



PLEASE COMPLETE ALL PAPERWORK AND RETURN TO OUR OFFICE:

The Psychology Clinic
2000 Southwood Drive
Lake Charles, LA 70605

THANK YOU FOR CONTACTING OUR OFFICE

WE HAVE SET YOUR APPOINTMENT FOR:

PLEASE COMPLETE AND RETURN THE ENCLOSED FORMS TO OUR OFFICE BY:

IF WE ARE HOLDING AN APPOINTMENT TIME AND DON'T RECEIVE THE FORMS 48 HOURS IN ADVANCE OF THE APPOINTMENT TIME WE'LL CANCEL YOUR APPOINTMENT. UPON RECEIVING YOUR PAPER WORK WE'LL THEN CONTACT YOU TO RESCHEDULE.

PLEASE ARRIVE 15 MINUTES EARLY SO WE CAN MAKE COPIES OF INSURANCE CARDS.

AGREEMENT TO PAY

ONCE AN APPOINTMENT IS SCHEDULED I UNDERSTAND IT'S MY RESPONSIBILITY TO NOTIFY THE OFFICE ABOVE 24 HOURS BEFORE THE SCHEDULED APPOINTMENT TIME IF I CHOOSE TO NOT KEEP THE APPOINTMENT OR IF I NEED TO RESCHEDULE DUE TO UNFORSEEN DIFFICULTIES. I AGREE TO PAY THE NON-REFUNDABLE FEE OF \$50 (LCSW/LPC) or \$75 (Ph.D) IF I GIVE LESS THAN 24 HOURS NOTICE OR IF I DO NOT SHOW UP FOR MY SCHEDULED APPOINTMENT.

(Print Name)

(Date)

(Signature of Responsible Party)

(Date)

Insurance Information

Clinician: _____ Appointment Date: _____
Patient Name: _____ DOB: _____ SSN: _____
Patient Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Alternate Phone: (____) _____

Insurance Company: _____ Phone: (____) _____

Subscriber ID: _____ Group No: _____

Subscriber's Name: _____ DOB: _____ SSN: _____ - _____ - _____

Subscriber's Address: _____ City, State, Zip: _____

Phone: (____) _____ Alternate Phone: (____) _____

Employer: _____

OFFICE USE ONLY

Effective Date: _____

Co-Pay/Co-Insurance: _____

Deductible: _____ Deductible Met?: _____

No. of Visits: _____

Authorization: _____

Out of Pocket _____

Psychological Testing Covered the Same? _____

Mail Claims To:

ADULT INTAKE FORM
THE PSYCHOLOGY CLINIC
2000 SOUTHWOOD DRIVE, LAKE CHARLES, LA 70605

DATE: _____

IDENTIFYING INFORMATION:

Client Name: _____

Address: _____

Date of Birth: _____

Contact Information: Indicate your preferred means of communication:

Cell Phone: _____	OK to leave a message:
Home Phone: _____	YES NO
Work Phone: _____	YES NO
	YES NO

Emergency Contact Information:

In case of emergency, I give permission for the following party to be contacted:

Name: _____

Relationship: _____

Phone: _____

Does this person know you are coming to therapy? YES NO

PSYCHO-SOCIAL HISTORY

The following information is requested in order that your therapist may develop an initial understanding of the issues for which you are seeking counseling. It is okay to leave questions unanswered if you do not know an answer or are uncomfortable providing the information.

PRESENTING PROBLEM (reason you are seeking counseling):

Please provide a brief description of the problems you are experiencing:

How long have you been experiencing these problems? If possible, provide the approximate date/time-period during which you first began to have concerns about these issues.

PSYCHIATRIC/MENTAL HEALTH HISTORY

Have you received previous counseling for these or other concerns? YES NO
Approximate dates of treatment: _____

Have you ever received psychiatric out-patient treatment? YES NO
Approximate dates of treatment: _____

Have you ever been hospitalized for mental health issues? YES NO
Approximate dates of hospitalization/s: _____

Is there a family history of psychiatric problems? YES NO
If you are able, please provide the relationship of family member/s and the diagnosis/es.

Have you experienced any trauma, recently or in the past? YES NO
If so, please provide a brief description and time frame of the event/s.

MEDICAL CONDITIONS/HISTORY:

Please list your current medical providers:

Primary Care Physician: _____
Psychiatrist: _____
Other: _____

Please provide a brief explanation of any chronic medical conditions:

Have you experienced any significant injuries or illnesses recently or in the past? If so, please provide a brief explanation.

Please list current medications:

Medication	Dose	Prescribing Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If necessary, please use an additional sheet of paper to complete medication list.

SUBSTANCE USE:

Have you received substance abuse treatment previously? YES NO
If so, approximate dates? _____

Do you drink alcohol? YES NO
Approximately how many drinks per week? _____

Do you use any substance other than alcohol? YES NO

FAMILY HISTORY:

Were you raised by your: Birth parents? YES
Another: _____ (Relationship)

Are both your parents still living? YES NO
Date of death: Mother _____ Father _____

Are/were your parents divorced? YES NO
Your age at time of divorce: _____

RELATIONSHIP HISTORY:

Are you currently married or in a committed partnership? YES NO

Date met current partner/spouse: _____

Date married/committed to current partner/spouse? _____

Are you currently experiencing difficulty with your relationship? YES NO

Have you previously been in a committed relationship/marriage? If more than one previous relationship/marriage, please provide dates for each:

Date married/committed:	Date separated/divorced
_____	_____
_____	_____
_____	_____

Please list your children and dates of birth:

Are there any other children in your household? YES NO
If so, please indicate relationship to you or your partner/spouse.

SOCIAL HISTORY:

Are you active in any social/civic/religious organizations? YES NO

Do you enjoy supportive friendships? YES NO

DEVELOPMENTAL HISTORY:

Provide a brief explanation of any significant developmental delays/learning difficulties in childhood:

Provide a brief explanation of any life situations which interfered with your education:

EDUCATIONAL/OCCUPATIONAL HISTORY:

Highest level education: (Please circle)

High School: Attended Graduate
College: Attended Graduate Bachelors Masters Doctorate

Current Employer: _____
Job Title: _____

LEGAL HISTORY:

Are you currently involved in any legal proceedings? YES NO

If so, please indicate the nature of the legal proceeding:

Family/divorce/custody: _____
Criminal: _____
Civil: _____

Do you have any previous convictions? YES NO

Please complete the symptom checklist on page 6.

Thank you for your time in completing this information packet. This information is kept strictly confidential.

Client Name: _____

Date: _____

Form completed by (if other than client): _____

Check the following symptoms/ behaviors you are currently experiencing (have been occurring in recent weeks or regularly for the past 2 to 3 months):

- | | | |
|---|--|--|
| Physical Symptoms | Behavior | Anxiety |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Shy | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Stressed |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Have run away | <input type="checkbox"/> Phobic |
| <input type="checkbox"/> Too much sleep | <input type="checkbox"/> Physically abusive | <input type="checkbox"/> Worry a lot |
| <input type="checkbox"/> Too little sleep | <input type="checkbox"/> Verbally abusive/threatening | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Problems with drugs/alcohol | <input type="checkbox"/> Frustrated easily |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Cheating/lying | <input type="checkbox"/> Tense |
| | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Shaky/Jittery |
| | <input type="checkbox"/> Sexual problems | |
| | <input type="checkbox"/> Unassertive | |
| | <input type="checkbox"/> Blaming of others | |
| | <input type="checkbox"/> Uncommunicative | |
| Mood | <input type="checkbox"/> Compulsions | Thought |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Physically abused | <input type="checkbox"/> Seeing/hearing things that aren't there |
| <input type="checkbox"/> Quarrelsome | <input type="checkbox"/> Verbally abused | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Difficulty in relationships | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Tired | <input type="checkbox"/> Controlling/domineering | <input type="checkbox"/> Want to run away |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Demanding | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Lonely | | <input type="checkbox"/> Distractible & inattentive |
| <input type="checkbox"/> Drastic & quick mood changes | <input type="checkbox"/> Opposition to authority | <input type="checkbox"/> Lack of trust |
| <input type="checkbox"/> Feeling inferior | <input type="checkbox"/> Irresponsible | <input type="checkbox"/> Feelings of unreality |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Lack self-control | <input type="checkbox"/> Forgetful |
| <input type="checkbox"/> Not enjoying things | <input type="checkbox"/> Make inappropriate noises | <input type="checkbox"/> Difficulty with memory |
| <input type="checkbox"/> Lack of interest | <input type="checkbox"/> Violent | <input type="checkbox"/> Lack self-esteem |
| <input type="checkbox"/> Detached | <input type="checkbox"/> Temper outburst | <input type="checkbox"/> Obsessive thoughts |
| | <input type="checkbox"/> Failing at school | <input type="checkbox"/> Spiritual confusion |
| | <input type="checkbox"/> Behavior problems at school | <input type="checkbox"/> Racing Thoughts |
| | <input type="checkbox"/> Attention seeking | |
| | <input type="checkbox"/> Unusual sexual behavior | |
| | <input type="checkbox"/> Work difficulties | |
| | <input type="checkbox"/> Dangerous behaviors | |
| | <input type="checkbox"/> Damaged/stolen property of others | |
| | <input type="checkbox"/> Overeating | |
| | <input type="checkbox"/> Binging/purging | |
| | <input type="checkbox"/> Gambling Excessively | |

For Your Information

We have prepared this form because we want you to know your rights and responsibilities as a client. Please read this information and sign at the end. Your signature documents that you have read and that you understand this information. We will be pleased to answer any questions you have regarding this or any related material.

Fees & Payment

The fee for a 45-minute first appointment intake session is \$150 for a LCSW/LPC or \$190 for a Ph.D.; following appointments are \$100 for a Clinician or \$150 for a Ph.D. per visit. There may be charges for other services such as testing, court appearances or depositions, reports, phone calls exceeding ten minutes with you or third parties (attorneys, doctors, insurance carriers, managed care reviewers). Payment is expected at the time of service.

Missed Sessions

We will try to call you to verify your appointment a day in advance. It is your responsibility, however, to call and cancel an appointment at least 24 hours in advance to avoid being billed for missing a session. Missed session fees are half of the fee for a regular sit: \$50 for a LCSW/LPC and \$75 Ph.D. Fees for a missed session are NOT covered by insurance.

Insurance

The charges for our services are covered to varying extents by most health insurance policies. Our billing office is happy to assist you in filing with your insurance carrier for reimbursement. Our contract for payment, however, is with the client and NOT with the client's insurance carrier.

Insurance coverage varies a great deal among different policies. We will be happy to contact your insurance carrier for you and verify your coverage. The basic questions to be answered include:

Is there a deductible to be met?

Are outpatient mental health benefits covered and is pre-certification necessary?

What percentage of the fee will the insurance cover, and is there a limit on the eligible charges?

Is there a limit on the number of sessions allowed?

Are reviews by managed care required?

If there is more than one insurance company, are there special rules to follow?

Clients must make full payment at the time service is rendered until the deductible has been met. Thereafter, clients must pay their co-payment amount and we will submit claims to the insurance company for the remaining amount. It is the client and NOT the insurance company who is ultimately responsible for payment.

Insurance companies require that a diagnosis be provided in order for a claim to be processed. In some cases, insurance companies will not pay for some certain diagnoses.

If you have any concerns about your insurance billing, please feel free to discuss them with our staff.

Confidentiality

Any information that you reveal to your therapist is considered “privilege communication”, and it is your right to have that information kept confidential. Mental health professionals are not allowed to release any information about clients without a signed “Release of Information” form that permits the transfer of specific information to a specified individual. This form is valid for one year.

There are only rare situations in which information about clients may be released with or without the client’s permission. These situations are as follows:

When a child is physically abused, neglected, or sexually abused, we are required by law to contact the proper authorities (Police, State Department of Family Services).

When a client or another individual is in clear and immediate life threatening danger as with homicide or suicide, we are required by law to take steps to insure their safety, even if it means contacting authorities without the client’s permission.

In addition, there are situations in which the client is involved in civil or criminal litigation where the therapist and his/her records can be subpoenaed, particularly when the client is suing someone for damages based on emotional injury or when the client is involved in a child custody proceeding.

Emergency Coverage

Each therapist can be reached during office hours at (337)-474-2682. After ours, the phone will be transferred to an answering service that will locate either your therapist or the therapist on call for emergency situations. Please let the operator know if your call is an emergency. When your therapist is out of town, he/she will make arrangements for another therapist to cover crisis situations. In the unlikely event that your therapist and the on-call therapist cannot be reached quickly in an Emergency, you may consider calling your family physician, a local hospital, or the Lake Charles Mental Health Center at (337)-475-8022

I have read and I understand the office policy.

Signature

Date

Witness

Date