INSTRUCTIONS

Enclosed in this document you will find the following forms:

1. Client Information Sheet
2. Patient Request for Confidential Communications
3. Patient Signature Page

Please print, read and complete all of the forms and bring them to your first session with Dr. Berry.

Client Information Sheet

Your Name:	
Your Email:	
Your Nickname: *Please tell me what you prefer to be called.*	
Your Home Address:	
Your Cell Phone Number:	
Your Home Phone Number:	
Your Occupation:	
Your Place of Employment:	
Your Medications:	
Your Date of Birth:	
Your Social Security #:	

Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ In a committed relationship
Permission to Contact:	*Do you give me permission to contact you via email for scheduling and a simple check-in between appointments?*			☐ Yes ☐ No

Who referred you to this practice?	
Major issues with drugs or alcohol*: If yes, please explain.*	
Reasons for Coming in: *Please be brief.*	

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I, Dr. Karen Berry, assume that I may contact you by telephone at your home and at your work, and in writing at your home, unless you instruct me otherwise.

Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. I will approve your request if in my opinion it is reasonable. Once I agree to your request, I am obligated to honor it, except if an emergency arises. I wish to be contacted as follows (check all that apply):

☐ At my home telephone number:_____
____You can leave messages with detailed information
____ Leave message with call-back number only

☐ At my cell phone number: _____

☐ In writing at my home address: :_____
_____

☐ Email Address:_____

_____ _____
Signature of Patient Date

_____
Print Name

Approved:

_____ _____
Signature of Healthcare Practitioner Date

PRIVATE PRACTICE POLICIES

I have read the Private Practice Policies carefully and I understand and agree to comply with them.

Print Name_____

Signed_____ Date_____

INFORMED CONSENT FOR INDIVIDUAL THERAPY

I have read the Informed Consent to Individual Psychotherapy carefully and I understand and agree to comply with the policies.

Signature: _____ Date: _____
(of patient or person authorized to consent for patient)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OF KAREN W. BERRY, Ph. D.

I hereby acknowledge that I have received the Notice of Privacy Practices of Karen W. Berry, Ph.D. effective April 15, 2005.

Print Name(s) _____
Signed_____ Date_____