THE CENTER for Psychological Services

ADULT INTAKE PACKET

Dear Client:

Welcome to The Center For Psychological Services Ltd. Attached you will find our registration packet which includes the following forms:

I. BIOGRAPHICAL INFORMATION

II. AGREEMENT FOR SERVICES

III. HIPAA: NOTICE OF PRIVACY PRACTICES - *signature page*

IV. LIMITS OF CONFIDENTIALITY

V. ELECTRONIC COMMUNICATIONS STATEMENT

Please take time to read over the information and sign where necessary. *Be sure to ask your doctor or therapist any questions you may have.*
We look forward to working closely with you on making changes that you and/or your family members hope to make as a result of the therapy process. We have found that those who experience the most successful outcomes here have:

1. **Clearly defined as goals** what they hope to achieve. Usually this is done during the first or second session and revised as necessary.
2. **Formed an effective working relationship** with their therapist or doctor. Be sure to talk over any concerns or questions you have about the therapy process with your therapist or doctor.
3. **Kept appointments as scheduled**; each visit builds on the ones before.
4. **Done any recommended "homework"** between sessions. In many ways, what you do at home, work or school can have a profound effect on your progress.
5. **Have discussed expectations** that may exceed the scope of private practice behavioral health services.

The Center is deeply committed to providing you with the highest quality comprehensive state-of-the-art behavioral health services for children, adolescents, adults, couples, and families. We utilize a variety of therapeutic approaches and services to help you successfully adapt and balance life's stressors and challenges as you move toward a fuller, richer life. We thank you for placing your confidence in us and look forward to meeting with you.

Sincerely,
Victoria L. Williams, MSN, Psy.D., LCP
Licensed Clinical Psychologist
Director, The Center for Psychological Services, Ltd.

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SECTION I: BIOGRAPHICAL INFORMATION

Date: _____ Therapist here to see: _____

CLIENT NAME: _____ DOB: _____ AGE: _____

SEX: __M __ F__ MARITAL STATUS: __ single __ married __ divorced __
Preferred Pronoun: _____ __ separated __ widow __ minor

ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

Home #: (___) ___ - _____ List Family Members / Ages: _____
Cell #: (___) ___ - _____ _____
Work #: (___) ___ - _____. _____

Please indicate preferred contact # _____ May we leave a message: ___ yes ___ no

Our system generates automatic reminder calls or texts to your preferred #.
Please check to choose format: **Call** - _____ **Text-** _____ **No Reminder-**_____

If you have any special direction concerning mail delivery to your stated address please note here:
_____

EMPLOYER: _____ OCCUPATION/POSITION:_____

EMERGENCY CONTACT: _____ RELATIONSHIP TO CLIENT: _____
EMERGENCY CONTACT PHONE #:(___) ___ - _____.

If there should be a need for us to contact your emergency contact person, we will only disclose any information that is related to the emergency situation. Please initial here that you understand this.

I understand that in an emergency situation, relevant information will be disclosed. _____
initial

If client is a minor, please complete the following:

WHO DOES MINOR RESIDE WITH: _____RELATIONSHIP TO CLIENT:_____
NAME OF RESPONSIBLE PARTY: _____ SCHOOL/GRADE:_____

How did you hear about us?

___ website: ___ friend: ___ relative: ___ school: ___ physician: ___ other: _____

FOR OFFICE USE:
DX: _____ Session fee: _____ Agreement for Services form read & signed __ Yes __ No
copy of insurance card ___ Driver's license ____ Credit card on file ____

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SYMPTOMS

Check the box beside each concern experienced recently

☐ Anxiety	☐ Depression	☐ Sleeping Problems	☐ Thoughts of Suicide
☐ Panic	☐ Unusual thoughts	☐ Anger Outbursts	☐ Weight Change
☐ Crying Spells	☐ Memory Problems	☐ Sexual Problems	☐ Relationship Issues
☐ Treated Unfairly	☐ Frequent Pain	☐ Low Energy/Lethargic	☐ Concentration problems
☐ Restlessness	☐ Nausea	☐ Eating Disorder	☐ Legal Difficulties
☐ Drug Use	☐ Alcohol Abuse/Heavy	☐ Boredom	☐ Hopelessness
☐ Stress	☐ Shyness	☐ Work Problems	☐ Confusion
☐ Feelings of Guilt	☐ Suspicion	☐ Loneliness	☐ Violent Thoughts
☐ Compulsions	☐ Worry	☐ Financial Problems	☐ Difficulty with decisions
☐ Specific Fears	☐ Mourning	☐ Physical Illness	☐ Lack of Motivation
☐ Feeling Abandoned	☐ Meaninglessness	☐ Perfectionism	☐ Unusually Sensitive
☐ Irritability	☐ Social Withdrawal	☐ Feeling Misunderstood	☐ Troublesome Thoughts
☐ Religious Concerns	☐ Disappointment	☐ Impulsive Behavior	☐ Hearing strange voices
☐ Feelings of Inferiority	☐ Irrational Thoughts	☐ Mood Swings	☐ No Present Concerns

Enter any additional concerns or symptoms in the blank space below:

_____

_____

_____

What stresses or life changes have you experienced recently?

_____

_____

_____

Have you seen a therapist in the past?

Year	Problem	Therapist or Clinic	Treatment Duration

Your family growing up:

Relationship	First Name	Personality / Mental health issues
Mother		
Father		

If you need more space for additional family members please continue below:

_____

_____

_____

Where are you currently living?

- ☐ Dorm/Campus Apartment
- ☐ Apartment
- ☐ House
- ☐ Other
- ☐ Health Care Facility
- ☐ Retirement Community
- ☐ With Relatives

Who lives with you now?

_____

Childhood

Check the box beside issues experienced in childhood:

☐ Happy Childhood	☐ Neglected	☐ Moved Frequently
☐ Physically Abused	☐ Few Friends	☐ Sexually Abused
☐ Weight Problems	☐ Popular	☐ Parents Divorced
☐ Family Fights	☐ Poor Grades	☐ Conflict with Teachers
☐ Drug/Alcohol Use	☐ Good Grades	☐ Sexual Problems
☐ Depressed	☐ "Spoiled"	☐ Anxious
☐ Not Allowed to Grow-Up	☐ Attention Problems	☐ Anger Problems

Enter any additional childhood experiences or symptoms in the space below:

_____

_____

_____

Relationship History

How many times have you been married? _____

How old were you at the time of your marriage(s)? _____

Briefly describe any problems in your current or past marriages or cohabitation relationships:

_____

_____

_____

Education and Occupation

Are you currently - (circle one) Working Unemployed in school

Highest level of education completed?

_____

What is (or was) your major or favorite subject? _____

How many hours per week are you working? _____

In what field do you usually work? _____

Briefly describe what you like and dislike about your employment or school:

_____

_____

Home Life

How do you spend personal time? (hobbies, sports, clubs, groups, family activities, etc.)

How many contacts do you have each month with friends outside of work or school?

Who can you talk with about personal feelings or private matters?

Are you satisfied with your romantic life?

Briefly describe what you like and dislike about your current romantic relationships and friendships:

_____

_____

_____

Health

Check each accident or illness you have experienced:

- ☐ Recent surgery
- ☐ Head injury
- ☐ Seizures
- ☐ Thyroid problems
- ☐ Drug/alcohol abuse treatment
- ☐ Neurological disorder
- ☐ Chronic pain
- ☐ Headaches
- ☐ Diabetes
- ☐ Hormone problems
- ☐ Infertility
- ☐ Miscarriages

List any other chronic health problems you may have:

_____

_____

_____

How many hours do you sleep in an average night? _____

How many drinks (containing alcohol) do you consume in an average week? _____

Which recreational drugs have you used in the last year? _____

List any prescription or over-the-counter medications you may take, along with the purpose of medicine?

_____

_____

_____

Do you exercise? How? How often?

_____

Do you use tobacco? How much?

_____

Who is your primary physician? (Include phone number if known.)

_____

_____

_____

When was your last physical? _____

Are you concerned about your physical health?

_____

Accomplishments & Additional Information

List your personal strengths and important accomplishments:

_____

_____

_____

THE CENTER for Psychological Services

SECTION II- AGREEMENT FOR SERVICES

Please read this document carefully as it outlines our professional service policies. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychological testing, evaluation and psychotherapy can have benefits and risks. These services often lead to better relationships, significant reductions in feelings of distress, and better performance in school or work. On the other hand, since these services often involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings (e.g., sadness, shame, guilt, anger). You may even feel worse for a period of time.

One of the best predictors of success in achieving your goals is the "goodness of fit" between you and your therapist. If you have any doubts about working with your therapist for any reason, we welcome you to share your concerns. Your therapist will do likewise, including if your needs go beyond the scope of this private practice. We are fortunate to have a large team of therapists at our Center, as well as connections within the community, so that we can offer additional recommendations better suited for you.

The beginning of services will involve an evaluation of your needs and goals, reasons for seeking testing or therapy services at this time, and a brief family and life history. In the first few meetings we will discuss initial impressions, treatment plan, and methodologies that are most likely to be useful for you.

APPOINTMENTS

Appointments will ordinarily be once per week as agreed upon. Typically sessions become less frequent as you gain traction in achieving your goals. It is important to be on time for your scheduled appointments since sessions will end on time regardless of your arrival time.

Should you need to cancel or reschedule a session, **please give at least 24 hrs notice**. Insurance companies do not provide reimbursement for canceled sessions. If you miss a session without canceling or cancel with less than 24 hrs notice, **our policy is to collect $50 per missed therapy session or $150 for missed testing sessions** (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, we will try to find another time to reschedule your appointment.

PROFESSIONAL FEES

The standard fee is $168 per hour. It is our practice to charge this amount on a prorated basis for sessions that require more time (e.g., Emergency Evaluations or Wellbeing Checks), other professional services that you may require such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings or consultations which you have requested, or the time required to perform other services which you may request.

PAYMENT TERMS AND INSURANCE

We strongly believe that part of a **healthy working alliance involves staying current with your account** here at The Center for Psychological Services. This enables us to pay your therapist/counselor for services rendered.

When you initiate services, our Billing Office will obtain a **quote of benefits from your insurance company** and will share that information with you. ***(as a reminder, this is a quote of benefits, not a guarantee of payment)***

If your insurance carrier or coverage should change, you are responsible for notifying us of this fact. If this results in an increase of your session fee, you are responsible for this additional payment; should it reduce your fee, we will adjust on our end.

If our Center is not a participating provider for services in your insurance plan, we will supply you with the invoice necessary to submit to your insurance company. We also offer a "fee for service" option.

Your portion of the session fee is due at the point of service. Please check in with our Front Desk to pay fees before your session; should our Front Desk not be available, kindly pay your therapist by the end of your session. If someone from your family is receiving services and not responsible for payment, please be sure payment arrangements are made before the session. We welcome credit cards, cash or check; there is a $30 charge for returned checks. Future appointments are scheduled when accounts are current.

CONTACTING YOUR THERAPIST

We check our voicemails throughout the business day at the Center and return calls typically within 24 hours except weekends and holidays. When leaving a voicemail or electronic communication, please be specific and brief.

If for unseen reasons, you do not hear from your therapist or there is difficulty in reaching you, and safety is a concern for you or your child, please go to your nearest Emergency Room or call 911 and ask to speak to the mental health worker on call.

Your therapist will let you know in advance of planned absences, and provide you with contact information of a mental health professional to contact if necessary.

_____

Signature of client / financially responsible party Date **Printed name** of client

Therapist signature: _____ **Date:**_____

SECTION III - HIPAA- NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA) - *notice of policy and practices to protect the privacy of your health information.*

Please review the HIPAA policy document located under "Forms" on our website *cpstherapy.com* **and sign & date below that you have read it: (if you're in the office filling this out, please refer to the HIPAA document attached to the clipboard.**

I, _____ , do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax:

I fully understand and accept the terms of this consent.

_____ _____ _____

Signature of client (at least 12 yrs of age) Date **Printed name** of client

THE CENTER for Psychological Services

IV - LIMITS OF CONFIDENTIALITY

In general, the privacy of all communications between client and therapist or psychologist is protected by law, and we can only release information about our work to others with your written permission. **But, there are a few exceptions**:

- In most legal proceedings, you have the right to prevent us from providing any information about your treatment. *In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony.* However, such an order is unlikely. We would advise you never to agree to any release of information without first discussing it with us.

- There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. For example, *if we believe that a child, elderly person or disabled person is being abused, we must file a report with the appropriate state agency.*

- *If we believe that a client is threatening bodily harm to another, we may be required to take protective actions.* These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for our clients.

- *If a client threatens harm to herself/himself, we may be obligated to seek a higher level of care including hospitalization, and/or to contact family members who may help provide protection.* If a similar situation occurs in the course of our work together, we will attempt to fully discuss it with you before taking any action.

The prior situations have rarely occurred in our practice. ***If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.***

We may occasionally find it helpful to consult with other professionals about a client in order to provide best care. During a consultation, we make every effort to completely disguise the identity of each client. Consultants are also legally bound to keep information confidential. If you don't object, we typically will not tell you about these consultations unless we believe it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful about potential exceptions to confidentiality, *it is important to discuss any questions or concerns that you may have as we go along*. We will be more than happy to discuss these issues with you. Please note, however, that we are not an attorneys, and formal legal advice is sometimes warranted because the laws governing confidentiality are quite complex.

_____ _____ _____

***Signature** of client* Date **Printed** name of client

THE CENTER for Psychological Services

V - ELECTRONIC COMMUNICATIONS STATEMENT

Electronic Medical Records/Communication:
At The Center for Psychological Services, we use an electronic medical records system and patient portal messaging system that is HIPAA compliant.

Email Communication:
This form of communication is not advised. Please use the "message" feature via your Patient Portal.

Text Communication:
Should you have an agreement with your therapist to utilize texting as means to communicate, Please be advised that due to the nature of variable security measures and phone service providers, we do not encourage or promote a text exchange that goes beyond non-personal dialogue, i.e. rescheduling/confirming an appointment.

Social Media:
Our center policy is to not communicate with clients through social media platforms like Twitter, or Facebook. In addition, if your therapist discovers that he/she has accidentally established an online relationship with you, they will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

Website:
We have a website which we use for professional reasons to provide information to others about our practice. You are welcome to access and review the information that is on the website, and if you have any questions about it, we should discuss this during your therapy sessions.

_____ _____ _____

Signature of client (at least 12 yrs of age) Date **Printed name** of client