INTAKE FORM - CONFIDENTIAL

Patient Information:

Date: _____

Last Name:_____First:_____ MI: _____

Date of Birth:_____Age:_____Sex:_____ SSN: _____

Mailing Address:_____

City/State:_____Zip: _____

Home Phone: (___) ____ - _____ Work: (___) ____ - _____ Marital Status: _____

Name of Person(s) Financially Responsible: _____

Relationship to Patient: _____

Address (if different than patients): _____

City/State:_____Zip: _____

Employer/School Information:

Name:_____ Occupation: _____

Address: _____

City/State:_____Zip: _____

Education/Degrees:_____Grade:_____

Parent/Spouse's Information:

Name:_____ Phone: ( ) _____

Relationship to patient: _____

Employer Name:_____ Work: ( ) _____

Address:_____City/State/Zip: _____

*In Case of Emergency, Contact: _____

Home:_____Work:_____Other:_____

Medical History

Patient Name: _____

Primary Care Physician:

Name of Practice:_____Dr._____

Address:_____ Phone: ( ) _____

Past Diagnoses (please give the year):

1. _____
2. _____
3. _____

Current Medications (include dosage and frequency):

1. _____ 3. _____
2. _____ 4. _____

Known Allergies: _____

_____

Severe Illnesses (childhood to present): _____

_____

Previous Out/In Patient Therapy (please specify which): _____

_____

Stressors affecting you or your family in the past 1 – 2 years:

_____Deaths	_____Job Change	_____Sexual Abuse
_____Births	_____School	_____Broken Relationship
_____Marriage	_____Step-children	_____Unwanted Pregnancy
_____Divorce	_____Separation	_____Substance Abuse
_____Moving	_____Physical Abuse	_____Medial
_____Chronic Illness	_____Other: _____	

Presenting Problems/Reason for Visit: _____

_____

Release of Information

I, _____ , consent to allow Dr. Roger Moore of The Center for Psychological Wellness to release and/or exchange information regarding the patient, _____.

This information will include:

_____ Procedures

_____ Medical Records

_____ Educational Records

_____ Other _____

_____ Psychological Testing

_____ Therapy Notes

_____ Discharge Summary

_____ All of the above

To/With (Name and Address of Person/Agencies)

_____

_____

_____

_____

I understand that this information will be used in the client's best interests to benefit current psychological evaluation and/or treatment. I understand that the information exchanged will be handled in a professional and confidential manner.

It is the policy of The Center for Psychological Wellness to not release the materials provided by physicians from outside this office regarding the patient's former or current care. You may obtain second party records by contacting the source directly. Second party records will only be released when such records are no longer available from the original source.

I also understand that I may revoke this consent at any time except to the extent that action based on this consent has already taken place. This consent expires in 360 days.

Signature: _____ Witness: _____

Relationship to Patient: _____ Date: _____

POLICIES AND PROCEDURES

APPOINTMENTS

The keeping of appointments is the most effective means of successful therapy. As schedule permits, we will work with you to find a convenient time for your appointments. Scheduling of appointments constitutes an agreement to pay for the professional time reserved for you. Our policy is to charge appointments missed or cancelled with less than 24 hours of notice at the rate of the reserved session. You will be billed directly for this time. We also charge for telephone and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate should the doctor deem it appropriate.

PAYMENT OF FEES

Payment for services is to be made at the time of the appointment. We accept cash, check and MasterCard or Visa. Unpaid account balances must be paid in full by the close of month. Unpaid balances older that 90 days will be charged an interest rate of 1.5% per month.

Should it become necessary to seek outside help to collect on an account the patient will be responsible for any additional fees or charges and an interest rate of 15%.

The patient is responsible for the provider's fee plus expenses should a court appearance become necessary. There will be a $25.00 charge for all returned checks.

Appointments may be rescheduled until payment is received.

CONSENT TO RELEASE INFORMATION

Patient agrees that his or her provider may share information with others providers in the practice to better provide quality care. This information will be confidential.

REPORTS, CONSULTATIONS AND OTHER CLERICAL DUTIES

Any reports, professional consultations or tasks involving time beyond that of the regular scheduled session will be pro-rated and charged according to the professional or clerical time involved.

PLEASE READ CAREFULLY AND SIGN BELOW: I have read and understand the above statements. I agree to comply fully with the policies of this office. I recognize and accept full financial responsibility for all services rendered.

Patient/Resp. Party Signature _____

Date_____Witness_____

The Center for Psychological Wellness

Patient Name _____ DOB _____

SS# _____

I understand that a patient's health information is private and confidential. I understand that The Center for Psychological Wellness works hard to protect my privacy and preserve the confidentiality of my health information.

I understand that The Center for Psychological Wellness may use and disclose my personal health information to help provide health care to me, to handle billing and payments, and to take care of other health care operations. In general, there are not other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatens to hurt another person.

This office has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice of Privacy Practices".

Within the Notice of Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records: restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communications be by specified methods or alternative locations.

The Center for Psychological Wellness has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements information, charges for copies and non-routine information needs, etc. I will assist the office by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of The Center for Psychological Wellness "Notice of Privacy Practices".

Patient or legally authorized individuals signature Date Time

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Relationship to patient(if signed by other then the Patient)