PENNY A. HAYS, PH.D.

LICENSED PSYCHOLOGIST
WWW.DRPENNYHAYS.COM

ADULT INTAKE INFORMATION

GENERAL INFORMATION:

Name:_____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work: (____) _____
Cell Phone: (__)_____ E-Mail Address_____
DOB: _____ Age: _____ SS# _____-_____-_____
Sex: _____M _____F Marital Status: _____
Notify in case of emergency:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work: (____) _____
Relationship to you: _____
Type of services sought: _____

RESPONSIBILITY FOR PAYMENT

Clients who carry Health Care Insurance should remember that professional services are rendered and charged to the Client and not to the Insurance carrier. All Clients are expected to take care of their fees as services are rendered (unless other arrangements are made with the therapist you are seeing). This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Any special arrangements must be discussed in advance with the therapist. **All cancellations require a 24-hour notice; otherwise, your account will be charged.**

I hereby accept full and complete responsibility for all debts and obligations incurred during the course of the above-named client's treatment and understand there is a charge for cancellation with less than 24 hours notice.

_____
Signature of Person Responsible for Bill.

3178 BOLERO WAY ATLANTA, GA 30341 (770) 414-0098 FAX (770) 414-6959

If person responsible for bill is different from client, please indicate:
Name: _____
Address: _____
SS#: _____

Home Phone: (___) _____ Work Phone: (___) _____

Who referred you to our office:

_____
Name

_____
Street

_____
City State Zip

Their telephone: (___) _____
Reason for Referral: _____
_____

Occupation: _____

Do you have Insurance? Yes _____ No _____ If so, give:

Name of Company: _____
Address: _____
_____
Group # _____ Policy # _____

Family History:

Marital Status: Married_____ Single_____Divorced_____Cohabitating_____
Previous Marriage (s) :
Dates: _____
Children: _____
Who currently resides in your home?
_____
If divorced, what are the custody arrangements?_____

GENERAL HEALTH

Medical History:
Circle the below description which best describes your health:

1. Excellent
2. Good
3. Fair
4. Poor

Date of your most recent physical exam: _____
Physician's name and address: _____
_____
Physician's Telephone: (___) _____
Pertinent findings: _____
_____
Have you or are you being treated for any medical problems? Please check if apply to you.

Irritable Bowel Syndrome _____
Cancer _____
Diabetes _____
Epilepsy _____
Heart Problems _____
Thyroid _____
Head Injury _____
Stroke _____
Myasthenia Gravis _____
Multiple Sclerosis _____
Bronchial Asthma _____
Hypertension _____
Fibromyalgia _____
Chronic Fatigue Syndrome _____
Migraine _____
Dementia _____
Addiction _____
Other (please list) _____

Are you taking any medications now? Yes _____ No _____
If so, list them: _____

Do you smoke? Yes _____ No _____ If so, state duration and frequency _____

Do you use alcohol? Yes _____ No _____ If so, state duration and frequency _____

Do you or have you in the past used drugs or had a problem with substance abuse? Yes_____No_____ If so, state duration and frequency_____

Do you drink caffeinated drinks? Yes _____ No _____ If so, state duration and frequency: _____

Are you allergic to anything? Yes _____ No _____ If so, list: _____
_____

Have you ever had major surgery? Yes _____ No _____ If so, list and give dates:
_____

History of abuse (emotional, physical, sexual)? Yes____ No____ If so, please inform duration and frequency_____

Have you ever had: (please give date and details)

A. High fever: _____
B. Head injury: _____
C. Seizures: _____

Family Health: (List family members by name, age, relationship, and any pertinent medical or psychological problems. For deceased family members, list the cause of death)

NAME	AGE	RELATIONSHIP	PERTINENT PROBLEMS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Present psychological difficulties: Please check if apply to you.

Depression _____
Thoughts of suicide _____
Anxiety _____
Problems with eating _____
Sleep problems _____
Problems with controlling your temper _____
Problems with marriage/family _____
Problems with job _____
Interpersonal problems _____

Legal situation _____
Financial problems _____
Problems with intimacy _____
Other (please list) _____

What do you wish to accomplish (what are your goals) in treatment?

_____
_____
_____
_____

NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your psychologist is considered privileged and confidential. We will not release any information without your written release. (The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes). The only exception to these conditions may occur in situations such as child abuse, danger to life, or workers' compensation where by law other action is permitted. Please discuss this with your doctor/therapist.

OFFICE HOURS

We are typically available from 9:00 a.m. to 5:00 p.m. Monday through Friday. When we are not available, please call your psychologists number and either leave a message or contact him/her through their cell phone or pager. The first priority and our primary concern is your well being. In an emergency, please go to the nearest hospital emergency room (ER) for help with your problem, and contact us by saying "This is an emergency!"

SCHEDULING APPOINTMENTS

An appointment can be scheduled directly with your psychologist/psychometrist.

APPOINTMENT LENGTH:

Individual, couples, and family therapy are billed on the basis of a 45-50 minute hour. Group therapy is based on a 90-minute session. If an appointment runs longer, you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from someone else in need. **Therefore, except in the case of an acute emergency, we require a 24-hour notice of any cancellation; otherwise, your account will be charged for the visit.** In addition, because we are unable to bill insurance for missed appointments, you will be held financially responsible for these charges. If our office is closed, leave a message on your psychologist's voice mail to inform us of your cancellation so the time may be used appropriately.

FEES:

FEES FOR PROFESSIONAL SERVICES ARE DUE AND PAYABLE AT THE TIME THEY ARE RENDERED. ALL CLIENTS ARE EXPECTED TO TAKE CARE OF THEIR FEES AS SERVICES ARE RENDERED. ANY OTHER ARRANGEMENT IS CONSIDERED A SPECIAL ARRANGEMENT AND MUST BE DISCUSSED IN ADVANCE WITH YOUR THERAPIST. DELINQUENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY.

Collection of insurance benefits or any other arrangement regarding third party payment is the responsibility of the client (parent or guardian, if the client is a dependent child). An insurance receipt is available for your convenience in submitting your insurance claim. Additional copies can be made for you on request.

ASSESSMENT AND/OR TESTING:

Testing is billed on the basis of the type of test and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with the type of test and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. The written report, if requested, is generated after payment in full for testing services is received.

REPORTS:

Reports not included in assessment and/or testing fees will be billed as a separate procedure. Requests for such reports and the fees will be discussed with you in advance.

I acknowledge responsibility for all fees incurred.

I have read and understand these policies.

Date: _____

_____

PRINTED NAME OF CLIENT/person responsible for payment

_____

SIGNATURE OF CLIENT/person responsible for payment

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to psychological services by _____. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of undergoing psychological services may include obtaining a professional opinion, reduction of my psychological symptoms, and an increased understanding of myself. I understand that potential risks may include predictive validity of psychological assessment (when applicable), possible disagreement with the opinions offered to me, and possible emotional distress when addressing my situation. I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with the progress of my treatment.

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below: (1) where abuse or harmful neglect of children, the elderly, or disabled or incompetent individual is known or reasonably suspected; (2) where the validity of a will of a former patient is contested; (3) where such information is necessary for the psychologist to defend against a malpractice action brought by the client; (4) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist; or (6) where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue; (7) where I am in danger of harming myself by suicidal behavior, and (8) where the client is examined pursuant to a court order. I hold _____harmless for releasing information under the above conditions.

_____Signature _____Date

_____Name of Client

PERMISSION FOR RELEASE OF INFORMATION

This release of information is for the purpose of allowing your psychologist to contact another person/professional.

I do hereby request and authorize: _____
(Name)
to release and discuss the results of my evaluation and/or treatment and to obtain information relevant to my treatment from:

_____
_____

Covering dates of service:
From (date) _____ to (date)_____

Signature of Client: _____
Signature of Professional: _____

Date: _____