**Intake Form**

***PLEASE PRINT CLEARLY*** Today’s Date

**PERSONAL INFORMATION**

**PATIENT (S)**   **RESPONSIBLE PARTY**

Date of Birth Gender Responsible Party’s SSN

Address Address (if different)

City, State Zip City, State Zip

Home Phone Home Phone (if different)

Work Phone Work Phone (if different)

Cell Phone Cell Phone (if different)

***Please indicate with an \* which phone numbers we may NOT leave a message.***

Patients’ relationship to Responsible Party (check one): Self\_\_\_\_\_\_\_ Spouse\_\_\_\_\_\_\_ Child\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_

Relative or friend in case of emergency

Name Phone

Source of referral Reason for referral

How did you hear about Anxiety and Depression Solutions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL**

I understand that Anxiety and Depression Solutions does not accept insurance. I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment I will be billed $65. I have been given the opportunity to ask questions regarding this statement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party Printed Name Date

**MEDICAL INFORMATION**

**1. Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you ever been treated for emotional difficulties before (When and Where?)

Physician: Name/Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone

Date of last physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight

How is your general health now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications?

Are you presently being treated by a physician for any physical condition?

Have you had any serious illness? (List)

Have you ever had any surgery? (List)

**Please briefly explain your reason for seeking treatment at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)**

|  |  |  |
| --- | --- | --- |
| \_\_\_Anger  \_\_\_Anxiety  \_\_\_Behavior Problems  \_\_\_Changes in Appetite/Eating Habits  \_\_\_Criminal Activity  \_\_\_Decreased Energy  \_\_\_Delusions  \_\_\_Depressed Mood  \_\_\_Disruption of Thought Process/Content  \_\_\_Emotional/Physical/Sexual Trauma  \_\_\_Excessive Crying  \_\_\_Family Conflicts | \_\_\_Grief  \_\_\_Guilt  \_\_\_Hallucinations  \_\_\_Hopelessness  \_\_\_Hyperactivity  \_\_\_Impulsiveness  \_\_\_Interpersonal  Conflicts  \_\_\_Irritability  \_\_\_Manic  \_\_\_Mood Swings  \_\_\_Oppositional  \_\_\_Panic Attacks | \_\_\_Paranoia  \_\_\_Physical Aggression  \_\_\_School/Work Problems  \_\_\_Self Abusive Behavior  \_\_\_Sleep Disturbance  \_\_\_Somatic Complaints  \_\_\_Suicidal Thoughts/Attempt  \_\_\_Weight Gain  \_\_\_Weight Loss  \_\_\_Worthlessness  \_\_\_Other (Specify) |

**Privacy Practices Form**

You, or a member of your family, are about to become involved in counseling or psychotherapy with Allison Rapp, LCPC. Allison received her BA in Clinical Counseling from Washington College in 2004. She then went on to earn her MS degree in Clinical Counseling and Health Psychology from Philadelphia College of Osteopathic Medicine in 2008. Since then, she has been certified in performing Cognitive Behavioral Therapy and has been recognized as a Licensed Clinical Professional Counselor and Supervisor by the state of Maryland (LC 4190). We would like to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this

appointment, the following decisions will be made with you:

a) Type of therapy needed (individual, group, medication referral, etc.)

b) Frequency of therapy sessions (weekly, biweekly, etc.)

c) Goals of therapy (what you hope to gain from this process.)

1. APPOINTMENTS: Each appointment is approximately 50 minutes. At the end of each appointment you can discuss

future appointments with your therapist.

1. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged $50 for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.
2. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. If

you do not pay in full at the time of service, charges for services in addition to therapy may be levied (i.e., involvement in

client litigation, document preparation, etc.). These fees will be negotiated individually with your therapist. We accept cash and check. Please make checks out to “ADS” or “Anxiety and Depression Solutions”.

1. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for.

We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Mental Wellness Counseling are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party “gate keeper”. Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges.

1. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at

Anxiety and Depression Solutions and is considered confidential within the office unless specified by you in writing. However,

each therapist at this office reserves the right to use specialty consultation with other therapists at the office as deemed

necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.