Jennifer Harned Adams, PhD
Licensed Psychologist
222 Milwaukee Street, Suite 211
Denver, CO 80206
303.325.1633
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www.boomhealthdenver.com

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Health & Wellness Services
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Client Information Form

Today's date: _____

Your name: _____ Date of birth: _____ Age: _____
Preferred Name: _____
Home street address: _____ Apt.: _____
City: _____ State: _____ Zip: _____
Preferred phone: _____ e-mail: _____
Calls or e-mail will be discreet, but please indicate any restrictions: _____

Referral Information: Who gave you my name to call?
Colorado Reproductive Endocrinology: ___ Dr. Woodford ___Dr. Trout

Other provider: _____

Internet Search: ___ Google ___ Psychology Today ___Good Therapy
_____ RESOLVE ___ ASRM ___I don't know
___ Other: _____

Emergency information
If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: _____ Phone: _____ Relationship: _____

Your medical care: From whom or where do you get your PRIMARY medical care?
Clinic/doctor's name: _____ Phone: _____
Date of last physical/medical exam: _____

Your current employer
Employer: _____Occupation: _____

Religious and racial/ethnic identification
Current religious affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Ethnicity/national origin/ Race/ or other similar way you identify yourself and consider important:_____

Education and Employment History

High School (Name and City): _____ Graduate? ❑ No ❑ Yes _____ (year)
Vocational Training (if applicable): _____ Graduate? ❑ No ❑ Yes _____ (year)
College (if applicable): _____Graduate? ❑ No ❑ Yes _____ (year)
Graduate Studies (if applicable): _____ Graduate? ❑ No ❑ Yes _____ (year)

Did you ever have any significant educational concerns or support, such reading support, speech theapy, repeat or skip a grade, or receive gifted services? If so, please describe: _____
_____

Please list the three most recent occupational or volunteer positions you have held:

Dates	**Position (indicate PT/FT)**	**Organization**	**Reason for leaving**
1.			
2.			
3			

Family-of-origin history

Relative	**Name**	**Current age** *or age at death & year*	**Health Concerns** *or cause of death*	**Relationship Status**
Mother				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Father				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Sibling				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Sibling				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Sibling				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Other important relative				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA
Other important relative				❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress/not speaking ❑ NA

Significant Adult Relationship History

Relationship	Partner's First Name	Relationship status	Reason for break-up
Current or Most recent		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ NA/ ended	❑ NA - current

Children

Name	DOB/Current Age	Relationship Status
		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ estranged
		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ estranged
		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ estranged
		❑ Satisfactory ❑ A source of mild stress ❑ A source of major stress ❑ estranged

HEALTH HISTORY

Please list any major illness, important diagnoses (ie, autoimmune diseases), injuries and surgeries below. Continue on the back of this sheet if you need more space.

Health Concern	Date/Age	Still an active problem?	Impact on life today
		❑ yes ❑ no	❑ no impact ❑ mild impact ❑ moderate impact ❑ major impact DESCRIBE: _____
		❑ yes ❑ no	❑ no impact ❑ mild impact ❑ moderate impact ❑ major impact DESCRIBE: _____
		❑ yes ❑ no	❑ no impact ❑ mild impact ❑ moderate impact ❑ major impact DESCRIBE: _____
		❑ yes ❑ no	❑ no impact ❑ mild impact ❑ moderate impact ❑ major impact DESCRIBE: _____

Health habits

What kinds of physical exercise do you get? _____
_____

Have you ever tried to restrict your eating in any way?
When? _____

How? _____

Why? _____

Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems? _____
_____

For women

At what age did you start to menstruate (get your period): _____

Menstrual period experiences:

a. How regular are they? _____

b. How long do they last? _____

c. How much pain do you have? _____

d. How heavy are your periods? _____

e. Other experiences during periods? _____

Please describe any pregnancies:

Your age	Pregnancy Loss (pls indicate gestational age at time of loss)	Termination	Live birth	Important information

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Mental Health Counseling or Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or relationship counseling services before?
❑ No ❑ Yes If yes, please describe below. Please include reason and age at time of services

Have you ever taken medications for psychiatric or emotional problems?
❑ No ❑ Yes If yes, please describe. Please indicate name of medication, dosage and age when taking (*to the best of your memory)*

Abuse history:
❑ I was not abused in any way.
❑ I was abused. Please describe:

Chemical/substance use
1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____.

How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____

How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes

7. How much beer,wine,or hard liquor do you consume each week,on the average? _____

8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ No ❑ Yes

9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes

If yes, which and when? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

Legal history

Do you have any significant CURRENT legal concerns? ❑ No ❑ Yes Describe: _____

Do you have any significant PAST legal concerns? ❑ No ❑ Yes Describe: _____

Please indicate any concerns you may have regarding using donor sperm. If your concern is not included here, please feel free to write it in below. Thank you!

❑ Disclosing conception to my future child
❑ Concerns related to religious beliefs
❑ Becoming a parent
❑ Mental health concerns during pregnancy
❑ Mental health concerns postpartum
❑ Answering questions from family/friends/acquaintances
❑ Concerns related to the impact this will have on my partner
❑ Concerns related to the impact this will have on me
❑ Health concerns about the pregnancy
❑ Other: _____

If you have other questions related to any aspect of this process, or related to any mental health or counseling issues, please indicate those here.

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Adult Checklist of Concerns

If you are experiencing any of the following concerns, and you'd like to discuss them today, or receive additional information/resources/referrals on any of these issues, please indicate below.

❑ I have no problem or concern bringing me here
❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
❑ Aggression, violence
❑ Alcohol use
❑ Anger, hostility, arguing, irritability
❑ Anxiety, nervousness
❑ Attention, concentration, distractibility
❑ Career concerns, goals, and choices
❑ Childhood issues (your own childhood)
❑ Codependence
❑ Confusion
❑ Compulsions
❑ Custody of children
❑ Decision making, indecision, mixed feelings, putting off decisions
❑ Delusions (false ideas)
❑ Dependence
❑ Depression, low mood, sadness, crying
❑ Divorce, separation
❑ Drug use—prescription medications, over-the-counter medications, street drugs
❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
❑ Emptiness
❑ Failure
❑ Fatigue, tiredness, low energy
❑ Fears, phobias
❑ Financial or money troubles, debt, impulsive spending, low income
❑ Friendships
❑ Gambling
❑ Grieving, mourning, deaths, losses, divorce
❑ Guilt
❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems
❑ Housework/chores—quality, schedules, sharing duties
❑ Inferiority feelings
❑ Interpersonal conflicts
❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility
❑ Judgment problems, risk taking
❑ Legal matters, charges, suits
❑ Loneliness
❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings
❑ Motivation, laziness
❑ Nervousness, tension
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems (see also "Career concerns ...")
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

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Disclosure Statement

Degrees, Licenses & Experience:

B.A.	Franklin and Marshall College, Psychology
M.A.	University of Houston, Psychology
Ph.D.	University of Houston, Clinical Psychology

Clinical Psychology Internship:
University of Texas Houston Health Sciences Center
Department of Psychiatry and Behavioral Sciences

Postdoctoral Training:
Postdoctoral Fellowship in Cancer Prevention
University of Texas M.D. Anderson Cancer Center

License: Colorado, Psychologist, #3123

I maintain a practice that includes treatment of adults seen as individuals, couples and in groups. My scope of practice encompasses a wide variety of difficulties and disorders including relationships, phase-of-life concerns, mood disorders, loss, trauma, and parenting and women's health issues. I will provide you with additional information about my past experience and areas of practice upon request.

I am a licensed psychologist in the State of Colorado, and the practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Colorado Department of Regulatory Agencies. The Psychologist Examiners Board is located at 1560 Broadway #1550, Denver, CO 80202, and may be reached by telephone at 303-894-7800. In a professional relationship, sexual intimacy between a therapist and client is never appropriate and its occurrence should be reported to the Board of Psychologist Examiners.

Confidentiality
Information provided by you to a psychologist in the course of an evaluation or treatment is privileged communication, which means it is legally confidential. In most cases information can be released to another individual only by written permission from you. However, there are certain exceptions to the confidentiality law (CRS 12-43-218). For example, if you become suicidal, or unable to care for yourself, I am legally required to ensure that you are safe and receive the care that you need. If I believe that you seriously intend to harm someone else, I am required to warn that person, and the appropriate authorities, to ensure that individual's safety (CRS 21-10-101 & 13-21-117). If a child or elderly person is suspected of being abused, I am required to report the abuse to the Department of Social Services (CRS 19-3-301).

I may discuss your case with a consultant, but your name or information which could specifically identify you will not be used. Another mental health professional may provide emergency coverage for me when I am out of town; however, I will not share information with them about you unless there is a specific need which I have already addressed with you.

Sperm Donor Consultation: Methods, Duration, & Cost

For consultation services, I typically meet with couples for approximately 90 minutes, during which time we will review the packet you've completed and discuss common concerns of couples going through this process. The intent of this appointment is to simply help you think through circumstances that often arise for families with children conceived by donor sperm, and to offer you and your partner a forum to discuss these in a productive way.

My fee for this consultation is $175, which may be paid in cash, check or by Visa/MC. This fee includes the appointment, a letter to your clinic, and a list of resources that may be helpful based upon topics discussed during our meeting. **If you cancel with less than 24 hours notice, or no-show to our appointment, you will be charged.** In case of accident or illness which onset less than 24 hours before the appointment, call to cancel your session as soon as possible. In general, I do not charge for phone consultation, unless there are unusual circumstances. Should phone charges occur, I will discuss this with you.

I understand and agree that no doctor–patient or therapist–client relationship exists or will be created between myself and the evaluator. I understand that I may withdraw my consent to this evaluation and to the transfer of information at any time by means of a written letter. However, I also understand that my withdrawal will not be retroactive (that is, it will not apply to testing and information transfer that have already taken place). If I do not withdraw my consent, it will automatically expire in 90 days from the date I signed this form.

Electronic Communication

My email address is : jenniferharnedadams@me.com. Feel free to email me regarding administrative concerns, such as cancellations and scheduling changes. Please do not discuss confidential information in email, as email is not a secure method for private communication. Please do not use email as a method of contacting me in the event of an emergency.

Emergency Contact Options

You can reach me by my cell phone at 303-325-1633. I will return all voice mail messages as soon as possible. If you are in emergent need and unable to reach me, call 911, or go to the nearest hospital emergency room

Your rights

At any time, you may question and/or refuse therapeutic or diagnostic procedures or methods or request additional information regarding procedures. Please do not hesitate to discuss any concerns and/or complaints with me so that we can work toward a resolution. Concerns can also be brought to the attention of the Colorado Department of Regulatory Agencies.

Consent to Treatment

I consent to participation in consultation services with Jennifer Harned Adams, Ph.D. and I agree to the policies of her practice as detailed in the above paragraphs. I have had the opportunity to ask questions and clarify my understanding of these policies and there are no misunderstandings or disagreements. I have been given a copy of this document for my own records.

_____ _____

Client Signature Date

I have reviewed the above policies and informed consent with the patient and there is no misunderstanding or disagreement.

_____ _____

Jennifer Harned Adams, Ph.D. Date

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Notice Of Privacy Practices
Effective March 1, 2009
As required by the privacy regulations created as a result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. My commitment to your privacy:
My practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *Protected Health Information*, or PHI). In conducting my business, I will create records regarding you and the treatment and services I provide to you. I am required by law to maintain the confidentiality of health information that identifies you. I am also required by law to provide you with this notice of my legal duties and the privacy practices that I maintain in my practice concerning your PHI. By federal and state law, I must follow the terms of the Notice of Privacy Practices that I have in effect at the time.

I realize that these laws are complicated, but I must provide you with the following important information:
- How I may use and disclose your PHI,
- Your privacy rights in your PHI,
- My obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by my practice. I reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that my practice has created or maintained in the past, and for any of your records that I may create or maintain in the future. My practice will post a copy of my current Notice on my website (www.bloomhealthdenver.com) at all times, and you may request a copy of my most current Notice at any time.

B. If you have questions about this information, please discuss it further with me. If you feel your privacy rights have been violated by me, please contact:

Office of Civil Rights
US Department of Health and Human Services
1961 Stout Street, Room 1426
Denver, CO 80294
303-844-2024
303-844-20225-Fax

C. I may use and disclose your PHI in the following ways:
The following categories describe the different ways in which I may use and disclose your PHI.
1. Treatment. Treatment refers to the provision, coordination, or management of healthcare including mental health related to one or more providers. The information provided to insurance and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

2. Payment. My practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, I may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, I may use your PHI to bill you directly for services and items. I may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Contacting the Client. I may contact you to remind you of appointments and to tell you about treatments or other services which may be of benefit to you.

4. Health Care Operations. My practice may use and disclose your PHI to operate my business. As examples of the ways in which I may use and disclose your information for my operations, my practice may use your PHI to evaluate the quality of care you received from me, or to conduct cost-management and business planning activities for my practice. I may disclose your PHI to other health care providers and entities to assist in their health care operations.

5. Disclosures required by law: My practice will use and disclose your PHI when I am required to do so by federal, state or local law. This includes but is not limited to: reporting child abuse or neglect, when court ordered to release information, when there is a legal duty to warn or take action regarding imminent to danger to others, when the client is a danger to self or others or is gravely disabled, when required to report certain communicable diseases and certain injuries; and when a Coroner is investigating a client's death.

6. Health Oversight Activities. My practice may disclose your PHI to a health oversight agency for activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, and regulatory programs or determining compliance with program standards.

7. Crimes on the Premises or Observed by me: Crimes that are observed by me or directed at me or occur at my business location will be reported to law enforcement.

8. Involuntary Clients: Information regarding clients who are being treated involuntarily pursuant to law, will be shared with other treatment providers legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

9. Family Members: Except for certain minors, incompetent clients or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, you object, PHI will not be disclosed.

10. Emergencies: In life threatening emergencies, I will disclose information necessary to avoid serious harm or death.

11. Client Authorization to Release of Information: I may not use or disclose PHI in any other way without a signed Authorization or Consent to Release Information. When you sign a consent to release information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent I have already taken action in reliance thereon.

D. Your Rights as a Client:

1. Access to Protected Health Information (PHI): You have the right to inspect and obtain a copy of the PHI information that I have regarding you and the record. There are some limitations to this right, which will be explained to you at the time of your request, if such a limitation applies. To make such a request, please talk to me.

2. Amendment of Your Record: You have the right to request that I amend your PHI. I am not required to amend the record if it is determined that the record is accurate and complete. When there are other exceptions, which will be provided to you at the time of your request, along with an appeal process.

3. Accounting of Disclosures: You have the right to receive an accounting of certain disclosures that I have made regarding your protected health information. That accounting does not include disclosures that were made for the purpose of treatment, payment, or healthcare operations. There are other exceptions that will be provided to you, should you request an accounting.

4.Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of PHI from me by alternative means or locations. For example, if you do not want bills sent to your home, you may request a different address. There are limits to such requests that will be provided to you.

5. Copy of the Notice: You have the right to obtain another copy of this Notice upon request.

E. Additional Information:

1. **Privacy Laws:** I am required by State and Federal Law to maintain the privacy of PHI. In addition, I am required by law to provide clients with notice of its legal duties and privacy practices with respect to PHI. That is the purpose of this notice.

2. Terms of Notice and Changes to the Notice: I am required to abide by the terms of this Notice and any amended notice that may follow. I reserve the right to change the terms of this notice and to make new Notice provisions for all PHI that it maintains.

3. Additional Information: If you desire additional information about your privacy rights, please contact me.

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I have received the Notice of Privacy Rights and Policies Documentation as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____
Client Name (Printed)

_____
Client Signature

_____
Date

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AUTHORIZATION TO DISCLOSE INFORMATION

Client(s) Name: _____

Client Address: _____

_____

Records requested from:
Jennifer Harned Adams, Ph.D.
222 Milwaukee Street, #211
Denver, CO 80206

To be disclosed and shared with:
_____ Colorado Reproductive Endocrinology

Complete below if provider other than CRE

_____

_____

_____

Type and Amount of Information to be disclosed:
Report related to consultation for third-party reproduction medical services

Purpose: As per request of clients and _____ (clinic name)

Dates of Release (period of 90 days): _____

I understand that the information released by this authorization will include information discussed during our consultation appointment. I understand that this authorization will expire, without my express revocation from one year from the date of signing. I understand that this authorization of this information is voluntary and I can refuse to sign this authorization.

_____	_____	_____
Client Printed Name	Client Signature	Date

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Credit/Debit Card Payment Consent Form

Client Name _____

Name on Card if different _____

I authorize Jennifer Harned Adams. PhD and Propay.com to charge my card for professional services for the amount of $175.00 .

Type of Card: VISA MasterCard Discover

Exp. Date: _____

Three-digit security code: _____

Card Number _____ - _____ - _____ - _____

Card Holder's Billing Address for Monthly Card Statements

_____
Street

_____
City State Zip

Please write yes or no for each of the following options:

____ I would like emailed receipts of this transaction from Propay.com

Card Holder's Email:_____

Card Holder Signature _____ Date ____ /____ /____

Charges will appear on your card statement as jenniferharnedadams@me.com and then Propay.com