Dr. Daniel Chorney & Associates

Psychological Services

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Thank you for choosing Dr. Daniel Chorney & Associates. We want to make the most of our time together, and one way of doing so is for you to write down some basic information in advance of coming to your first appointment. Please fill out the following form as completely and legibly as possible. This information will be kept confidential after you bring it to your first appointment. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Your full name: _____ Date of Birth: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ OK to Call Work (Circle): **Yes/No** Leave a Message? **Yes/No**

Email Address: _____ OK to email? **Yes/No**

Education: (grade completed, any postsecondary): _____

Current Occupation: _____

Person to alert in the event of a medical emergency: _____

Relationship to you: _____ Phone #: _____

Family Doctor: _____ Phone #: _____

Relationship Status (Circle One): Single Married Partnered Separated Divorced Widowed

Spouse/partner's name (if applicable): _____

Children (name/gender/age): _____

In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. Use additional paper if you like:

_____

_____

_____

Family of Origin

Where were you born: _____

Where were you raised (City/Town): _____

Parent's First Name: Parent's First Name:

Type of work/profession: Type of work/profession:

(Circle one) Living / Deceased Circle one): Living / Deceased

Siblings:	First Name	Age	Where Living
	_____	____	_____
	_____	____	_____

Work History:

Briefly describe your work history (if applicable):

Describe your current position(s) and feelings towards your work/job:

Social History:

What activities do you currently take part in for enjoyment/pleasure?

How do you like to spend your free time?

Please describe what others see as your strengths:

Please indicate any history of legal problems (if applicable):

Medical History:

Please describe any significant current or past medical problems or health conditions:

_____

_____

Any history of the following: Seizures: **Yes / No** Strokes: **Yes / No** Head injury: **Yes / No**

Please list any medications you currently take. Include prescription and over-the-counter medications **and** the dosage of each:

_____

_____

Have you had any previous psychological care or counseling? Yes _____ No _____

If yes, please give the name of the clinician(s), the approximate months you were seen (e.g., Oct '09 – Feb '10), and the nature of the difficulty at that time:

_____

_____

_____

Have you ever been hospitalized for a psychological difficulty? Yes _____ No _____

If yes, please give the approximate dates and the nature of the difficulty at that time:

_____

_____

Goals For Current Treatment:

Cognitive-behavioral therapy is most effective when driven by a goal or direction. To be most effective, this goal is clear and specific, and something that can be measured. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your clinician. Feel free to list more than one goal if you wish and/or use additional paper if you like.

_____

_____

_____

Family History:

A review of family history if often extremely helpful in understanding both the biological and environmental causes of certain behavioral problems. Please think about parents, siblings, grandparents, aunts/uncles, and cousins as you fill in the table below:

Family Mental Health History		
Please check the item (middle column) if you suspect or know that a family member has or had any of the following. Please indicate the relation to the yourself in the final column.		
Illness or Problem	**X**	**Relation to You**
Attention Problems (e.g. "ADD")		
Hyperactivity (e.g., "ADHD")		
Significant anger management difficulties		
Learning Disability		
Tics or Tourette's Disorder		
Special Education services		
Developmental Disability/Cognitive delay		
Autism Spectrum Disorder/Asperger's		
Depression		
Bipolar Disorder (e.g., "Manic Depression")		
Schizophrenia		
Suicide or Suicide Attempts		
Deliberate self-harm		
Psychiatric Hospitalization		
Obsessive-Compulsive Disorder		
Severe Anxiety/Phobias/Fears		
Panic Attacks/Panic Disorder		
Eating Disorder (Anorexia/Bulimia/Bingeing)		
Alcoholism		
Drug/Substance Abuse		
Victim of Abuse		
Post-Traumatic Stress Disorder		
Legal Problems/Law-breaking behaviors		
Other (please write in below):		

Questions:

What are some of the questions you have prior to coming in that you would hope to have answered during your first visit?

1.

2.

3.

Referral Information:

How did you hear about our practice? Please provide additional information where indicated:

- ☐ Word of mouth: _____
- ☐ Physician:_____
- ☐ Web Search:_____
- ☐ Other Practice:_____
- ☐ Teacher/Guidance Counselor:_____
- ☐ Professional Directory:_____
- ☐ Public Talk/Presentation:_____
- ☐ Other:_____

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Cancellation/Late/No-Show Policy

Appointment times are reserved exclusively for you, and without sufficient notice we can not provide that time to other individuals and families who may benefit from that time. Our online booking software can send reminder emails and text messages that allow for multiple opportunities to cancel or reschedule your appointment if necessary.

1. We require **48hrs of notice** for no administrative fees to be charged for cancelled/missed appointments.

2. Appointments cancelled with **less than 48 hours notice** will be charged 50% of the session rate of the time reserved for you (regardless of reason for cancellation).

3. Appointments cancelled with **less than 24 hours** of notice or "no-show" appointments will be charged the full session fee ($200 for recurring appointments, $300 for initial appointment).

4. Any receipt issued for a missed appointment will clearly indicate "Missed Appointment" as many insurance providers will not provide coverage for missed appointments.

5. I understand that in order to remember my appointment time(s), I can do any of the following:

    a. Ask for an appointment reminder card to be filled out for me at clinic visits
    b. Call (902) 444-1160 and ask my provider when my next appointment is
    c. Email my clinician directly (emails are found on www.chorneyandassociates.com) to inquire about my next appointment time

I have read and agree to the above cancellation policy. ☐
(Initials)

_____ _____ _____
(Clients Signature) (Client's Printed Name) (Date)

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Client Information and Consent to Services

Services

Psychologists at Chorney & Associates provide a range of psychological services which may be customized to meet your specific needs or the needs of your family. We provide services to children, adolescents, adults, and families. Please note that no psychologist at this practice specializes in custody evaluations, parental alienation concerns, or parental capacity assessments. To provide the best quality of care to our clients, parents in legal/divorce/custody proceedings should be aware that we would not provide any legal opinions about the capabilities of either parent unless required by law. Emergency psychological services are not provided and should be addressed by your local emergency department or by calling police/ambulance/emergency services (e.g., 9-1-1).

Fees

Psychological services are billed at the rate of $200.00 per therapy hour (50 minute session, with 10 minutes devoted to chart review and progress notes). Additional time and other services pertinent to your care are charged on a prorated basis. Examples of this include longer session times (e.g., if 1.5hrs is needed or desired), report writing, attendance at meetings or school visits, extended correspondence via email, and/or phone calls in excess of 15 minutes. The Initial Evaluation is typically 1.5 hours in length ($300) given the time to review your records and background, review confidentiality and consent, discuss your current situation in detail, and establish goals for treatment. We accept a variety of payment options, including: Interac/debit, VISA, MasterCard, and cash payments. Credit card information can also be stored on our online practice management software ("JANE") if you request this. Cheques are currently not accepted. Upon payment prior to your session, a receipt will be provided to you for reimbursement/tax purposes.

Insurance

Psychologist's fees are not covered under the Nova Scotia's MSI Plan. Many private extended health care plans cover part, or a significant portion of psychological services. Please talk to your insurance provider directly to see what your specific plan covers. At this time we do **not** offer direct billing to insurance companies, therefore, regardless of third-party coverage we require payment in full prior to beginning each session.

Cancellation/Late/No-Show Policy

Appointment times are reserved exclusively for you, and without sufficient notice we can not provide that time to other individuals and families who may benefit from that time. Our online booking software can send reminder emails and text messages that allow for multiple opportunities to cancel or reschedule your appointment if necessary. We require **48hrs of notice** for no administrative fees to be charged for cancelled/missed appointments.

Appointments cancelled with **less than 48 hours notice** will be charged 50% of the session rate of the time reserved for you (regardless of reason for cancellation). Appointments cancelled with **less than 24 hours** of notice or "no-show" appointments will be charged the full session fee ($200 for recurring appointments, $300 for initial appointment). Receipts issued for missed appointments will state "Missed Appointment."

Confidentiality and Privacy

Please note that the use of our online practice management, charting, and scheduling software (Jane | janeapp.com) results in your treatment chart and Personally Identifiable Information/Protected Health Information (PII/PHI) being stored in secured Canadian based data storage servers.

All discussions with a psychologist are strictly confidential and your privacy is important to us. No information will be released to third parties without your explicit consent, except where required by law or in situations where the psychologist is ethically and legally required to disclose information to others without your consent. The following are examples of when your information may be released **without** written consent:

1. When an individual poses potential or **threatened harm to themselves OR to others** (in this circumstance the psychologist will act to protect the person(s) in danger by informing police, medical personnel, parents/caregivers, or other relevant individuals who may assist).
2. Suspicion of or risk of **child abuse** (psychologists are mandated reporters and required to report relevant information the Department of Children's Services).
3. Suspicion of **adult/elder abuse** (physical, sexual, and/or mental cruelty to anyone over 16 at risk of being abused due to physical or mental disability that impedes their ability to care for themselves).
4. In the event your information is **subpoenaed by a judge** or court of law in the case of legal proceedings.
5. If services are **being paid by a third-party** (e.g., insurance), certain information may be disclosed (e.g. dates/time of service, who was present, fees charged).
6. Internal **consultation** amongst psychologists within Chorney & Associates Psychological Services.

Consent to Treatment

In order to voluntarily provide consent to treatment, an individual should understand **1)** the nature of the assessment and treatment, **2)** the potential benefits, risks, and side effects of treatment, and **3)** any reasonable alternatives to treatment (including refusal). It is important to note that consent is an ongoing process and you have the right at any time to ask questions about your treatment or terminate your treatment at this clinic.

> ***Adolescents.*** In the case the individual consenting to treatment is an adolescent, consent to treatment is obtained on a case-by-case basis and the consent/signature of a legal guardian or parent may be required depending on the ability of the adolescent to understand the points listed above. In most cases, privacy is protected to ensure the adolescent feels able to share confidential information (including drug use, lying, or sexual behavior) and this information will remain confidential unless a significant risk of harm to themselves or to others is revealed.

By signing below, I agree that I have read (or had read to me) and agree to all items with the Client Information & Consent form. I have discussed and asked questions about any portion of the form I find unclear or unacceptable, and have had my questions, if any, answered. I agree to act in accordance with the points and information listed above, and by signing I consent to taking part in both assessment and treatment with the provider named below.

_____ _____

(**Client** Signature) (**Client** Printed Name)

_____ _____

(**Clinician** Signature) (**Clinician** Printed Name)

_____

(**Date**)