ROBERT G. KRAFT, Ph.D., P.C.
CLIENT INFORMATION SHEET

Date_____
Client ID_____

CLIENT INFORMATION

Full Name: _____Birth Date: _____ Age: _____Sex: M / F MTF/FTM/Other

Address: _____City/State/Zip: _____

Employer: _____Home Phone: _____Work Phone: _____
Marital Status: _____ Highest Grade Completed: _____ Cell Phone: _____
Religious Preference:_____

In Case of Emergency, Contact: Name:_____

Emergency Contact: Home Phone: _____ and Work Phone: _____

INSURED'S INFORMATION

I want Robert G. Kraft, Ph.D., P.C., to file Insurance Claims: ___Yes ___No

Full Name: _____Birth Date: _____ _Age: _____ Sex: M / F MTF/FTM/Other

Address: _____City/State/Zip: _____

Employer: _____Home Phone: _____Work Phone: _____
Marital Status: _____ Relationship to Client: _____ Cell Phone: _____

Insurance Co.: _____Ins. ID No.:_____

Ins. Group No.:_____

FAMILY INFORMATION

Please list everyone living in the client's home:

Name	Age	Sex	Relationship	Name	Age	Sex	Relationship

Does client have children who are not living in the home? Yes _____ No _____

OTHER INFORMATION

Whom may we thank for referring you? _____

Has client had previous counseling/therapy? None _____Office (outpatient services) _____Hospitalization_____

Is client taking prescribed medication? No _____ Yes _____ (specify):_____

If the client is a minor whose parents are divorced, to which parent has the court given custody?

Mother_____ Father_____ Other (specify): _____

I (or the parent, legal guardian, or authorized representative of the patient) authorize Robert G. Kraft, Ph.D., P.C., to provide reasonable and proper psychological and/or medical treatment;, to release information to process insurance claims; to receive from my insurance company directly all benefits otherwise payable to me; and I agree I will be responsible for all expenses related to treatment that are not paid under my insurance plan(s). I realize I have to pay the full fee if I do not give a 1 week notice of cancellation (except for illness or weather reasons).

_____ _____
Date Signature of Client (Parent/Guardian if client a minor)

ROBERT G. KRAFT, Ph.D., P.C.
11909 Arbor Street, Suite J, Omaha, NE 68144-2970

Consent to Treatment, and to Use and Disclose, Your Health Information

This form is an agreement between you, _____ and me/us, Robert G. Kraft, Ph.D., P.C. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____ .

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this Consent Form agreeing to it and what is in our Notice of Privacy Practices we cannot treat you.

We have the right to change our Consent and Notice of Privacy Practices and we will notify if we change them. You are always welcome to a copy of our Notice and our Policies and procedures. If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your written request.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____
Signature of Client or His or Her Personal Representative Date

_____ _____
Printed Name of Client or Personal Representative Relationship to the Client

_____
Description of personal representative's authority

Date of NPP: 4/14/03 Copy given to the client/parent/personal representative_____

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11909 Arbor Street, Suite J, Omaha, NE 68144-2970

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Shortened Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This Notice is a shortened version of the full, legally required Notice of Privacy Practices which is available in the waiting room, so refer to the Complete Notice for more information. Even in the Complete Notice we can't cover all possible situations so please talk to your provider or our Privacy Officer (see the end of this information) about any questions or problems.

Use and Disclosure of your Protected Health Information (PHI)

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called, in the law, **health care operations**. After you have read this NPP, we will ask you to sign a **Consent Form** to agree to be treated and to let us use and share your information. **If you do not consent and sign the Consent Form, we cannot treat you.**

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an **Authorization** to allow this.

We will keep your health information private but there are times when the laws require us to use or share it, such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We have to report suspected child abuse or adult abuse, some instances of suicidal ideation, and some instances of homicidal ideation. We will only share information with a person or organization whom we believe is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations which don't happen very often. They are described in the complete version of the Notice of Privacy Practices which is available in the waiting room.

Your Rights Regarding Your Health Information

1. **Restriction on Communication Channel:** You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment.
2. **Restriction of Whom PHI Communicated to:** You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. **Inspect and Copy:** You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records but we may charge you. Psychotherapy Notes are handled in a very specific way and need a specific Authorization.
4. **Amend:** If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information.
5. **Copy of Notice:** You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and on our website (if we have one).
6. **Complaint:** You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and/or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.
7. **Accounting of Disclosures:** When we disclose our PHI, we keep records indicating whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Dr. Robert G. Kraft and can be reached by phone at (402) 330-0800 or by mail at the above address.

_____ _____

Signature Date

_____

Printed Name

Current Problem Checklist

For each problem listed: Circle "Y" if you have had the problem within the past two weeks. Circle "N" if you have not had the problem in the last two weeks.

Y N Poor concentration…can't pay attention, easily distracted, my mind goes blank.
Y N Poor memory…cannot remember as well as I should.
Y N Cannot make decisions…can't tell what to do as well as I could before.
Y N Restless…can't sit still for long, feel restless.
Y N Unrealistic fears…afraid of things or people I know won't hurt me.
Y N Impulse control…act too quickly, I don't think things through.
Y N Self-conscious…with others, I feel very uncomfortable when people watch me.
Y N Loss of Interest…do not care about things like I used to.
Y N Repetitive thoughts…can't stop thinking about something or someone
Y N Suicidal thoughts…I want to die, I would rather be dead than alive.

Y N Bad habits…keep doing things that could cause a serious problem.
Y N Easily hurt…others seem unfriendly, don't understand me.
Y N Feelings of regret…I feel ashamed, guilty, or feel like a "bad" person.
Y N Depression…feel blue, low, or down much of the time.
Y N Hopelessness…things just will not work out right in the future.
Y N Tense or anxious…too worried or keyed up about various things.
Y N Feeling fearful…about self or others, I fear something bad will happen.
Y N Feel inferior…feel not as good as others, feel uneasy around others
Y N Loneliness…feeling like no one cares about me.
Y N Irritable…easily upset or angered, I am touchy.
Y N Panic episodes…I become terrified, overwhelmed, very frightened.
Y N Crying episodes…I cry easily, at the wrong times, I can't stop crying at times.
Y N Suspiciousness…I can't trust others, I need to be on guard with others.
Y N Angry…I feel like I want to hurt someone or smash and break things.
Y N Loss of control…I feel like someone or something is controlling my mind.
Y N Need to be punished…I feel like my sins are unpardonable.

Y N Social problems…I can't get along with others or I argue and/or fight too much.
Y N No friends…I have no one to talk to or to discuss serious things with.
Y N Shyness…I avoid people and/or I am uncomfortable with members of the opposite sex.
Y N Fear of failure…I fear failure at school and/or work. I feel unable to succeed.
Y N Being ignored…I am not getting the credit or recognition I deserve.
Y N Absences…I am missing more work and/or school than is really necessary.

Y N Sexual problems…"bad" habits, feelings, or actions about sexual issues.
Y N Poor appetite...I don't eat enough and/or I don't want to eat.

Y N Sleep problems…I have difficulty going to sleep or staying asleep or I have nightmares.
Y N Problems arising…I have difficulty waking up or getting going in the morning.
Y N Chronic pain…I have problems with headaches and/or stomach problems and/or back pain.
Y N Heart problems…I have pounding in my chest or with skipping heart beats or pain or racing heart.
Y N Hot-cold flashes…I have problems with sweating and/or chills not related to the air temperature.
Y N Lack of energy…I am easily tired or fatigued. I feel physically tired often.
Y N Dizziness…I have problems with fainting and/or fear of falling and/or feelings like I am spinning.
Y N Tingling…I have prickly sensations in my hands, feet, or other body parts.
Y N Numbness…I have no sensation in one or more body parts.
Y N Distortions…I have problems with seeing, hearing, feeling things that are not real.
Y N Other physical problems: List: