Client Information Form

Please complete before your first appointment. Print clearly or fill in on screen.

ADE, Inc.
Dr. Martha H. Ireland
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Hardeeville, SC 29927
(703) 722-2324 | info@irelandphd.com

ADE, Inc. is a fee-for-service practice. We do not bill insurance and payment is due at the time of service. You may request a monthly statement to submit to your own insurance company. Please review the Fee Schedule and Client Consent and Practice Policies before your first visit.

CLIENT INFORMATION

TODAY'S DATE | DATE OF FIRST APPOINTMENT | DATE OF BIRTH | AGE

LAST NAME | FIRST NAME | MIDDLE NAME | NAME YOU PREFER TO BE CALLED

LEGAL NAME, IF DIFFERENT FROM ABOVE | FORMER NAME, IF ANY

PRONOUNS

☐ He / him / his ☐ She / her / hers ☐ They / them / theirs

PRONOUNS NOT LISTED ABOVE

GENDER IDENTITY

☐ Man ☐ Woman ☐ Non-binary ☐ Prefer not to say

GENDER IDENTITY NOT LISTED ABOVE

RELATIONSHIP STATUS

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Contact and Address

STREET ADDRESS | CITY | STATE | ZIP

MAILING ADDRESS, IF DIFFERENT | CITY | STATE | ZIP

CELL PHONE | HOME PHONE | WORK PHONE

EMAIL ADDRESS | ALTERNATE EMAIL ADDRESS

OCCUPATION | EMPLOYER | EMPLOYER CITY AND STATE

How Did You Hear About Dr. Ireland?

☐ Physician or other provider ☐ Website or online search ☐ Friend or family member ☐ Former or current client

☐ Professional colleague ☐ Conference or presentation ☐ Close to home or work ☐ Other

NAME OF PERSON OR SOURCE WHO REFERRED YOU

WHAT BRINGS YOU IN

IN YOUR OWN WORDS, WHAT WOULD YOU LIKE HELP WITH?

HOW LONG HAS THIS BEEN GOING ON?

HAS IT GOTTEN BETTER OR WORSE RECENTLY?

WHAT WOULD YOU LIKE TO BE DIFFERENT BY THE TIME WE FINISH WORKING TOGETHER?

Have you worked with a therapist or counselor before? ☐ Yes ☐ No

IF YES, WITH WHOM, WHEN, AND WHAT WAS HELPFUL OR UNHELPFUL

Are you currently working with another mental health provider? ☐ Yes ☐ No

IF YES, NAME AND ROLE

YOUR HEALTH CARE PROVIDERS

Coordinating care with your medical providers helps us treat you safely, particularly where eating, weight, medication, or physical health are involved. Sharing this information here does not authorize Dr. Ireland to contact anyone. A separate Authorization for Disclosure of Protected Health Information must be signed before any contact is made.

PRIMARY CARE PHYSICIAN | PHONE | CITY AND STATE

PRESCRIBING PROVIDER, IF DIFFERENT | PHONE | CITY AND STATE

DATE OF LAST PHYSICAL EXAM | DATE OF NEXT SCHEDULED APPOINTMENT | REGISTERED DIETITIAN, IF ANY

EMERGENCY CONTACTS

Please list two people we may contact in an emergency. At least one should not live at your address.

CONTACT 1 NAME | RELATIONSHIP TO YOU | CELL PHONE | ALTERNATE PHONE

CONTACT 2 NAME | RELATIONSHIP TO YOU | CELL PHONE | ALTERNATE PHONE

NEAREST HOSPITAL OR EMERGENCY ROOM TO YOUR HOME | CITY AND STATE

If you are in immediate danger, call 911 or go to your nearest emergency room. For crisis support, call or text 988 (Suicide & Crisis Lifeline) or chat at 988lifeline.org.

PERSON RESPONSIBLE FOR PAYMENT

Complete this section only if someone other than the client is responsible for payment.

NAME | RELATIONSHIP TO CLIENT | DATE OF BIRTH

ADDRESS | CITY | STATE | ZIP

CELL PHONE | EMAIL ADDRESS

PERMISSION TO CONTACT

I give ADE, Inc. and Dr. Martha Ireland permission to contact me, and to leave messages, about appointments, administrative matters, and urgent or emergency issues. Please check every method you approve and provide the number or address. You may decline any method, and you may change or withdraw this permission at any time by telling Dr. Ireland in writing.

- ☐ Cell phone call
- ☐ Text message
- ☐ Home phone call
- ☐ Email
- ☐ Postal mail
- ☐ Do not contact me by any method other than those chec

CELL PHONE NUMBER FOR CALLS OR TEXTS | EMAIL ADDRESS FOR CONTACT

HOME PHONE NUMBER | MAILING ADDRESS FOR POSTAL CONTACT

Detail Level of Messages

- ☐ You may leave a detailed message
- ☐ Leave name and callback number only
- ☐ Do not leave a message

Is it acceptable for someone else in your household to receive a message on your behalf? ☐ Yes ☐ No

IF YES, WHO

Standard cell phone calls, text messages, and email are not fully secure and confidentiality cannot be guaranteed. Dr. Ireland maintains an encrypted, HIPAA compliant email address at info@irelandphd.com for clinical correspondence. Please do not use email or text to cancel an appointment or to report an emergency. Email and text are not monitored continuously.

SIGNATURE

I confirm that the information above is accurate to the best of my knowledge, and I authorize ADE, Inc. and Dr. Martha Ireland to contact me using the methods I have selected.

CLIENT SIGNATURE | DATE

PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE SIGNATURE | DATE

PRINTED NAME | IF SIGNING AS REPRESENTATIVE, STATE YOUR LEGAL AUTHORITY