Confidential Client Information Form

Contact Information

Date:

Name:

Street Address: OK to send mail?

City/State/Zip: ☐ Yes ☐ No

D.O.B./place:

	OK to call?		OK to leave message?	
Home phone:	☐ Yes	☐ No	☐ Yes	☐ No
Cell phone:	☐ Yes	☐ No	☐ Yes	☐ No
Work phone:	☐ Yes	☐ No	☐ Yes	☐ No

OK to email?

Email: ☐ Yes ☐ No

Please provide a name and phone number of whom to call in case of an emergency:

Client Information Form

Receipt Information

Will you be requesting a bill? If yes, please choose one:

☐ Bill is for insurance (requires a diagnosis, and we will discuss this).

☐ Bill is for flex spending (no diagnosis required).

Demographic Information

Sex:

Gender:

Your Gender Pronoun(s):

Sexual Orientation(s):

Ethnicity:

Disability Status:

Partner(s)/relationship:

Occupation/Employer:

Referral Information

Who referred you to me or how did you hear of my practice?

Current reason(s) for seeking therapy:

Client Information Form

Estimate the severity of the problem for which you are seeking care:

☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

How many sessions or how much time do you think you might need to successfully resolve this problem?

☐ 1 – 10 sessions ☐ 20 or more sessions

☐ 10 – 20 sessions ☐ ongoing, longer-term therapy

Health Information

Have you ever been hospitalized? (If yes, please provide details):

Are you currently taking any medications? (Please list names, dosages, and prescribing doctor.):

Have you previously been in psychotherapy?

When and for what issues?

Was it helpful? (Why or why not?)

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (Indicate age, circumstances, and whether it led to hospitalization or legal problems).

Please list any past/present drug and alcohol use. What have you used and how much? What are you currently using and how much? Has it ever affected your work or your relationships?

Relationships

Do you live with others? What is their relationship to you?

Present Spouse/Partner(s) (first name(s), occupation(s), how would you describe your relationship satisfaction?):

Are there any other current relationships that are a significant focus in your life right now? Please describe:

Keely Kolmes, Psy.D. 1904 Franklin Street, Suite 415, Oakland, CA 94612 (415) 501-9098
Website: http://drkkolmes.com Email: drkkolmes@hushmail.com

Other

What are your main worries or fears?

What do you consider your main strengths?

What are your primary challenges right now?

What are your most important hopes or dreams?

Please add any additional information that may be helpful to our work together.

Follow Up

To help me continue my development as a clinician, I send a brief survey to clients 4-6 weeks after they have ended treatment with me.

Completing this form is optional and anonymous. Please choose one of the following:

☐ Please email me the link to the form. I understand that I can decide at that time whether or not I wish to complete it.

☐ Please opt me out of receiving this form. I do not wish to receive it.

I am also interested in whether you are able to maintain your treatment goals when you complete therapy with me. I would like to send a brief form to check in with you a year after you finish treatment.

Please choose one:

☐ You are welcome to contact me one year after I complete therapy to check in on how I am doing. I understand that I can decide at that time whether or not I wish to respond.

☐ Please opt me out of the one-year follow up.

Keely Kolmes, Psy.D.

CA License: PSY21284

I use practice management software to consolidate several aspects of my practice. This is a product called Simple Practice, and it is a HIPAA-compliant, cloud-based software product. The pros of my using this product are that I will be able to access your data from anywhere. If I am traveling and you need a copy of your superbill or a change to your schedule, I will be able to access your data wherever I am. The cons of my using this product are that as opposed to using paper, there is the potential for loss of data or data breaches. Of course, if I learn of any such breaches, I will notify you immediately.

Since I respect and understand that people have varying preferences and concerns about paper vs. electronic storage, I still keep paper charts for anyone who prefers that option. This consent form serves to document your choices, including the ability to opt-into the cloud storage software at different levels. You may also change your mind about this at any time. If I have kept digital copies of your chart, you may decide later that you prefer paper charts and I can print your information and delete your record.

Please feel free to ask me any questions you have, and also to give this additional thought if you need more time to make a decision.

For those who want to only have paper records:

☐ I prefer to have all my data on paper. Please do not create a record for me in Simple Practice.

For those who wish to opt-into electronic storage at one or more of the following levels (check all that apply):

☐ I am comfortable with you keeping my contact information and calendar information on Simple Practice.

☐ Keep my psychotherapy notes on Simple Practice.

☐ Please send me appointment reminders.

I prefer to have the reminders sent via:

☐ Text
☐ Email
☐ Voice

I prefer to get these reminders (choose one):

☐ 24 hours before the session
☐ 48 hours before the session
☐ 72 hours before the session

☐ Include my financial information on Simple Practice & use it to create Superbills (this will include your diagnosis if you use insurance).

☐ Automatically bill my credit card for my sessions*. (*This card will be charged for no shows or late cancellations with less than 48 hours' notice.

CC #: ____________________________ Expiration month/year: ______________________ CVC: ______________

_____________________________________ ____________________

printed name date

_____________________________________ ____________________

signed name date

Emergency Planning Consent

In case I am suddenly unable to continue to provide professional services or to maintain client records due to incapacitation or death, I have designated a colleague who is a licensed Social Worker as my professional executor.

If I die or become incapacitated, my professional executor will be given access to all of my client records and may contact you directly to inform you of my death or incapacity; to provide access to your records; to provide psychological services, if needed; and/or to facilitate continued care with another qualified professional, if needed.

My professional executor is Avry Todd, LCSW. I have also designated Dr. Meg Stein as a back up. If either Mx. Todd or Dr. Stein has a conflict of interest with you, they will have another professional manage your records.

If you have any questions or concerns about this professional executor arrangement, I will be glad to discuss them with
you.

I have read and understood the above:

______________________________________ ____________
Signature Date

______________________________________ ____________
Signature Date

Acknowledgement of Notifications

I acknowledge the receipt of both Dr. Kolmes's Office Policies and Agreement for Psychotherapy Services and Dr. Kolmes's Social Media Policy and I understand and agree to comply with these policies. I understand that these policies will always be available to me on Dr. Kolmes's website but that I may always request a hard copy if I am unable to access them.

I understand that Keely Kolmes, Psy.D., is a licensed psychologist (PSY21284) In the state of California.

I also acknowledge the receipt of the HIPAA Notice of Privacy Practices for my review. I understand that the HIPAA form will remain available on Dr. Kolmes's website but that I may always request a hard copy if I am unable to access it.

______________________________________ ____________
Signature (Client 1) Date

______________________________________ ____________
Signature (Client 2) Date

______________________________________ ____________
Signature (Client 3) Date