*Updated for 2024*

*Intake Form*

Shari Pescatore, LPC

800 West State Street

Unit 303

Doylestown, PA

(215) 343-3091

Patient’s name:

DOB:

Address: City: State: Zip Code:

Home Phone:

Cell Phone:

Occupation:

Employer:

Referred by:

Phone Number:

Emergency contact:

Emergency Contact Phone number:

Marital status:

Spouse/Partner Name:

Children (names and ages):

Name: Age:

Name: Age:

Name: Age:

Name: Age:

Name: Age:

Pets:

(Use back of form if necessary)

Are you currently taking, or have you ever taken, medications for a psychiatric problem? If yes, please list the name, dosage, and dates of each medication: (Use back of form if necessary):

Psychiatrist/Physician

Name: Phone number:  
May I contact?

Have you ever been hospitalized for a psychiatric problem? If yes, please list the hospital(s), date(s), and reason(s):

Are there any medical problems that have resulted in a significant impact on you? If yes, please describe:

Are you currently taking any medications for medical problems? If yes, please list the name and dosage of each medication: (Use back of form if necessary:

Please check each problem below for which you would like help:

\_\_\_ Anxiety

\_\_\_ Depression

\_\_\_ Fear

\_\_\_ Headaches

\_\_\_ Inactivity

\_\_\_ Mood swings

\_\_\_ Regrets

\_\_\_ Shyness

\_\_\_ Self-esteem

\_\_\_ Marital problems

\_\_\_ Alcohol abuse

\_\_\_ Suicidal

\_\_\_ Assertion

\_\_\_ Loneliness

\_\_\_ Irritable bowel

\_\_\_ Impulsivity

\_\_\_ Sexual problems

\_\_\_ Physical complaints

\_\_\_ Difficulty controlling eating

\_\_\_ Substance abuse

\_\_\_ Anger

\_\_\_ Aggression

\_\_\_ Low energy

\_\_\_ Problem solving

\_\_\_ Social skills

\_\_\_ Insomnia

\_\_\_ Self-criticism

\_\_\_ Procrastination

\_\_\_ Conflict resolution

\_\_\_ Decision making

\_\_\_ Violence

\_\_\_ Hopelessness

\_\_\_ Work

\_\_\_ Friendships

\_\_\_ Overweight

\_\_\_ Underweight

\_\_\_ Agitation

\_\_\_ Panic

\_\_\_ Obsessive Thoughts

Please describe any checked above:

Have you experienced any sources of stress in the past year? If yes, please describe:

Have you ever experienced a trauma? If yes, please describe:

Are there any situations or people you avoid because they make you feel anxious? If yes, please describe:

Do you exercise? If yes, please describe:

What are your typical recreational activities?

Have you ever had or do you have, a problem with substance abuse?   
If yes, please indicate substance(s) (alcohol, medication, and illicit drugs) and dates of use:

Have you ever had a period of 2 days or more when you experienced any of the following?

\_\_\_ Decreased need for sleep

\_\_\_ Racing thoughts

\_\_\_ Unusual desire to spend money

\_\_\_ Easily distracted

\_\_\_ Very talkative

\_\_\_ Unusually high self-esteem

\_\_\_ Driving very fast

\_\_\_ Very irritable or angry

Is there anything else you would like your therapist to know about you?

Family Medical History:

Please explain why you are seeking therapy:

List goals you may like to achieve through your counseling experience:

Your signature below indicates that you have read this agreement and agree to its terms during our professional relationship.

**Client’s Name:**

**Signature:**

**Signature of Parent**:

(if Child is under the age 14 years old)

**PRACTICE AGREEMENT**

Welcome to my practice and thank you for entrusting me with your care. This document contains important information about my professional services and business policies. So that misunderstandings may be avoided, it is very important that you read these policies carefully and ask for clarification when needed. After reading this, please sign and date this form. If you have any questions or concerns about your care, please contact me with your concerns.

**WHAT TO EXPECT FROM OUR PRACTICE**

(For those seeking a Certified Cognitive Behavior Therapist/Counseling): Our first few sessions will involve an evaluation of your needs. During this time, you and I will both decide if I am the best person to provide the services you need to meet your treatment goals. Once psychotherapy has begun, your scheduled sessions are 45 minutes in length as dictated by insurance criteria.

**FEE SCHEDULE** 

This practice accepts checks, payable to “Shari Pescatore, LPC.” as well as Master Card, American Express, Discover and Visa. The fees are as follows:

Initial Diagnostic Interview or Consultation: $250.00

Counseling Session: Standard 45 minute session $200.00

Pre-scheduled 30-minute session: $165.00

Telephone Consultations per quarter hour: $65.00

Form Preparation, per quarter hour increments: $65.00

Preparation or Attendance in Legal Proceedings, per hour: $1200.00

Missed appointment/Late cancellation: $155.00  Returned Checks: $45.00

**INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. Please note that Shari Pescatore is an “Out-of-Network" provider. If you choose to file insurance, our office will gladly fill out a bill that will enable you to submit to current insurance carrier.



**CANCELLATION POLICY:** Your appointment time is reserved exclusively for you. Unless cancelled at least 24 hours in advance, you will be charged, $200.00 for the missed appointment/late cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions emergencies.

**CONTACTING YOUR THERAPIST**: Prior to your initial visit, you will be provided with the office phone number and email address. Please note that email is not a secure form of communication, and its use is best for scheduling purposes. If someone is not available for your immediate attention, please leave a message on the voicemail and someone will make every effort to reach you within 24 hours of your call (with the exception of week-ends and holidays). For psychological emergencies, call 911 and go to your nearest hospital and ask for the psychiatrist on call. If someone will be unavailable for an extended period of time, you will be notified and referred to another colleague, as needed.

**CONFIDENTIALITY**: In general, the law protects the privacy of all communications between a client and a psychotherapist. In most situations, information can only be released about your treatment to others with your written permission, but there are a few exceptions. You should be aware that this practice contracts with independent business associates for administrative purposes, such as, billing and quality assurance.

Disclosures required by healthcare insurers or for overdue fee collection are discussed elsewhere in this Agreement. If the therapist believes that her client presents an imminent danger to his/her health or safety, she may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

If your therapist has cause to suspect that a child under 18 is abused or neglected, or if there is reasonable cause to believe that a disabled adult is in need of protective services, the law requires that a report is filed within the appropriate state agency. If the therapist believes that a client presents an imminent danger to the health of another, the therapist may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the Therapist/client privilege law. The therapist cannot provide information without your written authorization, or a court order. If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend our practice.

Sometimes it is helpful for the therapist to consult each other and other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our clients. The consultant is also legally bound to keep the information confidential. If you don’t object, your therapist will not tell you about these consultations unless we feel that it is important to our work together.

that I cannot be the guardian of any one partner’s secret from the other. If either partner would like to release a copy of the record, I cannot give it to you unless both of you agree as you both have the right to privacy. If the relationship breaks up and either or both of you wish to pursue individual counseling, I will use my discretion in deciding if I can continue working with you. Often in these cases, I refer to other therapists in order to minimize a conflict of interest.

**ACCESSING RECORDS:**

**The client must execute A SEPARATE CONSENT TO RELEASE MEDICAL RECORDS form** before we can release these records. At which time your therapist will provide a Treatment Summary Letter regarding your Clinical Experience with your Therapist.

**NOTICE OF PRIVACY PRACTICE**

**Shari Pescatore, LPC**

**800 West State Street**

**Unit 303**

**Doylestown, PA 18901**

**215-343-3091**

This document describes how I, Shari Lynn Pescatore, LPC may use and disclose

Psychological, medical and financial information about you (protected health information – PHI) that is in our possession. It also describes how you can access this information. We may change our privacy practices at any time as allowed by state and federal law. If we make a significant change in those practices, we will amend this Notice and make the new Notice available on request. To request a copy of our Notice or for more information about our privacy practices, please contact Shari Pescatore. Please review this notice carefully.

**I. TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

Federal law does not require us to obtain consent to use or disclose your PHI for treatment, payment and health care operations. Accordingly, we may use or disclose your to another health care professional to provide treatment to you. We may use or disclose your PHI to obtain payment for services we provide to you or to determine eligibility or coverage for services. We may also use your PHI in connection with

performance and operation of my practice which includes quality assessment, licensure and credentialing activities, training, audits, administrative services, case management and care coordination, among other similar activities.

**II. USES PURSUANT TO AN AUTHORIZATION**

As permitted by federal and state law, we may disclose your PHI with your consent. You may generally revoke your consent in writing at any time to the extent we have not already relied on that consent. It is understood that such consent may authorize the release of information to which you have not had access or to information that has not been generated at the time of the execution of the release.

III. FURTHER DISCLOSURES

Federal and state law does not require patient consent for the following disclosures:

A. Child abuse: We must report to the local Department of Social Services information that leads us to reasonably suspect child abuse or neglect. We must also comply with a request from the Director of the Department of Social Services to release records relating to a child abuse or neglect investigation.

B. Adult abuse: We must report to the local Department of Social Services information that leads us to reasonably suspect that a disabled adult is in need of protective services.

C. Judicial/Administrative Proceedings: We must comply with an appropriately issued court order or subpoena requiring that we release your PHI.

D. Serious Threat to Health or Safety: We may disclose your PHI to protect you or others from a serious threat of harm.

E. Worker’s Compensation: Under certain circumstances, we may disclose your PHI in connection with a Worker’s Compensation claim that you have filed.

F. As Required by Law: There may be other instances where either federal or state law requires that we release your PHI.

**IV. PATIENT RIGHTS**

A. You have a right to request restrictions on certain uses and disclosures of PHI; however, federal law does not require that we comply with all requests.

B. You can request and receive confidential communications of PHI by specified means and at alternative locations.

C. You may inspect or obtain a copy of PHI in certain circumstances. If we deny you that right, you may have this decision reviewed. We will answer your questions concerning the details of the reviewing process.

D. You may request an amendment of PHI so long as we maintain that PHI in our records. Federal law does not require us to agree to each such request. We will answer your questions concerning the amendment process.

E. You have a right to receive an accounting of most disclosures of PHI for which you have not provided consent. We will answer your questions concerning the accounting process.

F. You have a right to obtain a paper copy of this notice from us upon request, even if you have received this notice electronically.

**V. QUESTIONS**

G. If you have questions about this notice, disagree with a decision we make about access to your PHI or have other concerns, contact Shari Pescatore, Licensed Professional Counselor, PC004016 (215) 343-3091. You may also file a complaint with the Secretary of the US Department of Health and Human Services. We can provide you with that address. You have the right to be free from retaliation from us for exercising your right to file a complaint.

This policy is effective this 1st day of September, 2008.

**Acknowledgment of Receipt of Privacy Notice**

I have received a copy of this firm’s Notice of Privacy Practices.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SHARI PESCATORE, LPC

847 EASTON ROAD

SUITE 2300 B

WARRINGTON, PA 18976

215-343-3091

I am now requesting that all clients have a current credit or debit card number

(MasterCard, American Express or Visa) on file. This card will only be charged in

the event that you cancel less than 48 hours of your next

appointment. If you would like your credit card to be charged for any given

session it can be done upon your request.

Thank you.

Please let me know if you have any questions about this. Thank you.

Credit Card Information

Client Name:

Name on Card:

Card Number:

Three digits/four-digit code:

Expiration Date:

I authorize Shari Pescatore, LPC to bill my credit or debit card in accordance with the terms stated above.

**Signature: Date:**