Intake and Informed Consent Form

Please fill out this form and bring it to your first session.

Name:____ Date: ____________

Birth Date: _____ /_____ /_____ Gender: □ Male □ Female SSN:________________

Address:____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: (__)___________ May I leave a message? □ Yes □ No
Work Phone: (__)___________ May I leave a message? □ Yes □ No
Cell Phone: (__)___________ May I leave a message? □ Yes □ No

E-mail: ________________________________ May I email you? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/ages: ____
Ethnic/racial background: ____
Religious/spiritual background (if any): _________________________________

Are you currently employed?□ Yes □ No If yes, what is your current employment situation?
____
How did you hear about my services? ______________________________________
If referred by a professional, may I thank this person for the referral? □ Yes □ No

Medical and Psychiatric Inventory
Have you previously received any type of mental health services? □ Yes □ No
If yes, previous therapist/practitioner: ___________________________________
Are you currently taking any prescription medication? □ Yes □ No
Please list: ____
____
Have you ever been prescribed psychiatric medication? □ Yes □ No
Please list and provide dates:____
____
Who is your prescribing physician?______________________________________

Are you currently experiencing overwhelming sadness, grief, or depression? □ Yes □ No
If yes, for approximately how long? Please describe.

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ Yes □ No
If yes, when did you begin experiencing this?

Are you currently experiencing any chronic pain?□ Yes □ No
If yes, please describe:

How would you describe your current physical health?___________________________
Please list any specific health problems you are currently experiencing:

How many times per week do you use alcohol?______
What do you typically drink and what quantity? ________________________________
Please describe your past and current use of recreational drugs: __________________

Focus of Psychotherapy

What significant life changes or stressful events have you experienced recently?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What brings you to therapy at this time and what are your goals of treatment?

Confidentiality

Information shared with a psychologist is confidential and protected by law. I will not disclose confidential information about you without your formal consent. There are situations, however, in which I am required to break confidentiality. These include the following: if you are in danger of harming yourself or another person, are unable to care for yourself; if you state that you intend to physically injure someone; if there is suspected elder or dependent adult abuse, or child abuse or neglect; if I am court ordered to release information as part of a legal proceeding, or as otherwise required by law.

Cancellation Policy

Appointments are scheduled weekly and last 50 minutes. You will be billed for sessions that you miss or cancel with less than 48 hours notice. Sessions will end 50 minutes after the scheduled appointment time, even if you arrive late.

Payment (Please check one)

___ Private Pay Individual Therapy. I agree to pay Mary Deyo, Psy.D. the agreed upon fee of $150 for 50 minutes of individual psychotherapy at the time of service.

___ Private Pay Couples Therapy. I agree to pay Mary Deyo, Psy.D. the agreed upon fee of $175 for 50 minutes of couples psychotherapy at the time of service.

___ Insurance for Individual and/or Couples Therapy. I agree to authorize my insurance company to reimburse Mary Deyo, Psy.D. for services rendered and to pay co-pay, if applicable, at time of service.

Primary Insurance:_________________ Phone:_______________

Address:____

Identification#:________________________ Co-pay: __________

Policy Holder (if other than client):______________ Policy Holder's DOB:_______

Policy Holder's Address:____

I have read and understand this document and I have had my questions answered to my satisfaction. I understand the limits to confidentiality and I know that I can end therapy at any time that I wish. I accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in psychotherapy treatment.

__________________________ ____

Client Name (Print) Signature Date

I also certify that I have received a copy of Mary Deyo, Psy.D.'s Notice of Privacy Practices detailing the provisions of HIPAA.

__________________________ ____

Client Name (Print) Signature Date