**PRE-INTAKE AND ANNUAL REVIEW INFORMATION**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_ ZIPCODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where would you prefer we contact you? (circle) HOME CELL

Where can we leave a message? (circle) HOME CELL

AGE: \_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOC. SEC. # \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

DRIVER’S LICENSE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELIGIOUS AFFILIATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENDER IDENTITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ETHNIC IDENTITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEXUAL ORIENTATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LENGTH OF RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PARTNER'S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ANY CHILDREN AND THEIR AGES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW LONG EMPLOYED (ENROLLED, IF STUDENT):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_ ZIPCODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any source of income other than your employment (disability, workers compensation, family)?

(circle) YES NO

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIGHEST LEVEL OF EDUCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GIFTED? (circle) YES NO

LEARNING DISABILITY OR DIFFICULTY IN SCHOOL? (circle) YES NO

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU NOW OR HAVE YOU EVER BEEN UNDER A LEGAL CONSERVATORSHIP OR GUARDIANSHIP? YES NO

**Primary Insurance Carrier Information**

***Complete if the primary insurance policy holder is someone other than yourself:***

NAME OF POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ RELATIONSHIP TO CLIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is financially responsible for the account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP TO CLIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE – HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S CELL PHONE PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

NAME OF INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # ON CARD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # on CARD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize my therapist, Dr. Marie Williams to release information as to my diagnosis and treatment to my insurance company for the sole purpose of validating my claim. I also assign my insurance benefits to my provider and I authorize payment to be made directly to her office by my insurance company.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THE FOLLOWING SECTION TO BE COMPLETED ONLY IF PATIENT IS A MINOR**

PARENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_ ZIPCODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE – HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PARENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_ ZIPCODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE – HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF PARENTS ARE DIVORCED PLEASE EXPLAIN THE CUSTODY ARRANGEMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health History**

□ I have attended prior outpatient psychotherapy. If yes, for what psychiatric, emotional, or substance-related concern?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, I attended on \_\_\_\_\_\_\_ separate occasions. My most recent treatment was provided by \_\_\_\_\_\_\_\_\_\_\_\_\_ from \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_.

Please provide information about prior providers below.

Provider Name Contact Diagnosis Intervention Helpful?

□ I have received prior inpatient psychatric treatment. If yes, for what psychiatric, emotional, or substance-related concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, I attended on \_\_\_\_\_\_\_ separate occasions. My most recent treatment was provided by \_\_\_\_\_\_\_\_\_\_\_\_\_ from \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_.

Please provide information about prior institutions below.

Institution Name Contact Diagnosis Intervention Helpful?

Past Psychiatric Medication Dates Taken Outcome Why stopped?

□ I have a history of self-harm behavior. First Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of times\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last time\_\_\_\_\_\_\_\_\_\_\_ Method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I have a history of suicide attempts or suidical ideation?. First Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of times\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last time\_\_\_\_\_\_\_\_\_\_\_ Method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Are any members of your family diagnosed with a psychological disorder? (circle) YES NO

If yes, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are any members of your family currently using psychotropic medication? (circle) YES NO

If yes, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any members of your family struggled with substance abuse? (circle) YES NO

If yes, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any members of your family been treated in an outpatient/inpatient institution? (circle) YES NO

If yes, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Substance Use**

Please indicate when you began using each substance, how much, and how often you use it currently. If you no longer use it, please note the relative date when you stopped.

| Drug Type | Date Use Began | Date Use Ended | Current Amount Consumed | Current Frequency of Consumption |
| --- | --- | --- | --- | --- |
| Alcohol |  |  |  |  |
| Tobacco (specify type) |  |  |  |  |
| Marijuana |  |  |  |  |
| Other Recreational Drugs  (Please Specify) |  |  |  |  |
| Prescription Drugs  (Please Specify) |  |  |  |  |

**Relevant Health Information**

Select all that apply:

□ significant head trauma □ neurological disorder □ High cholesterol

□ coma/loss of consciousness □ motor or verbal tics □ High Blood Pressure

□ seizures □ headaches/migraines □ Thyroid dysfunction

□ List any other medical conditions or any surgeries:

Please list current medications, dosage, and frequency:

**Current Symptom Checklist**

Select any symptoms that have been present in the past two weeks or that someone else in your life has noticed in your behavior:

□ depressed mood □ shyness □ disorganized thoughts

□ decreased energy □ sensitive to criticism □ difficulty thinking

□ lack of motivation □ anxiousness □ delusions

□ lack of interest/enjoyment □ excessive worry □ unusual beliefs or thoughts

□ suicidal thoughts □ panic attacks □ hearing voices

□ thoughts of death □ obsessive thoughts/behaviors □ seeing things

□ grief/loss □ compulsive thoughts/behaviors □ paranoia

□ hopelessness/helplessness □ pounding/racing heart □ feeling disconnected

□ worthlessness □ dizziness □ flashbacks

□ guilt/inferiority feelings □ sweating □ nightmares

□ difficulty making decisions □ nausea/vomiting □ fear of dying

□ memory problems □ hot/cold flashes □ trembling

□ irritability □ shortness of breath □ increased appetite

□ anger □ numbness/tingling □ decreased appetite

□ elevated mood □ fear of situations/places □ binging

□ increased energy □ fear of losing control □ purging

□ mood swings □ difficulty concentrating □ restricting

□ increased self-esteem □ impulsiveness □ difficulty with sleep

□ increased goal direction □ poor decision making □ sleeping excessively

□ temper problems/poor control □ difficulty paying attention □ excessive activity

□ reliant on others □ unsure of yourself □ unwilling to make changes

□ racing thoughts □ procrastination/difficulty starting and/or accomplishing tasks

**Presenting Problem**

What brings you to treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have the symptoms persisted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE PROCEDURES AND CLIENT CONTRACT**

1) Please be aware that Talk Works and Skin Therapy Plus share a waiting room, but maintain separate and independent practices. No partnership exists between these individuals and each assumes liability solely and only for their own practice. As a client, I acknowledge and agree that I will not hold these providers accountable or liable for the actions of the other.

Initial\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Patients are seen by appointment only. Appointments may be made by calling the office between the hours of 9:00 am and 5:00 pm. Each clinician keeps his/her own schedule, and office staff will call patients to offer appointment dates and times. It is policy to change, confirm, add or cancel appointments ONLY with the patient or, if the patient is a minor, with the legal guardian. Sessions are generally 45-50 minutes in length.

Initial\_\_\_\_\_\_\_\_\_\_\_\_\_

3) If you cancel an appointment with fewer than **24** hours notice, you will be responsible for a full session fee, which insurance does not cover. Your appointment time is reserved solely for you and cannot reasonably be filled with less than 24 hours notice. Clients with three no-shows or late cancellations in any six month period will be referred to alternate providers. Your provider retains the right to cancel or reschedule appointments due to patient needs and/or emergencies, and will make every effort to contact you as promptly as possible, should such an occasion arise.

Initial\_\_\_\_\_\_\_\_\_\_\_\_\_

4) In case of emergency, contact 911 for help. Emergencies are considered life-threatening situations. Please be aware that clinicians are not always available to respond to emergencies. It is usually best in these situations to contact your psychiatrist, go directly to the nearest hospital ER or contact 911 for help.

This facility is not a 24-hour institution, so in the event that you have a psychological emergency when the office is closed please call **911** or the GA Crisis and Access Line **1 (800) 715-4225.** You may also text GA Crisis and Access by texting **‘GA’ to 741-741**.

Initial\_\_\_\_\_\_\_\_\_\_\_\_\_

5) In the event that you terminate treatment against medical advice, you can request referrals, contact the GA Crisis and Access Line for referrals and/or emergency service, or seek care from another provider or the emergency room. Risks of terminating treatment against medical advice may include: relapse or worsening of symptoms, need for inpatient hospitalization and treatment, suicidal ideation, completed suicide and death.

Initial\_\_\_\_\_\_\_\_\_\_\_\_\_

6) All communications that occur between therapist and patient are kept in the strictest confidence. No information will be discussed with anyone without prior written authorization from the patient/legal guardian. Under most circumstances, evaluation reports and therapy session notes will remain completely confidential; however, under law, there are several exceptions to this rule. The most common are:

a. Suspected abuse of a child, elderly, or disabled person.

1. You indicate an intention to harm yourself or any other person
2. Sexual exploitation by a former or current therapist
3. Cases, before a court of law, in which your mental health is an issue
4. Collection of past-due charges of fees.
5. All patients using third parties to provide partial or complete payment of fees should be aware that any and all of the information provided to the paying organization could be made available by that organization to: employers providing the insurance benefits, other insurance companies/agencies requesting the information, and other health-care providers that have contact with the insurance company Initial \_\_\_\_\_\_\_\_\_\_\_

7) If you want us to file insurance claims for you, you must supply the appropriate information and claim forms (if your insurance company requires special billing forms). If you do not supply us with accurate information to file your insurance claims, all charges become your responsibility. **We do not file claims for secondary insurance unless the primary insurance is Medicare.** We require at least 24-hours’ notice of any change in insurance in order to obtain the proper authorization for treatment and to file your claim. If you fail to give us at least 24-hours’ notice of a change in insurance, all charges become your responsibility. Please be advised that this office utilizes a billing service/EDI to process claims. All patient information is handled with utmost confidentiality and HIPAA compliance.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

8) I hereby give written permission to fax clinical data to managed-care companies, other third party payers, and/or other mental health care professionals.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

9) I hereby give permission for treatment.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

10) You have a right to withdraw from treatment at any time, unless treatment is court-ordered. If you would like a referral to a different therapist, your provider will gladly assist you in finding one. Leaving treatment against medical advice presents the possible risk of relapse of prior symptoms, need for inpatient hospitalization, suicidal ideation, or in extreme cases death.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

11) The ethical codes of psychologists prohibit dual relationships between clinician and patient. This means that if you ever are a patient, your therapist cannot meet with you for social occasions or be involved in any business activities with you other than providing psychological services.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

12) Often, patients seek psychological services because they wish to change some aspect of their lives, behavior, or environment. Changes in the patient frequently produce changes in personal relationships, work relationships, and other areas of the patient’s life. It is important that you recognize the potential impact of any changes that may occur before you begin treatment.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

13) As a requirement for treatment, I will provide an emergency contact and their phone number. In the event that my therapist reasonably believes that I am a danger to myself or another person, I specifically consent for the therapist to warn the person in danger and my emergency contact person and first responders..

**Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Initial\_\_\_\_\_\_\_\_\_\_\_\_

14) In the event you ask for letters for court, parole, probation, or disability, you should be aware that this request carries the minimum hourly rate of $150, along with the potential for additional fees that include the time and labor spent reviewing documentation, writing and sending letters (including postage), as well as creating reports.

Initial\_\_\_\_\_\_\_\_\_\_\_

15) Email and text messaging is used ONLY for scheduling such as making and changing appointment times. Do NOT send clinical information by email or text message. Email and text messaging is not a secure form of communication. You agree to assume all risks in the event that you chose to use email and text messaging.

Initial\_\_\_\_\_\_\_\_\_\_\_

16) This office does not accept credit cards. You may chose to send payments directly from your HSA, FSA, or by using a third party payer such as Venmo; however, the office does not have a business associate agreement with these payers and the payment may not be secure. You agree to assume all risks in the event that you chose to use these payment services. Initial\_\_\_\_\_\_\_\_\_\_\_

17) Your Psychologist understands that you may have questions or concerns after appointment times. Please understand we see clients by hourly appointments and are unable to do phone consults. If you have therapy questions that are not an emergency (life or death nature) please wait until your next appointment or call to schedule an appointment to discuss your concerns. **If you have any questions regarding medication please call your physician.** Initial\_\_\_\_\_\_\_\_\_\_\_

18)Returned checks have a fee of 10.00 for the first returned check that is received

and any charges that may be assessed by the provider's bank. The second returned check that is received will be discussed in therapy with the provider as well as a 25.00 charge plus any fees the provider is assessed from the bank. The third returned check the client will be referred to a new therapist as well as a 25.00 charge and any fees the provider is assessed from the bank. An insufficient fund receipt will be provided every time a notice is given by your provider.

**I HAVE READ AND UNDERSTAND THE CURRENT PROCEDURES STATED ABOVE, AND AGREE TO ABIDE BY THEM REQUISITE TO TREATMENT**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of patient/legal guardian Date**

**NOTICE OF PRIVACY PRACTICES**

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.

1. The privacy of your medical information is important. I understand that your medical information is personal, and am committed to protecting it. I create a record of the care and services you receive at this office. This record is needed to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways a therapist may use and share this information about you. It describes your rights and certain duties psychologists have regarding the use and disclosure of medical information.
2. Psychologists Legal Duty:

The Law Requires Psychologists To:

* 1. Keep your medical information private.
  2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
  3. Follow the terms of the notice that is now in effect.

Psychologists Have the Right To:

1. Change privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in privacy practices and the new terms of the notice effective for all medical information that is kept, including information previously created or received before the changes.
3. Before making an important change in privacy practices, the notice will be changed and a new notice will be available upon request.
4. Use and Disclosure of Your Medical Information:

The following section describes different ways that psychologists use and discuss medical information. Not every use of disclosure will be listed. Therapists will not use or disclose you medical information for any purpose not listed below, without your specific written permission. Any specific written authorization you provide may be revoked at any time in a written statement to your therapist.

* 1. For Treatment: Psychologists may use medical information about you to provide you with treatment or services. Psychologists may disclose medical information about you to doctors, nurses, technicians, or other people who are taking care of you.
  2. For Payment: Psychologists may use and disclose your medical information for payment purposes.
  3. Court-Ordered, Judicial, and Administrative Proceedings: Your therapist may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process under certain circumstances. These circumstances include a court order, warrant, or grand jury subpoena. Your therapist may share your medical information with law enforcement officials. Your therapist may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person.
  4. Victims of Abuse, Neglect: Your therapist may disclose information if she/he reasonably believes that a minor, disabled or elderly individual is a possible victim of abuse or neglect. Your therapist may inform an intended victim if there is a threat to their life or inform the authorities.
  5. According to the Patriot Act: Your therapist may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law your therapist cannot reveal when she/he has disclosed such information to the government, according to the Patriot Act.

1. Your Individual Rights:

You have a right to:

* 1. Look at or get copies of your medical information. You may request that your therapist provide copies in a format other than photocopies. Your therapist will use the format you request unless it is not practical to do so. You must make your request in writing. You may request the form from a member of our staff. If you request copies, the charge is $10.00 for 1-5 pages, and $2.00 per page thereafter. If you request that the copies be mailed, you may be charged postage.
  2. Request that your therapist place additional restrictions on the use of disclosure of your medical information. Your therapist is not required to agree to these additional restrictions, but if so, he/she will abide by the agreement, except in case of emergency.
  3. Request that your therapist change your medical information. Your requests may be denied. If your therapist denies your request, your therapist will, upon request, provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information that you want changed. If your request is accepted to change the information, a reasonable effort will be made to tell others, including people you name, of the change, and to include the changes in any future sharing of that information.

**I HAVE READ AND UNDERSTAND THE CURRENT PROCEDURES STATED ABOVE, AND AGREE TO ABIDE BY THEM REQUISITE TO TREATMENT**

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**SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE**

**FINANCIAL POLICY**

Thank you for choosing me as your mental health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of the FINANCIAL POLICY, which  *you are required to read and sign prior to the receipt of any treatment.* **CO-PAYMENTS AND/OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH AND CHECKS ONLY.**

**Insurance:** We will gladly discuss your insurance, and will answer any questions to the best of our ability. You must realize, however, that you are responsible for ensuring you are aware of your insurance benefits and liabilities.

Payment is due at the beginning of each appointment. Nonpayment of services which are thirty (30) days past due will result in termination of therapy. If termination is necessary, you will be given notice, and supplied with a list of alternative therapists or agencies in your area and/or referred back to your insurance company for further resources.

1. Your insurance is a contract between you, your employer, and your insurance company. We are not party to that legal contract.
2. The office fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of “usual and customary” fees. Current fees are considered usual, customary, and reasonable by most insurance companies. If you choose to send payments via electronic means (such as Venmo), you are responsible for ensuring your privacy settings are set to private to eliminate the risk of your electronic friends viewing the transaction.
3. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will NOT cover. It is YOUR RESPONSIBILITY to determine if the services provided to you are a covered benefit under your plan.
4. I must emphasize that, as a mental health care provider, my relationship is with YOU, and NOT YOUR INSURANCE COMPANY. While this office does file claims with your insurance company, **all charges are your responsibility from the date services are rendered.** If payment is not received, or if the payment that is received from the insurance company is incorrect, a reasonable effort will be made to contact your insurance company, you may then be billed directly for the amount not received. It will then be **your responsibility** to contact your insurance carrier to resolve the issue. If such problems do arise, you are encouraged to contact your insurance company promptly, as any balance unpaid within 60 days of the date of service may be turned over to a collection agency.

**MINOR PATIENTS**: The adult accompanying the minor patient shall be responsible for making a co-payment at the time of service. For minors not accompanied by an adult, non-emergency treatment will not be provided unless arrangements for co-payment have been made in advance.

**FORENSIC SERVICES**

(Professional Services related to Court appearances as an expert witness, and/or reports to be used in Court, or related legal areas.)

1. Hourly Rate $ 250.00

Includes:

A. Preparation Time

B. Travel Time

C. Consultation with attorneys, both in person and by phone

D. Time spent testifying as an expert witness

E. Review of documentation related to Court, Forensic Areas

F. Testing and/or report/letter preparation

2. Fees are not covered by insurance and are to be pre-paid. For Court appearances, a minimum of $2000 is required to be paid in advance and is nonrefundable..

4. A subpoena will not negate fees generated.

**I have read the information related to Forensic fees and acknowledge the terms.**

**QUESTIONS AND COMPLAINTS**

If you have any questions or would like to discuss any of the policies or procedures please contact your therapist:

Dr. Marie Williams 3001 Monroe Hwy Ste 600 C Bogart, GA 30622

**ACKNOWLEDGEMENT:**

**I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.**

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**SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE**

**TELEPSYCHOLOGY INFORMED CONSENT**

1. Telepsychology refers to any service that is provided by technology (including but not limited to video, phone, text, and email) and does not involve direct, face to face, communication. There are benefits and limitations to telepsychology services. I understand that I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.
2. I understand that telepsychology sessions can only be provided when I am physically located within the PSYPACT approved states (or California) due to state licensing laws and restrictions.
3. At the outset of each telepsychology treatment session, I agree to provide my physical location and contact phone number to verify that I am physically located in the state of Georgia (or California) and so that my provider is able to summon emergency services to my location if needed.
4. If a need for direct, face to face services arises, it is my responsibility to contact providers in my area or to contact this office for a face to face appointment. I understand that an opening may not be immediately available.
5. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.
6. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.
7. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means: a. In emergency situations b. Should service be disrupted c. For other communication
8. My psychologist may utilize alternative means of communication in the event of emergencies.
9. My psychologist will respond to communications and routine messages within two business days.
10. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
11. I will take precautions to ensure that my communications are directed only to my psychologist.
12. My communications exchanged with my psychologist will be documented in progress notes and/or printed (texts/emails as clinically indicated) and maintained in the client record. No copies of video sessions will be stored.
13. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services.

This document does not replace other agreements, contracts, or documentation of informed consent.

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Signature of client Printed name Date

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Signature of parent/guardian/representative Printed name Relationship Date