REGISTRATION
(PLEASE PRINT)

PHILMORE ASSOCIATES

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Philmore Associates, LLC

Payment Policy

We are dedicated to providing the best possible care for you and want you to completely understand our financial policies. By signing the patient registration form, you are acknowledging that you have read, understand, and agree to Philmore Associates, LLC financial payment policy.

Patient Responsibility:

- Keep in mind that your insurance policy represents a contract between you and your insurance company. As a courtesy to you, we will file your insurance claim for you. If payment is not received from your insurance company with 14 days, we may have to look to you for payment.

- Not all insurance plans cover all services. In the event your insurance plan determines a service is "not covered" or if you are not covered by an insurance plan you will be responsible for the full charge. Payment will be due at point of service.

- If you are insured by an insurance plan that our providers do not participate with or if you do not have insurance, you must pay for services prior to your visit or make payment arrangements with the office.

- Philmore Associates will only bill your primary and secondary insurance carrier. If you would like a third party billed, you will be responsible for doing so.

- Payment is due at the time of service. We accept payments in the form of cash, checks or credits cards. Please note that a 4% credit card processing fee will be added to your charge – this is the fee charged to the Philmore Associates by the credit card companies. A $35 returned check fee will be charged for checks returned due to insufficient funds. Failure to make payment at the time of your visit will result in a $10 administrative fee for each missed payment.

- If you schedule an appointment with our office and you are unable to keep your appointment, we kindly ask that you to notify us 24 hours in advance to avoid a $50 FEE.

- There will be a fee for letters and/or reports written on your behalf by our providers. The fee schedule will be discussed on a case by case basis as there may be specific requirements impacting the amount of time required for preparation and dissemination.

THE PHILMORE ASSSOCIATES

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made.

I accept full responsibility for all charges for services provided to me, to my minor/child, or to the patient for whom I have legal responsibility.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient, Parent, Guardian or Legal Representative Print Name

Witness Date

One Franklin Avenue • PO Box 599 • Nutley, NJ 07110
Phone 973.667.6074 • Fax 973.751.1626

THE PHILMORE ASSOCIATES

INTAKE INFORMATION

Please answer the following questions as thoughtfully as you can. Thank you for giving us the opportunity to assist you.

Name: _____ Birthdate: _____ Sex: □ M □ F

Address: _____

Phone: (hm) _____ (wk)_____(cell)_____

Today's Date: _____ Who referred you to us?: _____

Education: □ grade school □ some high school □ graduated high school

□ some college □ graduated college □ graduate degree

Were you ever diagnosed with a learning disability or Attention Deficit Disorder? ☐Y ☐N

Occupation: _____ Employer: _____

How long have you been employed in that position? _____

Are you satisfied with your current work situation? ☐ Y ☐ N

Is your current financial situation presenting significant difficulties for you? ☐Y ☐N

If yes, explain_____

Marital Status:

□ single □ married □ partnered □ widowed □ separated □ divorced □ remarried

With whom do you live? (check all that apply):self__parents__spouse__partner__other_

What led you to seek help at this time? _____

_____

_____

Description of Presenting Problems

Please explain the nature of your main problems: _____

_____

When did your problems begin? _____

_____

What seems to worsen your problems? _____

_____

What have you tried that has been helpful? _____

_____

Have you been in therapy before? _____ When/for how long? _____

Please list doctors/therapists you have been in treatment with:

_____

_____

Have you ever been hospitalized for psychological/psychiatric problems? ☐Y ☐ N

If yes, when and where? _____

Have you ever attempted / thought about suicide? ☐Y ☐ N

Has any relative/friend attempted or committed suicide? ☐Y ☐ N

If yes, please explain_____

_____

_____

Family physician: _____ Phone: _____

Please list any medications you are taking:

Name / Dose of medication / When did you begin this medication? Prescribing Doctor

_____

_____

_____

Do you have any concerns about your physical health? Please explain.

_____

_____

Describe your mother's (or mother substitute's) personality & her attitude towards you (past & present): _____

_____

_____

_____

_____

_____

How were you disciplined by your parents? _____

_____

_____

Did you witness violence or sexual abuse toward others?_____

_____

_____

Did you experience violence or sexual abuse from others? _____

_____

_____

Check any of the following that applied during your childhood/adolescence:

- ☐ happy childhood
- ☐ emotional/behavioral problems
- ☐ legal trouble
- ☐ death in family
- ☐ medical problems
- ☐ school problems
- ☐ sexual concerns
- ☐ ignored
- ☐ financial problems
- ☐ drug/alcohol use
- ☐ severely punished
- ☐ severely bullied
- ☐ eating disorder
- ☐ divorce
- ☐ relationship w/parent
- ☐ relationship w/sibling
- ☐ friendships
- ☐ physical development
- ☐ fears/worries

Please explain the above checked and/or any other significant detail about your childhood:

_____

_____

_____

_____

Have you ever lost consciousness? _____ Have you ever had a seizure? _____

Are you currently involved in any legal issues? ☐ Y ☐ N

Nature of issue: _____

Attorney: _____ Phone: _____

Personal and Social History

Father – Name/Age/Occupation: _____

Any significant health issues? _____

Mother – Name/Age/occupation: _____

Any significant health issues? _____

Siblings – Brothers age(s) _____ Sisters age(s) _____

Any significant details about siblings? _____

_____

If you were not brought up by your parents, who raised you and between what years?

_____

If you have a step-parent, how old were you when your parent (s) remarried: _____

How would you describe the atmosphere in your childhood home (how did parents get along; how did siblings get along?) _____

_____

_____

_____

Describe your father's (or father substitute's) personality & his attitude towards you (past & present): _____

_____

_____

_____

_____

_____

Check any of the following behaviors that apply to you:

☐ eating problems	☐ life is not worth living	☐ phobias/fears
☐ abusing drugs	☐ compulsions	☐ can't keep job
☐ impulsive	☐ smoking	☐ take too many risks
☐ unassertive	☐ shy/withdrawn	☐ lazy
☐ drink too much	☐ nervous tics	☐ aggressive behavior
☐ work too hard	☐ memory	☐ crying
☐ procrastination	☐ concentration	☐ overspending
☐ loss of control	☐ sleeping problems	☐ sexual concerns

Please explain checked behaviors:_____

_____

_____

What are some special talents or skills that you feel proud of? _____

_____

_____

What would you like to start doing? _____

_____

What would you like to stop doing? _____

_____

If you could have any two wishes granted, what would they be?

_____

_____

Do you have trouble relaxing or enjoying weekends/vacations? ☐Y ☐ N

Do you tend to focus on the negative aspects of a situation? ☐Y ☐ N

Do you engage in self-denigration (put yourself down)? ☐Y ☐ N

How satisfied are you currently with your life?

1 2 3 4 5

very dissatisfied very satisfied

How would you rate your level of stress during the past few months?

	1	2	3	4	5
very stressed				very relaxed	

Check any of the following feelings that apply to you:

☐ angry	☐ envy	☐ unhappy
☐ annoyed	☐ guilty	☐ bored
☐ sad	☐ happy	☐ restless
☐ depressed	☐ conflicted	☐ lonely
☐ anxious	☐ regretful	☐ content
☐ fearful	☐ hopeless	☐ excited
☐ panicky	☐ helpless	☐ optimistic
☐ energetic	☐ relaxed	☐ tense

Please explain checked feelings:_____

_____

_____

Do you ever see things or hear voices? If yes, explain_____

_____

_____

Do you feel people want to harm you? _____

_____

_____

List your three main fears:

1.
2.
3.

How have you tried to cope with these fears?_____

_____

_____

_____

What are some positive feelings you have experienced lately? _____

_____

When are you likely to lose control of your feelings? _____

_____

Are you bothered by thoughts that occur over and over again? _____

_____

Place a check mark in the column that most reflects your feelings about the following:

	Strongly Disagree	Disagree	Agree	Strongly Agree
I should not make mistakes.				
I should be good at everything I do.				
I am a victim of circumstances.				
My life is controlled by outside forces.				
Other people are happier than I am.				
I don't deserve to be happy.				
It is very important to please others.				
I should strive for perfection.				
It is my responsibility to make others happy.				
I should never be upset.				
There is a right & wrong way to do things.				

Interpersonal Relationships

Do you make friends easily? ☐Y ☐ N

Do you keep them? ☐Y ☐ N

Did you date much during high school? ☐Y ☐ N College? ☐Y ☐ N

Were you ever bullied or severely teased? ☐Y ☐ N

How comfortable do you generally feel in social situations?

1 2 3 4 5

Very anxious Very relaxed

Religious/Spiritual Affiliation: _____Active? ☐Y ☐ N

Sexual Orientation: ☐ Bisexual ☐ Heterosexual ☐ Homosexual ☐ Questioning

Does your sexual orientation present difficulties for you? ☐Y ☐ N

If yes, please explain:_____

How long have you known your spouse/partner? _____

How long have you been married? _____

What is your spouse's/partner's age? _____ His/Her occupation? _____

How satisfied are you with your relationship:

1 2 3 4 5
Very dissatisfied Very satisfied

Any relevant details about your first or subsequent sexual experiences? _____

_____

_____

Please note any sexual concerns: _____

_____

_____

How well do you get along with your spouse's/partner's friends and family?

1 2 3 4 5
Very poorly Very well

How many children do you have? ___ ages(s)? _____ gender? _____

Do any of your children present special problems? _____

_____

Any significant details about a previous marriage/relationship? _____

_____

_____

Alcohol/Drug History

Have you ever felt you should cut down on your drinking? ☐Y ☐N

Has anyone expressed concerns about your drinking/drug use? ☐Y ☐N

Have you ever been treated for drug and/or alcohol abuse? ☐Y ☐N

Have you used drugs/alcohol first thing in the morning to steady your nerves or get rid of a hangover? ☐Y ☐N

Have you used drugs and/or alcohol in situations that were physically hazardous to you and/or others? ☐Y ☐N

If you answered yes to any of the above, please continue.

SUBSTANCE	AGE of ONSET	CURRENTLY USING?	FREQUENCY?	AMOUNT?
Alcohol				
Amphetamines				
Barbiturates				
Benzodiazepines				
Cocaine				
Crack Cocaine				
Heroin				
Hallucinogens				
Inhalants				
Marijuana				
PCP				
Methadone				
Prescription Drugs				
Other				

Have you experienced any of the following related to substance abuse? Check all that apply:

Shakes /Tremors		Difficulty Sleeping	
Seizures		Missed Work	
Arrests /Assaults		Fears	
Nausea/Vomiting		Neglected Eating	
Accidents/DUI		Hallucinations	
Use more than you meant to get high		Loss of Job Due to Drinking/Drugs	
Memory lapses/blackouts		Drinking/Drug Use on the Job	
Suicidal thoughts/attempts		Secret Drinking/Drug Use	
Family/relationship problems		Unable to Stop Using	
Emotional Problems		Other (Explain)	

☐Presently Sober ☐ Currently Using ☐Past History of Substance Abuse

Longest Period of Sobriety? _____ How long ago? _____

How were you able to remain sober during this time? _____

Have you ever attended DETOX or REHAB? ☐Y ☐ N When? _____

Where? _____

Do you attend AA or NA meetings? ☐Y ☐ N How often? _____

Do you think you have a problem with drugs/alcohol? ☐Y ☐ N