Jamie Justus, LCSW
1310 South 1st St, Suite 200
Austin, TX 78704
(512) 940-7591

CONFIDENTIAL CLIENT INFORMATION

Date ______________________

Name _____________________________________

Address ____

City / State / Zip ____

Preferred Phone Number ______________________ Other Phone ____________________________

Email address ___________________________ Referred by ______________________________

Occupation _________________________________ Employer ______________________________

Gender __________ Age ___________ Date of Birth ___________

Relationship Status ________________

Identities important to you (e.g. race, sexual orientation, religion, nationality, gender identity, etc.)

____

Name(s) of previous therapist(s) and dates seen

____

____

Describe any health concerns ____

____

List drugs/medications you presently use ____

____

List psychotropic medications you have used in the past _______________________________________

____

Please describe briefly the concern(s) that bring you here _______________________________________

____

____

____

Please check any of the following items that concern you:

_____ Self-esteem, self-confidence
_____ Anxiety, nervousness, fears
_____ Depression
_____ Sexual concerns
_____ Angry, hostile feelings
_____ Traumatic experience
_____ Sexual concerns
_____ Eating or appetite problems
_____ Alcohol or drug problems
_____ Sleep problems
_____ Parent–child problems
_____ Survivor of abuse or neglect
_____ Other: ________________________

_____ Family conflicts or pressures
_____ Friendship conflicts
_____ Relationship concerns
_____ Shyness, being assertive
_____ Loneliness
_____ Procrastination or motivation
_____ LGBT concerns or exploration
_____ Suicidal feelings or behaviors
_____ Stress
_____ Excessive gaming or Internet use
_____ Health problems
_____ Self-control
_____ Work or career concerns

Please put a *second* check next to those that are of *particular* concern to you right now.

Have you had thoughts about suicide in the past month? ____________________________________

Any previous attempts of suicide? ____

Have you had thoughts about harming other people, animals, or property in the past month?

____

Please list the members of your immediate family (include parents, siblings, spouse/partner, children, and all others in your home) and others who are of a significant relationship to you:

Name	Relationship	Age	Occupation	City/State

Emergency Contact: Please list an emergency contact below. This contact will only be used if I believe that you or someone else is in immediate danger or if you become ill and unable to continue or depart therapy without assistance. Emergency Contact's
Name:______________________________ Relationship_________________________
Address:
____
Phone Number: ______________________________
Please initial your agreement for me to contact the above named person under emergency conditions. ________

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REQUEST AND AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________________, request and authorize:

______________________________________ ____________________
(Name) (Phone)

____
(Address)

____

to release to: Jamie Justus, LCSW; 1310 South 1st St, Suite 200, Austin, TX 78704; (512) 940-7591

the following information: ____

____

This disclosure is made for the following purpose: ____

____

Furthermore, I authorize Jamie Justus, LCSW to discuss information that is relevant to my treatment with the individuals or agencies named above. I authorize Jamie Justus to release any medical, psychological, or other information necessary to my insurance company (Blue Cross Blue Shield) in order to process any insurance or managed care claims or to request pre-authorization for treatment. I authorize payment of medical benefits to Jamie Justus for all mental health services provided. I specifically authorize the release of information pertaining to drug and alcohol abuse and/or HIV testing if such information is a part of the record.

I make this request and authorization of my own free will. I understand that my mental health records constitute privileged information that is protected by the laws of the State of Texas. I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by providing written notice to the above named individuals. I understand that this consent remains in effect until specifically revoked by me in writing. I understand that any revocation will not be effective to the extent that Ms. Justus has taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Signed: ____ Date Signed: ____________________

Printed Name: __________________________________

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CONFIDENTIAL CLIENT INFORMATION FOR IN-NETWORK INSURANCE PAYMENTS ONLY

Date: ______________________

Client's Name ________________________________ Date of Birth ____________

Address ____

City / State / Zip ____

Insurance Company ______________________Subscriber/Benefits ID Number _______________________

Group Policy Number (if applicable) ____________________________

Insured's Name (fill out if insured is different than client)
____

Insured's Date of Birth _________________________ Relationship to Client ______________________

Insured's Address ____

City / State / Zip ____

Insured's Employer
____

Pre-authorization number (if one has been provided to you): ____________________________________

If you have another health insurance plan, please provide the following information below:

Insurance Company _______________________Subscriber/Benefits ID Number ______________________

Group Policy Number (if applicable) ____________________________