FAMILY PSYCHOLOGICAL CENTER, P.A.
CHARLES NICHOLS, PSY.D. – CLINICAL PSYCHOLOGIST
623 NORTH WALNUT ST · HARRISON, ARKANSAS 72601
PHONE: (870) 743-6225 · FAX: (870) 743-6006
fpcpa.net

ADULT INTAKE FORM

(This form should be updated with any information changes. Please complete all items.)

Today's Date: _____-_____-_____
Month Day Year

PATIENT INFORMATION

Patient's Name: _____
First Middle Last

Date of Birth: _____-_____-_____ **Age:** _____ **Social Security Number:** _____-_____-_____
Month/Day/Year

Home Address: _____
Street Apt No. City State Zip

Home Phone: (____)____-_____ **Cell Phone:** (____)____-_____ **Work Phone:** (____)____-_____

Sex: ☐M ☐F **Race:** (check all that apply): ☐Asian ☐American Indian ☐Black ☐Hispanic/Latino ☐White ☐Native Hawaiian ☐ Other _____

Marital Status: ☐ Single (Never Married) ☐Married ☐Divorced ☐Separated ☐Widowed

OTHERS LIVING IN PATIENT'S HOME	DATE OF BIRTH	RELATIONSHIP TO PATIENT (wife , mother, stepfather, aunt, brother, stepsister, etc.)

GUARANTOR INFORMATION

Name of Responsible Legal Party/Guarantor: _____
First Middle Last

Guarantor's Relationship to Patient:_____ **Guarantor's Social Security Number:** _____-_____-_____

Guarantor's Date of Birth: _____-_____-_____ **Age:** _____
Month/Day/Year

Guarantor's Address: _____
Street Apt. No. City State Zip

Guarantor's Home Phone: (____)____-_____ **Guarantor's Mobile Phone:** (____)____-_____

Gender: ☐ M ☐ F **Guarantor's Employer's Name:** _____

Guarantor's Work Address: _____
Street City State Zip

Guarantor's Work Phone: (____)____-_____

REFERRAL SOURCE

How did you hear about us?

_____

HEALTH INFORMATION

Your Physician_____ **Physician's Address:** _____
Street City State Zip

Describe any medical health problems you now have._____

_____

CURRENT MEDICATIONS	DOSE/FREQUENCY	WHEN STARTED? (DATE)	WHO PRESCRIBES MEDICATION?

Describe any serious *PAST* medical illnesses and injuries have you had with approximate dates. _____

_____

List any prior surgeries with dates._____

Have you had prior mental health assessment or therapy? ☐ Yes ☐ No **If yes, list all dates/periods of treatment below.**

Mental Health Treatment Dates (Begin/End)	Facility/Treatment Provider	Type of Treatment (Medication, Therapy, Hospitalization)	Reason for Treatment/Diagnosis	Was Treatment Successful?

Have you ever been hospitalized for psychiatric treatment? ☐ Yes ☐ No **If yes, how many times and when?** _____

What was/were the reason(s) for your mental health hospitalization(s) (if applicable)? _____

_____

SERVICES REQUESTED

Please indicate the type of services you are interested in (check all that apply):

☐ Psychological Testing ☐ Individual Treatment/Counseling ☐ Couples/Marital Therapy ☐ Family Therapy
☐ Learning Assessment ☐ Personality Assessment ☐ Legal/Court Issues ☐ Diagnostic Clarification

Please describe your primary reasons for seeking services. _____

_____

CURRENT SYMPTOMS

Rate the degree which you have experienced the following symptoms and how long each has occurred.

0 = None, Not at All 1=Mild, Rarely a Problem 2=Moderate, Sometimes It's Difficult 3=Severe, I Can Barely Stand It

Symptom	0-3	How Long?
Prolonged Sadness or Depression		
Loss of Energy		
Loss of Sex Drive		
Sleep Too Much/Too Little *(circle one)*		
Negative View of Future/Hopelessness		
Weight Loss/Gain (circle one)		
Difficulty Making Decisions		

Symptom	0-3	How Long?
Alcohol Misuse		
Drug Misuse		
Decreased Work Performance		
Decreased Academic Performance		
Conflict (spouse, child, parents, supervisor) *(circle)*		
Parenting Problems		
Excessive Sex Drive		

Appetite Increase/Decrease *(circle one)*		
Excessive Joy or Grand Feelings		
Risky Behaviors (splurges, drive fast, stealing) *(circle)*		
Racing Thoughts		
Pressure to Talk More than Usual		
Abnormally High Physical Activity or Energy		
Prolonged Anxiety/Nervousness		
Fear of Being Criticized in Public		
Muscle Tension		
Forgetfulness (losing things, forget appointments)		
Difficulty Relaxing		
Panic or Anxiety Attacks		
Nightmares		
Memories of Traumatic Event(s)		
Fear of Objects or Situations		
Constant and Disturbing Worries		
Ritualistic/Compulsive Behaviors		
Nervous in Public/Avoid Groups		
Problems with Finding Words/Speaking Difficulty		
Confusion/Becoming Lost *(circle those that apply)*		
Forgetting How to Do Common, Everyday Tasks		

Hallucinations (hearing voices, seeing things) *(circle)*		
Physical Violence		
Suspicious Thoughts/Difficulty Trusting Others		
Temper Problems/Rage		
Physical Problems that Increase with Stress		
Fear of Having a Disease		
Short Attention Span		
Difficulty Completing Tasks		
Poor Organization		
Difficulty Following Directions		
Difficulty Sitting Still/Restlessness		
Excessive Talking		
Not Thinking Ahead about Consequences		
Legal Problems/Probation *(circle those that apply)*		
Twitches/Tics *(circle those that apply)*		
Worry about Gaining Weight/Restricting Calories		
Purging/Inducing Vomiting		
Self-Mutilation		
Side Effects from Medication(s)		
Other:		
Other:		

INSURANCE AND WORK INFORMATION

A copy of all your active insurance card(s) is (are) required to confirm your insurance benefits and file claims.
Please present your insurance card(s) when you return this form.

Do you plan to use insurance? If so, please complete information below using your insurance card(s).

PRIMARY Insurance Company: _____

Name of Insured on Card: _____
First Middle Last

Group Number:_____ **Member Number:** _____

SECONDARY Insurance Company: _____

Name of Insured on Card: _____
First Middle Last

Group Number:_____ **Member Number:** _____

Who is Responsible for Payment of Services? _____
First Middle Last

Relationship of Responsible Party to Patient: _____

Employer and Address: _____
Company Street City State Zip

Landlord: _____ **Phone #:** (____)_____-_____

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____
Name of Insured/Responsible Party Name of Insurance Company

to pay and hereby assign directly to Family Psychological Center all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred, including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services, and I hereby authorize the release of pertinent healthcare information to insurance carriers. I understand and agree that I am ultimately responsible for the balance of my account, regardless of my insurance status. I have read all the information on these sheets and have completed all of the answers that apply to me and/or the patient. I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in the above information, including my address, employment, and insurance status. I further acknowledge that any insurance benefits, when received by and paid to Family Psychological Center, P.A. will be credited to my account, in accordance with the above said assignment.

_____ _____ _____
Signature of Insured/Responsible Party Printed Name of Insured/Responsible Party Date

MEDICARE RECIPIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Family Psychological Center, P.A. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine benefits or the benefits payable for related services.

_____ _____

Signature of Patient or Legal Representative Date

NOTICE OF OFFICE POLICIES FOR ADULTS

CONFIDENTIALITY

Confidentiality is a fundamental priority. The information you disclose remains confidential except when you provide signed consent to release it (such as to your physician) or when legal or ethical principles apply. Confidentiality must be breached if any form of abuse involving a child, elder, or other incapacitated person is disclosed. Other instances include suicidal intentions, a specific harm against an identified person, or a court order. You should openly verbalize any concerns about confidentiality with your treatment professional. By signing below, you acknowledge receiving a copy of the "Patient Notice of Privacy Practices" from the Family Psychological Center, P.A. Which can be obtained from our office or our website at fpcpa.net.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier(s) to assign all health care benefits, if applicable, to Family Psychological Center, P.A. I also authorize release of health care information necessary to process all insurance claims. I agree to provide full and complete information for all my active insurance policies on this form and *will update Family Psychological Center, P.A. if changes to my insurance coverage occur*.

PAYMENT POLICY

Your payment must be collected at the time of your appointments, before sessions begin. We accept cash and checks only **(not credit cards or debit cards)**. Before your intake appointment, we will provide you with an estimate of your charges for services. If you have insurance and your provider is in-network, we will contact your insurance company as a courtesy to check eligibility and benefits. If our provider is contracted with your insurance carrier(s) and your policy covers the services provided, we will accept their negotiated rate for the charges billed. However, some insurance companies do not provide coverage for required billable services that are time consuming for our provider (e.g., writing letters if requested, psychological testing, testing more than allowable hours in the same day). You will be required to pay in full for all services not covered by your insurance policy at the time of your appointment. If non-billable services are requested or required, you will be advised beforehand, *if possible*. We **do not** bill insurance for court-related evaluations and therapy; services provided in a legal context must be paid in full before services are provided.

BILLING FOR PSYCHOLOGICAL TESTING

If psychological testing is conducted, your provider will spend time administering tests to you. After you leave the office, your provider will invest additional time to score, interpret, and write up your test results in a professional report. Although the time needed to interpret testing results varies based on the specific tests and number of tests administered, our providers require approximately one to two hours of scoring and report writing time for every two hours of direct face-to-face test administration with you. You will be required to pay your estimated portion of the fees for each appointment just before the start of each appointment (if using insurance, based on benefits information your insurance company provides to us). Billing adjustments will be made if actual benefits differ from information provided by your insurance company and/or if scoring and interpretation take more or less time than this estimate. If your provider is in network for your insurance carrier(s) and coverage is provided for testing services that you receive, we will accept their negotiated rate. Although most insurance companies now reimburse providers for testing as well as scoring and report writing time, you will be required to pay for all services not covered by your insurance at the time of service.

ATTENDANCE AND CANCELLATION POLICY

Our office requires that if you need to cancel or reschedule appointments, we must receive notice from you **at least one full business day, that is 24 hours (weekend days do not count toward notice),** before the appointment. This allows us time to contact another client and schedule them in your vacated appointment slot. We reserve the right to charge a no show/late cancel fee of **$100.00 per scheduled hour**. For instance, if 3 hours are reserved for your appointment, the no show/late cancel fee would be $300. This fee must be received before your next appointment is scheduled. Cancellations must be made in person or by phone, *not email*. Voicemails must be left on our office line (870-743-6225) if the phone is not answered at the time you call to reschedule or cancel an appointment. Prompt arrival is also essential. If you arrive **more than 10 minutes late**, your appointment may have to be rescheduled. In that case, a no show/late cancel fee would also apply.

I GIVE CONSENT TO TREATMENT AFTER READING, UNDERSTANDING, AND FULLY AGREEING TO ABIDE BY THE ABOVE RELEASE OF HEALTHCARE INFORMATION, PAYMENT ARRANGEMENTS, CANCELLATION POLICY AND FEES, AND ALL OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____

First Middle Last

CONSENT TO CALL

With permission, we remind patients by phone about appointments. If patients are not available, we do not leave messages unless the patient or authorized representative authorizes us to do so. Initial the methods of contact you will permit.

_____ I consent and authorize Family Psychological Center, P.A. to call my residence for appointment reminders.
_____ I consent and authorize Family Psychological Center, P.A. to leave a message at my residence for appointment reminders.
_____ I consent and authorize Family Psychological Center, P.A. to call my cell phone for appointment reminders.
_____ I consent and authorize Family Psychological Center, P.A. to leave a message on my cell phone for appointment reminders.
_____ I consent and authorize Family Psychological Center, P.A. to call my place of employment for appointment reminders.

I understand and allow Family Psychological Center, P.A. to contact me by means of the initialed methods above. I understand that phone contact may become known by anyone with access to my phone or caller ID systems.

_____ Patient Name

_____ Date of Birth

_____ Signature of Patient or Authorized Representative

_____ Date

PATIENT NOTICE OF PRIVACY PRACTICES

The undersigned hereby acknowledges receiving a copy of the "Patient Notice of Privacy Practices" from Family Psychological Center, P.A. This is available from our office or at fpcpa.net.

_____ Patient's Name

_____ Date of Birth

_____ Signature of Patient or Authorized Representative

_____ Date

We appreciate your interest in our professional services and look forward to working with you!

Remember: Present all active insurance cards when you submit this form.
Also: To avoid delays, please make sure you have completed every question and signed before turning in this form.

OFFICE USE ONLY

Date Received _____

Received By _____

Incomplete Sections _____

Notes_____