Progressive & Innovative Counseling Services
5618 White Bluff Road, Suite B&C
Savannah, Ga 31405

Phone (912)231-7031 or Fax (912)250-6025

Date: __________________

Name: ____ SSN: ________________________________

Date of Birth: _________________________ Age: _____ Gender: _______ Race/Ethnicity: ____________

Address: ____ Phone: ________________________

City: ____ State: __________ Zip: _______________________

Employer: ____ Work #: ________________

Employer Address: _______________________________ City/State/Zip: ___________________________

Previous Treatment: ____________ Provider's Name: ____

Referred by: Friend______ Relative______ Doctor______ Therapist_____ Other____________________

Medications: ____

Emergency Contact: ____

Name: ____ Relationship: _________________

Phone: (H)__________________________ (W)_______________________ (C)________________________

Person Responsible for the Bill (if different from above): ____

Name: ____ SSN #: _________________________________

Date of Birth: ____________________ Age: _____ Gender: ______ Race: ___________________________

Address: ____ Home Phone: ________________________

City: ____________________________________ State: _______ Zip: _____________________________

Employer: ______________________________________ Work #: _________________________________

Clinician of choice: ____

Would you like a holistic approach?

- Yes
- No

Email: ____

Primary & Billing Address:
Dr. Crystal Malloy, PHD, LPC, MAC, CEAP
174 Scholar Road
Guyton, GA 31312

Telephone: (912)231-7031
Fax: (912)250-6025

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Insurance Coverage

Date: ______________

Patient Name: ____ DOB: _____________________

Primary

Ins Co: ________________________________ ID#: _____________________ GRP: __________________

Insured's Name: ____ DOB: _____________________

Insured's SSN: ____ Tel#: (____)__________________

Employer's Name: ____

Address (if different from insured): ____

Claims Address: ____

____

EAP: Y ___ N ___ Number of sessions: ______ Auth#: ____

MOU/SOU: sign ____

Auth. Req'd: Y ___ N ___

Number of visits: _____per calendar/fiscal yr.

Co-Pay: _________ Deductible: ________ How much has been met: _________________________________

Network: In: ____ Out: ____ Percentage Ins: ____________

Patient: ________________________

Additional Information: ____

____

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Financial Responsibility

Your Insurance claim will be filed, and all reasonable efforts will be made to collect reimbursement from your insurance company; however, this does not release the patient, the guarantor or responsible party from financial responsibility for services rendered. If the insurance company fails to honor claims filed for services rendered, it is ultimately my responsibility to pay for the services render by Progressive & Innovative Counseling Services. Co-pays are due at the time services are rendered.

____ ____________
Signature patient or guardian or responsible party Date

Release and Assignment

I understand it is necessary to release my demographic information in order to process my insurance claims.

____ ____________
Signature of patient or guardian Date

Consent for Treatment

I consent, agree, and authorize evolution and treatment by Progressive & Innovative Counseling Services and I further confirm & acknowledge I reviewed the NOPP (Notice of Privacy Policy) outlining HIPAA, Hi-Tech act, and FCC compliance.

____ ____________
Signature of patient or guardian Date

Missed Appointment

I understand that I will be billed $65.00 for any appointments that I do not cancel 24-hours prior to the scheduled appointment.

____ ____________
Signature of patient or guardian Date

______ Check and initial ______ to consent receiving text reminders on my cell phone

______ Check and initial ______ to consent to receiving a reminder message on my home phone

______ Check and initial ______ to consent for the following individual to be involved, informed, or notified of my treatment/Name ______________________________________ Relationship ______________________

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Patient Assessment Index

Patient: ____

Your active participation in the treatment planning process is essential if you expect to gain the most from your treatment experience. Therefore, it is important that you spend some time thinking about what it is that you want out oof treatment. You may want to change certain behaviors or address prior personal issues. To help you identify your treatment goals, and to assist your counselor in their effort to work with you in achieving those goals, please take the time to answer this questionnaire thoughtfully. Read it over first, then complete it and return to your counselor who will utilize it in conjunction with other documents to formulate an individual treatment plan with you.

Please read each area of concern listed below and place a check by any goal, which is of importance to you.

- Overcoming my desire to use drugs.
- Overcoming my desire to use alcohol.
- Becoming more motivated towards self-betterment.
- Improving my relationship with my spouse or significant other.
- Improving my relationship with my children
- Improving my relationship with (other): _________________________
- Using my leisure time better.
- Learning how to make new friends.
- Becoming more open as a person to others.
- Becoming less critical and fault finding.
- Learning how to forgive myself and others.
- Resolving resentments.
- Learning how to communicate responsibly.
- Learning how to control my temper.
- Getting rid of angry feelings.
- Feeling less depressed.
- Dealing with suicidal feelings.
- Overcoming anxiety provoking thoughts.
- Learning new ways of filling the emptiness I feel inside.
- Developing more self-confidence.
- Learning how to make decisions.

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Stressors

Are you experiencing significant changes, loss, or difficulties in the following areas?

Financial	Y N U
Primary relationship (family/friends)	Y N U
Housing	Y N U
Physical health of self or family member	Y N U
Access to health care	Y N U
Occupational/employment	Y N U
Legal	Y N U
Education	Y N U

Other ____

Education

How many years of schooling have you completed? ____
Do you hold any degrees or diplomas and if so, which? ____
Do you now, or have you ever had a learning disability? ____
If so, what was the disability? ____

Employment

Are you currently employed? Y N U
Occupation/employer ____
Are you satisfied with your present job? Y N U
Do you think your employer satisfied with your job performance? Y N U

Religion

Do you have a religious preference? Y N U
If yes, describe ____
Are your spiritual beliefs an important part of your life? Y N U

Legal

Have you ever been arrested/incarcerated? Y N U
If yes, describe ____
Are you currently on probation/parole? Y N U
If yes, who is your probation officer ____

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Burn's Depression and Anxiety Inventory

Over the last two weeks, how often have you been bothered by any of the following problems? *

0=not at all   1=several days   2=more than half three days   3=nearly every day

1. Little or no interest or pleasure in doing thing. 0 1 2 3
2. Feeling down, depressed, hopeless. . 0 1 2 3
3. Trouble falling asleep/staying asleep/sleeping too much. 0 1 2 3
4. Feeling tired or having little energy. 0 1 2 3
5. Poor appetite or overeating. 0 1 2 3
6. Feeling like you're a failure or you have let others down. 0. 1 2 3
7. Trouble concentrating such as when reading or watching tv. 0 1 2 3
8. Moving or speaking so slowly that others may have noted, or being more fidgety or restless than usual 0 1 2 3
9. Thoughts that you'd be better off dead/hurting yourself in some way. 0 1 2 3

- Trouble with everyday decisions. 0 1 2 3
- Trouble with important decisions 0 1 2 3
- Feeling guilty about things that have happened in the past. 0 1 2 3
- Difficulty stopping tears/crying. 0 1 2 3
- Engaging in one or more self-destructive activities. 0 1 2 3
- Thoughts of killing or harming another. 0 1 2 3
- Hurting others with your words and/or actions. 0 1 2 3
- Experiencing sexual problems. 0 1 2 3
- Criticizing yourself/getting down on yourself. 0 1 2 3
- Going for days without needing sleep. 0 1 2 3
- Experiencing extreme energy changes. 0 1 2 3
- Worrying a lot/unable to relax. 0 1 2 3
- Difficulty going places by yourself. 0 1 2 3
- Avoiding (nonfamily) situations. 0 1 2 3
- Experiencing panic attacks. 0 1 2 3
- Making impulsive decisions or increased risk-taking. 0 1 2 3
- Experiencing recurrent distressing dreams. 0 1 2 3
- Experiencing recurrent intense memories of a traumatic event. 0 1 2 3
- Finding it difficult to control your irritability or anger. 0 1 2 3
- Hearing or seeing things that others do not see or hear. 0 1 2 3
- Feeling that people are out to get you. 0 1 2 3
- Experiencing harm or harmful intentions from others. 0 1 2 3
- Difficulty interacting with others. 0 1 2 3
- Experiencing intense moods and mood swings. 0 1 2 3
- Trying to please others to the detriment of your own needs. 0 1 2 3
- Engaging in excessive checking/hoarding/cleaning. 0 1 2 3

*If you checked any of the above, circle the difficulty level these problems have created for :

Work/Taking care of things at home

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult