make the most effective recommendations regarding my appropriateness for surgery and level of care indicated.
- I know that should I be approved for, and undergo bariatric surgery, that it is required that I attend a minimum of three post-operative counseling sessions and three post-operative nutritional sessions, 3, 12, and 18 months following my surgery. The cost per session depends on my insurance coverage.
- I am aware that optional group counseling is available to me, following my surgery, as a means of getting additional support. The cost for group is \$35 per session, or my co-pay. Regular attendance is encouraged.

My signature indicates that I understand and agree to all of the above.

Client/Representative Signature _____

Print Name _____ **Date** _____



CONSENT TO TESTING

PLEASE READ CAREFULLY PRIOR TO COMPLETING THE PSYCHOLOGICAL TESTING

- I consent to take part in testing for the purpose of accurate diagnosis and treatment planning. I understand that it is in my best interest to actively participate in testing and to follow the treatment recommendations that result.
- I understand that I have the right to refuse or discontinue testing at any time. However, doing so could impede effective diagnosis and treatment planning.
- I understand that I have the right to review test results with my evaluator. However, I will not be provided with raw test data.
- I understand that there is no guarantee that any particular outcome will result from testing.
- I understand that there is a fee for testing. In the event that insurance does not reimburse for testing, or reimburses at a minimal rate, I understand that I am responsible for the remaining balance.

Please read each test item carefully and answer honestly. Avoid over-thinking items, as it is best to go with your initial response to each question. It is possible that your test results will not be able to be used if you attempt to portray yourself in an overly positive way. Honesty is of utmost importance, as some forms of testing can detect dishonest and/or defensive responding. Realize that it is normal and expected for people to report problems. If your test results are found to be invalid, that may interfere with our ability to make a decision regarding appropriate treatment or, if applicable, to make recommendations for surgery.

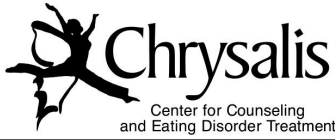
If you have any questions or concerns, please address them with your therapist and/or the office manager before signing this. Your signature indicates that you have read and understood this information.

Client/Representative Signature

_____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Staff Signature _____ **Date** _____



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Release/Request for Information

The purpose of this form is to authorize the parties indicated to disclose and exchange client information to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services with Chrysalis Center clinicians. The original of this form will be placed in your record and a copy may be sent to other parties.

I, _____ (client name), authorize the Chrysalis Center clinicians or administrative staff to exchange the specified information for the purpose of coordinating care. I understand that:

- I have the right to be told and to review the information being exchanged.
Information may be exchanged via phone, fax, or email.
This information will only be disclosed to parties specifically indicated, at which time those parties are responsible for maintaining the privacy of your information.
I may refuse or revoke my consent at any time by writing a letter to Chrysalis Center. I understand that the revocation will not apply to any information already used or disclosed under this authorization.
This consent will be valid for one year following conclusion of treatment at Chrysalis Center, unless otherwise indicated.
For further information regarding privacy practices, please see you "Rights and Consent to Treatment" and "Notice of Privacy Practices" given to you at the time of intake.

Company/Individual Name

Phone/Fax/Address

Blank lines for entering company/individual name and phone/fax/address.

Please fax or send copies of the following information: (check all that apply)

- Attendance, Biopsychosocial history, Current medications, Diagnosis(es), Discharge Summaries, Follow up plan, Lab records, Medical notes/records, Nutrition Records, Psychiatric evaluations, Psychological evaluations, Testing records, Recommendations, Therapy notes/records

Other: _____

Signature: _____ (of client or representative)

Date: _____

for:

Name (print): _____ & relationship to client (if representative)

Date of Birth: _____