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 APPOINMENT TIME AND DON'T RECEIVE THE FORMS 48 HOURS IN ADVANCE OF THE APPOINTMENT TIME WE'LL CANCEL YOUR APPOINTMENT. UPON RECIEIVING 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)

Assignment of Insurance Benefits
Acknowledgement of Indebtedness
& Consent to Release Information

Insured Patient: _____
(Please Print)

For services provided, I hereby irrevocably assign and transfer to The Psychology Clinic of Lake Charles, LA, my rights and interest in all benefits due under the applied insurance policy or in my rights against any third party who might be held liable for the services described in the statements rendered by the hospital.

I hereby consent that The Psychology Clinic may release information concerning the above party and furnish copies of my records if requested by the insurance company. I hereby release The Psychology Clinic from legal responsibility or liability for furnishing such records or information to the extent indicated and authorized herein. I acknowledge that the Law of the State of Louisiana controls and governs the interpretation of this agreement.

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

_____ _____ _____
Date Signature Relationship to Patient

Person Responsible for Payment

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic of Lake Charles for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

I hereby stipulate and agree to pay all cost of collections or attorney fees and court fees should it become necessary to resort to court action or turn my account over to a collection agency.

_____ _____
Date Signature

In order to control our costs of billing, office visits are to be paid at the time the service is rendered.

Insurance Information

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:
_____

_____

The Psychology Clinic
2000 Southwood Drive
Lake Charles, LA 70605

Privacy Consent

I understand that as a condition to my receiving treatment at The Psychology Clinic, The Psychology Clinic may use or disclose my protected health information for the purpose of 1) providing treatment and 2) obtaining payment for treatment, and 3) as necessary for the operations of The Psychology Clinic. These uses and disclosures are explained more fully in the Notice of Privacy Practices, which has been provided to me and which I have had the opportunity to review.

I understand that the privacy practices described in the Notice of Privacy Practices may be revised in the future, and that I have a right to request from The Psychology Clinic a copy of any revised Notice.

_____ _____

Name Date

_____ _____

Witness Date

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:

		OK to leave a message:	
Cell Phone:	_____	YES	NO
Home Phone:	_____	YES	NO
Work Phone:	_____	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 N0
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

_____ Insomnia
_____ Nightmares
_____ Headaches
_____ Weight loss
_____ Too much sleep
_____ Too little sleep
_____ Loss of appetite
_____ Weight gain

Mood

_____ Angry
_____ Quarrelsome
_____ Depressed
_____ Tired
_____ Withdrawn
_____ Lonely
_____ Drastic & quick mood changes
_____ Feeling inferior
_____ Irritable
_____ Not enjoying things
_____ Lack of interest
_____ Detached

Behavior

___ Shy
___ Impulsive
___ Lethargic
___ Have run away
___ Physically abusive
___ Verbally abusive/threatening
___ Problems with drugs/alcohol
___ Cheating/lying
___ Legal problems
___ Sexual problems
___ Unassertive
___ Blaming of others
___ Uncommunicative

___ Compulsions
___ Physically abused
___ Verbally abused
___ Difficulty in relationships
___ Controlling/domineering
___ Demanding

___ Opposition to authority
___ Irresponsible
___ Lack self-control
___ Make inappropriate noises
___ Violent
___ Temper outburst
___ Failing at school
___ Behavior problems at school
___ Attention seeking
___ Unusual sexual behavior
___ Work difficulties
___ Dangerous behaviors
___ Damaged/stolen property of others
___ Overeating
___ Binging/purging
___ Gambling Excessively

Anxiety

___ Nervous
___ Anxious
___ Stressed
___ Phobic
___ Worry a lot
___ Panic
___ Frustrated easily
___ Tense
___ Shaky/Jittery

Thought

___ Seeing/hearing things that aren't there
___ Suicidal thoughts
___ Homicidal thoughts
___ Want to run away
___ Difficulty concentrating
___ Distractible & inattentive

___ Lack of trust
___ Feelings of unreality
___ Forgetful
___ Difficulty with memory
___ Lack self-esteem
___ Obsessive thoughts
___ Spiritual confusion
___ Racing Thoughts

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 visit: $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 a 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