

Michelle L. Jester, Ph.D.

118 Westfield Drive
Knoxville, TN 37919

Office Policy and Authorization for Treatment

Informed Consent of Treatment: I authorize Michelle L. Jester, Ph.D. to provide treatment as deemed medically necessary for my welfare. I understand that my participation is completely voluntary and that I have the right to terminate therapy at any time.

Limits of confidentiality: Therapy sessions are confidential. Information about sessions or about you will be released only with your permission except:

1. As mandated by law: including but not limited to reporting any situation when immediate danger to your or another person exists.
2. When there is any evidence of child abuse-past or present.
3. In the case of a civil, criminal or disciplinary action arising from the counseling where the therapist is a defendant. In cases involving more than one person as client, the couple or group is deemed to be "the client," and written permission must be obtained from all legally accountable persons who have been present during the counseling before any disclosure can be made. The therapist will not testify in any court proceedings without consent of all people seen by the therapist.

Crisis Management: Please call my office if you are severely depressed, suicidal, or homicidal. If you cannot reach me, you need to go to an area hospital (emergency room). The psychiatrist on call will treat you. Or, you may call Mobile Crisis telephone numbers: **Adults: (865) 593-2409, Children: (865) 791-9224.**

Fees: The fee is **\$150.00** per 45 to 60 minute session. Some individuals may be eligible for an adjusted fee based on gross annual income or other extenuating circumstances. The fees may be paid by any combination of insurance, cash, money order, cashier check, or personal check. The client is responsible for insurance amounts not paid directly to this office.

Authorization for Insurance Company to Pay Fees: I hereby authorize and direct my insurance company to pay directly to Michelle L. Jester, Ph.D. any and all benefits up to the amount of my bill.

Release of Records/Information to Insurance Companies: I hereby authorize Michelle L. Jester, Ph.D. to release any records/information acquired in the course of my treatment to process claims for services rendered.

Agreement: By my signature below, I certify that I have read and understand the above policies and disclosures.

Name of Patient (Printed)

Patient/Authorized Signature

Relationship to Patient

Date

Witnessed By: _____ Date: _____

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Client Information:

| | | |
|---|--|---------------------|
| Client SS# _____ | If Child, Name of Responsible Party: _____ | |
| Last Name: _____ | First Name: _____ | MI: _____ |
| Street Address: _____ | City: _____ | |
| State: _____ | Zip: _____ | County: _____ |
| Home Phone: () _____ - _____ | Work Phone: () _____ - _____ | |
| E-Mail Address: WWW. _____ @ _____ | Cell Phone: () _____ - _____ | |
| Date of Birth: _____ | Age: _____ | Gender: male female |
| Marital Status: single married divorced separated widow(er) | | |
| Client's Occupation: _____ | | |
| Employer &/or School: _____ | | |
| Address: _____ | | |
| Work Phone: () _____ - _____ | School Phone: () _____ - _____ | |

Insurance Information:

| | | |
|---|-------------------------------|-------------------------------|
| Insurance Company: _____ | | |
| Subscriber's Name: _____ | Subscriber's Employer: _____ | |
| Subscriber's ID# _____ | Group#: _____ | |
| Subscriber's Date of Birth: _____ | | |
| Subscriber's SS#: _____ - _____ - _____ | Relationship to Client: _____ | |
| Subscriber's Address: _____ | | |
| Home Phone: () _____ - _____ | Work Phone: () _____ - _____ | Cell Phone: () _____ - _____ |

Emergency Contact Information:

| | | |
|-------------------------------|-------------------------------|-------------------------------|
| Name: _____ | Relationship to Client: _____ | |
| Address: _____ | | |
| Home Phone: () _____ - _____ | Work Phone: () _____ - _____ | Cell Phone: () _____ - _____ |

Special Needs:

| | | |
|---|-------------------|-----------------|
| Hearing impaired | Visually impaired | Speech impaired |
| Transportation>>>>Options: _____ | | |
| Language Need: Spanish French German Sign Language Other: _____ | | |
| Interpreter Needed: _____ | | |
| Disability(s) _____ | | |

| | |
|---|--------------------------|
| How did you hear about us? _____ | |
| Payment Arrangements Made? Yes No Date: _____ | |
| First Appointment Scheduled: _____ | Co-pay/Deductible: _____ |

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Name of Client: _____

Medical History:

Allergies: _____

Medical Conditions: _____

Current Medications: _____

Primary Care Physician: _____ Phone: () _____ - _____

Address: _____

Date of Last Physical Exam: _____

CD Issues/Substance Use in the last 6 Months: Amount(s) Daily/Weekly

| | | | |
|---|-------|-------|--------|
| Caffeine:..... | _____ | daily | weekly |
| Nicotine:..... | _____ | daily | weekly |
| Alcohol:..... | _____ | daily | weekly |
| Misuse of Prescription or O-T-C drugs:..... | _____ | daily | weekly |
| Marijuana:..... | _____ | daily | weekly |
| Cocaine:..... | _____ | daily | weekly |
| Sedative Hypnotics: valium..... | _____ | daily | weekly |
| Opiates: <i>heroin, morphine</i> | _____ | daily | weekly |
| Inhalents:..... | _____ | daily | weekly |

Legal Problems/Involvement(s): (If applicable)

Legal Status: _____

Probation Officer: _____ Phone: () _____ - _____

Problem Duration: Less than 1-Month 1 Month or greater, less than 1 year
1 Year or greater, less than 2 years 2 Years or greater, less than 5 years
5 Years or greater

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Name of Client: _____

Do you Have or Have you Had:

| | | | | |
|---|-------------|----------------------------------|---------------|--------------|
| Physical Disabilities | Accident(s) | Head Injury: When? _____ | | |
| Car Wreck(s): When? _____ | | How Many? _____ | | |
| Headaches: How often? _____ | | Back/Spine/Limb Problems | | |
| Neurological Impairment: What type? _____ | | | | |
| Injury from Violence: When? _____ | | How? _____ | | |
| Blindness/Serious Vision Problems | | Deafness/Serious Hearing Problem | | |
| Chronic Physical Problems: What type? _____ | | | | |
| Alzheimer's | Dementia | AIDS/HIV | Hepatitis A/B | Other STD(s) |
| Other Health Related Problems | | NONE | | |

Comments: _____

Referral(s) to Community Resources:

Developmental History (Adolescent(s) & Children:

Primary Care Physician: _____ Phone: () _____ - _____

Significant Developmental Concern(s):

Child Developmental Milestones reached at normal age(s)? yes no, explain: _____

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Name of Client: _____

Family Situation(s):

Who has legal Custody? _____

If Joint, who is custodian of child? _____

How many Sibling(s)? _____

Living with child: _____

Living with someone else? _____

Parent(s): Both alive Both deceased

One parent deceased, which one? _____

Parent(s) suffering from illness? Which one & what? _____

Living Arrangement(s): _____

Social Adjustment: _____

Academic Performance/Adjustment: _____

Child Abuse or Neglect Issues: _____

EPSDT information given? _____

Is child up to date on screenings? yes no

Refer client to PCP for EPSDT screening? yes no _____

Current Family Situation(s): _____

Family of Origin Information: _____

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Name of Client: _____

Previous Mental Health Treatment(s) *check all that apply*

| | | |
|----------------------------|--|-------------|
| Mental Health Inpatient | Date of last Inpatient Stay? _____ | |
| | Doctor name: _____ | |
| Mental Health Outpatient | Date of last Outpatient Appointment? _____ | |
| | Doctor name: _____ | |
| Residential Treatment | Supportive Housing | Psych Rehab |
| Case Management | Crisis Service(s) _____ | |
| Substance Abuse Inpatient | Date(s): _____ | |
| Substance Abuse Outpatient | Date(s): _____ | |
| Inpatient Detox | Date(s): _____ | |
| Outpatient Detox | Date(s): _____ | |

Comment(s): _____

Chief Complaint: *(quote by patient, how patient describes problem)*

History of Present Illness:

Symptom(s): _____

Precipitant(s): _____

Duration &/or Frequency: _____

Degree of Distress or Impairment: _____

Other attempt(s) to seek help & Response(s): _____

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Name of Client: _____

Current Social Functioning: *If patient has A&D problem(s), past or present, assessment(s) must include any separation from family due to use, lose of job, etc.,..*****

Social Support System:

Adequate: family Friends Church Clubs Pets
Inadequate (explain): _____

Financial Situation (if client is child, assessment should apply to family)

Income Source(s): Job Disability (SSI,SSD, etc,) AFDC Medicare
 Retirement NONE Other: _____
Financial Issues that Impact Presenting Problem: _____
Financial Issues that Might Impact Response to Treatment: _____

Housing/Transportation: Resides In: Public Housing Private Housing

Housing Situation: Satisfactory Unsatisfactory
Comment(s): _____

Transportation: No problems Problems
Comment(s): _____

Community Living Skills: No problems

Problems with: Self-help skills Hygiene Money management
Leisure skills Accessing/Using Community Resource(s)
Accessing/Using Health Service(s)

Vocational/Educational:

Employed Unemployed (see registration page)
Currently in school: yes no GED: yes no
Grade (current or highest) _____
Problem(s) with Job/School: _____

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Name of Client:

| | | |
|---------------------------------|-------------|----------|
| Sexual Orientation/Functioning: | No problems | Problems |
| Comment(s): | _____ | |
| _____ | | |

| | | |
|------------------------|--------|----------|
| Developmental History: | Normal | Problems |
| Comment(s): | _____ | |
| _____ | | |

| | | |
|---------------------|--------|----------|
| Leisure/Recreation: | Normal | Problems |
| Comment(s): | _____ | |
| _____ | | |

| | | |
|------------|---------|--------|
| Diagnosis: | Initial | Update |
|------------|---------|--------|

Assessment:

| | | |
|-------------|---|---|
| Axis I: | _____ | |
| _____ | | |
| Axis II: | _____ | |
| _____ | | |
| Axis III: | _____ | |
| _____ | | |
| Axis IV: | Primary Social Support Social Environment Housing Access to Health Care Other | Educational Occupational Economic Legal System NONE |
| Axis V: | Current: _____ | Highest (past 6 months): _____ |
| | Lowest (past 6 months): _____ | |
| Comment(s): | _____ | |

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Name of Client: _____

22-Initial Discharge Plan:

| | |
|----|-------|
| 1. | _____ |
| 2. | _____ |
| 3. | _____ |
| 4. | _____ |

Clinician Signature

Date

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Date: _____

Presenting Problems:

| | | |
|--------------------|-------------------------|-------------------------|
| Substance Abuse | Childhood Abuse/Neglect | Sexual Dysfunction |
| Job/School | Depression | Unresolved Grief Issues |
| Parenting Problems | Legal Issues | Anxiety/Stress |
| Sexual Abuse | Marital/Couple | Financial Issues |
| Suicidal Ideation | Violent Behavior | Spouse Abuse |
| Elder Care | Addictive Behavior | Eating Disorder |
| Family Conflict | Chronic Illness | |

Mental Status Evaluation & Assessment:

| | | | | |
|-------------------------|---------------------------------|--|-----------------------------|--|
| Appearance: | Appropriate Bizarre | Well Groomed Disheveled | Meticulous | Inappropriate |
| Attitude: | Cooperative Belligerent | Guarded | Domineering Oppositional | Uncooperative |
| Speech: | Normal Perseverating | Soft Pressured | Delayed Loud | Slurred Incoherent Excessive Monotone |
| Motor Activity: | Calm Catatonic | Hyperactive | Agitated | Tremors/ticks Crying |
| Affect: | Appropriate | Labile | Expansive | Constricted Blunted Flat |
| Mood: | Normal Hypo manic | Bland | Depressed | Anxious Euphoric |
| Orientation: | Person | Place | Time | Situation |
| Thought Process: | Intact | Circumstantial-tangential Loosening of Associations | | Flight of ideas |
| Hallucinations: | Not present | Present | Auditory | Visual olfactory Command |
| Delusions: | Not present Being Controlled | Present | Persecutory Bizarre | Grandiose Hypochondriacal |

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Name of Client: _____

Date: _____

Continue Mental Status Evaluation & Assessment:

| | | | | |
|-------------------------------|-------------|---------------|------------------------------------|----------------|
| Dissociative States: | Not Present | Present | Frequent | Infrequent |
| Memory: | Adequate | Inadequate | Short Term Loss | Long Term Loss |
| Attn./Concentration: | Adequate | Inadequate | | |
| Judgment: | Adequate | Inadequate | Skippage in areas of conflict Only | |
| Impulse Control: | Adequate | Inadequate | | |
| Insight: | Good | Fair | Poor | |
| Intelligence Estimate: | Superior | Above Average | Average | Below Average |
| | | Borderline | Retarded | |
| Motivation for Change: | Good | Fair | Poor | |

Additional Information:

| | | | | | |
|--|-----|----|----------------------------|-----|----|
| Suicidal Ideation: | Yes | No | Homicidal Ideation: | Yes | No |
| Elopement: | Yes | No | Plan? | Yes | No |
| Previous Suicide, Homicide, Elopement attempt(s), Gesture(s): _____ | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| Patient Contract(s) Against Harm to Self or Others? | | | Yes | No | |
| Comment(s): _____ | | | | | |
| _____ | | | | | |

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Date: _____

Assessment:

| | | | | |
|--|---|------------------------------|--------------------|-------------------|
| Depressed Mood | Labile | Flashbacks | Tearfulness | Sleep Disturbance |
| Poor Judgment | Decreased Energy | Appetite Disturbance | Defects in Memory | |
| Grief | Impulsiveness | Poor Attention/Concentration | Hopelessness | |
| Hyperactivity | Poor Attention/Concentration | Religiosity | Helplessness | |
| Disruption of Thought Process/Content | Fearful-Hyper vigilant | Worthlessness | | |
| Delusions | Worrying | Hallucinations | Guilt | Paranoia |
| Anxiousness | | | | |
| Dissociative States | Panic Attacks | Oppositionalism | Somatic Complaints | |
| Obsessions/Compulsions | Elevated Mood | Irritability | Hostility | |
| Concomitant Medical Condition | Emotional/Physical/Sexual Trauma Victim | | | |
| Emotional/Physical Sexual Trauma Perpetrator | | | | |

Substance Use (check one)

| | | |
|--------------------------|-----------------------------|-------------------------|
| Active Substance Abuse | Early Full Remission | Early Partial Remission |
| Sustained Full Remission | Sustained Partial Remission | |

Other (specify): _____

Other (specify): _____

Symptoms have been present for:

| | | | |
|------------------------------|-----------------|-------------|-----------------------------|
| Less than 1-month | 1-6 months | 7-11 months | 1 year or more, less than 2 |
| 2 years or more, less than 5 | 5 years or more | | |