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Adult Intake Form

Name: _____ Date: _____

Address: _____ Phone: _____

City: _____ State/Zip: _____

DOB: _____ Age: _____

Gender: ☐ Male ☐ Female

Presenting Problems and Concerns

Please check all the behaviors and symptoms that you consider problematic:

☐ Distractibility	☐ Change in appetite	☐ Suspicion/paranoia
☐ Hyperactivity	☐ Lack of motivation	☐ Racing thoughts
☐ Impulsivity	☐ Withdrawal from people	☐ Excessive energy
☐ Boredom	☐ Anxiety/worry	☐ Wide mood swings
☐ Poor memory/confusion	☐ Panic attacks	☐ Sleeping problems
☐ Seasonal mood changes	☐ Fear away from home	☐ Nightmares
☐ Sadness/depression	☐ Social discomfort	☐ Eating problems
☐ Loss of pleasure/interest	☐ Obsessive thoughts	☐ Gambling problems
☐ Hopelessness	☐ Compulsive Behavior	☐ Computer Addiction
☐ Thoughts of death	☐ Aggression/fights	☐ Pornography
☐ Self-harm behaviors	☐ Frequent arguments	☐ Parenting problems
☐ Crying spells	☐ Irritability/anger	☐ Sexual problems

☐ Loneliness
☐ Low self-worth
☐ Guilt/shame
☐ Fatigue
☐ Homicidal thoughts
☐ Flashbacks
☐ Hearing voices
☐ Visual hallucinations
☐ Paranoia
☐ Work/school
☐ Alcohol use
☐ Disturbed memories

Other:_____

_____

Are your problems related to the following?

☐ Handling everyday tasks
☐ Hygiene
☐ Legal matters
☐ Sexual activities
☐ Self-esteem
☐ Work/school
☐ Finances
☐ Health
☐ Relationships
☐ Housing
☐ Recreational

Have you ever had thoughts, made statements, or attempted to hurt yourself? ☐ Yes ☐ No

Is 'yes' please describe.

_____

_____

_____

Have you ever had thoughts, made statements, or attempted to hurt someone else? ☐ Yes ☐ No

Is 'yes' please describe.

_____

_____

_____

Have you recently been physically hurt or threatened by someone else? ☐ Yes ☐ No

Is 'yes' please describe.

_____

_____

_____

Family and Developmental History

Relationship	Name	Age	Quality of Relationship		Family Mental Health Problems	Who?
Father					Hyperactivity	
Mother					Sexually abused	
Stepfather					Depression	
Stepmother					Bipolar	
Sibling 1					Suicide	
Sibling 2					Anxiety	
Sibling 3					Panic Attacks	
Sibling 4					Obsessive-Compulsive	
Sibling 5					Anger/Abusive	
Spouse/Partner					Schizophrenia	
Child 1					Eating Disorder	
Child 2					Alcohol Abuse	
Child 3					Drug Abuse	
Child 4						
Child 5						

☐ Parents legally married or living together
☐ Father remarried # of times: _____
☐ Mother remarried # of times: _____

☐ Parents temporarily separated
☐ Father remarried # of times: _____
☐ Mother remarried # of times: _____

☐ Parents divorced or permanently separated
☐ Father remarried # of times: _____
☐ Mother remarried # of times: _____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse	☐ Neglect	☐ Foster home
☐ Sexual abuse	☐ Violence in the home	☐ Multiple moves
☐ Physical abuse	☐ Crime victim	☐ Homeless
☐ Parent substance abuse	☐ Parent illness	☐ Loss of a loved one
☐ Teen pregnancy	☐ Placed a child for adoption	☐ Financial problems

Previous Mental Health Treatment

Yes	No	Type of Treatment	When	Provider/Program	Reason for Treatment
☐	☐	Outpatient Counseling			
☐	☐	Medication (Mental Health)			
☐	☐	Psychiatric Hospitalization			
☐	☐	Drug/Alcohol Treatment			
☐	☐	Self-help/support Groups			

Substance Use History

Substance Type	Current Use (last 6 months)				Past Use		
	Yes	No	Frequency	Amount	Yes	No	Frequency
Tobacco	☐	☐			☐	☐	
Caffeine	☐	☐			☐	☐	
Alcohol	☐	☐			☐	☐	
Marijuana	☐	☐			☐	☐	
Cocaine/crack	☐	☐			☐	☐	
Ecstasy	☐	☐			☐	☐	
Heroin	☐	☐			☐	☐	
Inhalants	☐	☐			☐	☐	
Methamphetamines	☐	☐			☐	☐	
Pain Killers	☐	☐			☐	☐	
PCP/LSD	☐	☐			☐	☐	
Steroids	☐	☐			☐	☐	
Tranquilizers	☐	☐			☐	☐	

Have you had withdrawal symptoms when trying to stop using any substances? ☐ Yes ☐ No

Is 'yes' please describe.

_____

_____

_____

Have you had problems with work, relationships, health, law enforcement, etc. due to substance use?
☐ Yes ☐ No

Is 'yes' please describe.

_____

_____

_____

Medical Information

Date of last physical exam:_____

Name and contact of primary care physician: _____

Have you experienced any of the following medical conditions during your lifetime?

☐ Allergies	☐ Asthma	☐ Headaches
☐ Stomach aches	☐ Chronic pain	☐ Surgery
☐ Serious accidents	☐ Head injury	☐ Dizziness/fainting
☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High fevers	☐ Diabetes	☐ Hearing problems
☐ Miscarriage	☐ Sexually transmitted disease	☐ Abortion
☐ Sleep disorder		

☐ Other _____

Please list any CURRENT health concerns.

_____

_____

_____

Current prescription medications: ☐Yes ☐No

Medication	Dosage	Date First Prescribed	Prescribed by

Current over-the-counter medications (including vitamins, herbal remedies, etc.). ☐Yes ☐No

_____

_____

_____

Allergies and/or adverse reactions to medications: ☐Yes ☐No

_____

_____

_____

Interpersonal/Social/Cultural Information

Please describe your social support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends
☐ Students ☐ Co-workers ☐ Support Group
☐ Community Group
☐ Religious/Spiritual Center (Name: _____)

To which cultural or ethnic group do you belong? _____

Please describe and difficulty you have experienced due to cultural or ethnic issues.

_____

_____

_____

Please describe your strengths, skills, and talents.

_____

_____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.).

_____

_____

_____

Insurance/Financial Information

Name of Primary Insurance: _____

Policyholder's Full Name: _____

Policyholder's Address: _____

Policyholder's Date of Birth: _____

Policyholder's Social Security Number: _____

Policyholder's Employer: _____

Group Number: _____

Policy/ID Number: _____

Insurance Telephone Number: _____

Client's or authorized signature. I authorize both the release of any medical information necessary to process my claim and authorized payment or medical benefits to The Psychology Clinic and the providing therapist.

Name: _____ Date: _____

Do we have permission to communicate with the person/organization referring you to this office?

☐ Yes ☐ No

Name: _____ Date: _____

Secondary Insurance/Financial Information

Do you have a secondary insurance? ☐ Yes ☐ No

Name of Secondary Insurance: _____

Policyholder's Full Name: _____

Policyholder's Address: _____

Policyholder's Date of Birth: _____

Policyholder's Social Security Number: _____

Policyholder's Employer: _____

Group Number: _____

Policy/ID Number: _____

Insurance Telephone Number: _____

Client's or authorized signature. I authorize both the release of any medical information necessary to process my claim and authorized payment or medical benefits to The Psychology Clinic and the providing therapist.

Name: _____ Date: _____

Do we have permission to communicate with the person/organization referring you to this office?

☐ Yes ☐ No

Name: _____ Date: _____

Policies and Procedures

Health Insurance Portability and Accountability Act

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Georgia Notice, which is attached to this agreement, explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session.

Confidentiality

All communications between client and therapist will be held in confidence, and will not be revealed to anyone unless you give written authorization to release this information. Your legal right to privileged communication between a licensed professional counselor and a client will be upheld unless overruled in a court of law during a legal proceeding. Georgia law required that confidentiality be waived when the client's or other's personal safety is threatened or when disclosure of neglect/abuse of vulnerable populations, is made to the therapist. If we determine that a client presents a serious danger of violence to another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

Financial Arrangements and Insurance

The 50-minute individual and/or family sessions are billed at a range of $75- $200 per clinical hour. It is your responsibility to pay your bill. Our office will be glad to file your primary and secondary insurance for you (please provide our office with a copy of your insurance card). We cannot file tertiary insurance. **If your insurance company is unwilling to pay, it is your responsibility to make payment and contact the insurance company.**

Your signature below indicates that you have read and understand the policies and procedures of The Psychology Clinic and agree to abide by these terms. It also serves as an acknowledgment that you have received/reviewed the HIPPAA notice form described above.

Name: _____ Date: _____

Late Cancellation/Missed Appointment Policy

We reserve a therapeutic hour for each person(s) scheduling an appointment; and our income is based entirely on the hours we see clients. If someone cancels late or misses an appointment, we incur a loss of income for that hour and are not able to offer that time to someone who may be waiting, possibly in crisis. Therefore, we must have an agreement that the appointment will be kept or, if you must cancel, we need to have ample notice to prevent this type of loss.

Regardless of cause, The Psychology Clinic requires a 48-hour notice on cancellation to release you from your responsibility for that time scheduled. **You will be billed for late cancellation and/or missed appointments at a rate of $65.00 per clinical hour.** Please note that insurance companies do not reimburse for canceled or missed sessions.

I agree to the above terms of the late cancellation/missed appointment policy of The Psychology Clinic and will make prompt payment on any charge I incur for a late cancellation or missed appointment. I understand the therapeutic and economic necessity of such a policy.

Name: _____ Date: _____

Georgia Notice Form

Notice of Counselor's Policies and Practices to
Protect the Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider such as your family physician or another psychologist.
- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our [office, clinic, practice] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our [office, clinic, practice], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given more protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided that each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage. Law provides the insurer the right to contest the claim.

III. **Uses and Disclosures with Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.
- *Adult and Domestic Abuse* – If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authorities.
- *Health Oversight Activities* – If we are the subjects of an inquiry by the Georgia Board of Professional Counselors, we may be required to disclose protected health information regarding you in proceedings before the Board.
- *Serious Threat to Health or Safety* – If we determine, or pursuant to the standards of our profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

I have read the above and understand that it is my responsibility to make sure all insurance requirements are fulfilled. It is also my responsibility to notify this office of any changes in my insurance. I agree to be responsible for all charges incurred with The Psychology Clinic that result from non-covered services or client's failure to meet insurance requirements.

Name: _____ Date: _____