

**Grace C. Graham, Psy.D.**  
**Charis Counseling and Psychological Services**  
**6220 Chase Oaks Blvd., Suite 104**  
**Plano, TX 75023**  
**Tel: 469-467-7595**  
**Fax: 469-467-0916**  
**chariscounseling@tx.rr.com**

**PATIENT INTAKE FORM  
(17yrs. and up)**

**GRACE C. GRAHAM, PSY.D.**

Patient Information

Date Completed: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: M F

Marital Status: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(Name) (Relationship) (Phone)

Chief Complaint: \_\_\_\_\_  
(What brought you here today?)

How did you hear of us? \_\_\_\_\_

Family Physician: \_\_\_\_\_ Family Physician's Phone: \_\_\_\_\_

I authorize Dr. Graham to speak with my Primary Care Physician:

\_\_\_\_\_ at \_\_\_\_\_  
Doctor's Name Phone Number and Complete Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Insurance Information**

Insurance Carrier:

\_\_\_\_\_

Phone: \_\_\_\_\_ Policy ID: \_\_\_\_\_

Group: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Subscriber's Social Security Number \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Any other insurance? \_\_\_\_\_ Authorization Number for Today's Visit: \_\_\_\_\_

**Assignment of Benefits**

I authorize the release of any medical or other information necessary to process this claim to my insurance company. This may also include case managers with your insurance company. I also authorize payment of medical benefits to Dr. Grace Graham for services rendered to me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***Missed Appointment / Late Cancellation & Reminder Call Policy***

It is the policy of this office to charge a **\$125.00 fee** for each 45-minutes missed/cancelled\* appointment (\* appointments cancelled with less than a literal 24-hour notice).

*As a courtesy to you*, we would be happy to call you or email you the day before your appointment to remind you of your scheduled appointment. However, please note that if in some circumstances we cannot call you, ***we will not be held responsible if you miss your appointment.*** Please indicate below if you would like appointment reminders, and if so, how you would like to be contacted.

\_\_\_\_\_ **NO**, I do not wish to receive appointment reminders at this time.

\_\_\_\_\_ **Yes**, I would like appointment reminders.

Please **email** me at: \_\_\_\_\_

Please **call** me at: \_\_\_\_\_  
phone number

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# Financial Policy

- \* The "Patient Intake Form" must be completed before the first visit.
- \* Co-payments, co-insurance, and deductibles are expected at the time of service.
- \* Initial Authorizations from your insurance company are your responsibility to obtain and failure to do so may result in your having to pay for the visit in full.
- \* We accept Cash
  - Checks (returned check fee is \$35.00)
  - Master Card / Visa
- \*Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments and late cancellations at the rate of a \$125.00 fee. 24 hours is a LITERAL 24 hours required for canceling, not just "the day before".
- \* Psycho-educational and neuro-psychological testing usually requires Dr. Graham to reserve an entire morning or afternoon of her/his time. As a result, it requires a FIVE DAY advance notice for cancellation. Failure to cancel without a five-day notice will result in your being charged for all of the time reserved for you at \$188.00 per 45 minutes of the reserved time. This cancellation cannot be billed to your insurance company.
- \* \*Dr. Graham charges \$250.00 per hour for her regular services. Additionally, she charges \$62.50 for every increment of 15 mins. for her time used outside of sessions. This fee will apply to phone consultations, returning phone calls, responding to emails, non-insurance related paperwork, reviewing of documents, writing letters and reports. These fees are not reimbursed by insurance.
- \*For court appearances and depositions (either as a fact or expert witness), my hourly rate is \$350.00/hour. A retainer is required in advanced in increments of either half of a day (4 hrs. x \$350/hr. = \$1400.00) or a whole day (8 hrs. x \$250/hr. = \$2800.00). Depending on the complexity of and the volume of documents involved in the case, an additional 1 or 2 hours (at the rate of \$250/hr.) may be required for review of records. Please be advised that my primary duty as a witness is to be impartial and fair regardless of whichever party pays for the retainer. The retainer requested in advance is for the reimbursement for my (billable) time away from my office and not for my testimony.
- \*Our office reserves the discretion to increase the fees charged as deemed necessary by our office. This consideration may be applied to all fees including fees charged for counseling, telephone calls, record requests, consultation with other providers, and litigation

**I have read, understand and will abide by the above financial policy**

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Printed name of Signer

Relationship to patient

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Signature

Date

# IMPORTANT

Most insurance companies handle mental health benefits differently than your other health benefits. In **MANY** cases, **pre-authorization** is required and **needs to be initiated by the patient**.

It is very important that you call your insurance company prior to your first visit to see if authorization is required and if so to set it up. Failure to obtain authorization will result in your insurance company not paying your claim.

Therefore, it is our office policy that you call your insurance company prior to your first visit and obtain the following information. **Please bring this sheet with you to your first visit. If you do not return this sheet, you will be required to pay for your visits in full until this information is provided.**

Patient Name: \_\_\_\_\_

I called my insurance company on \_\_\_\_\_ and spoke with  
\_\_\_\_\_.

Authorization:

\_\_\_\_\_ Is not required

\_\_\_\_\_ Is required and the authorization number is: \_\_\_\_\_

Thank you for your understanding and cooperation in this matter.

**You must return this form at your first visit**

**I have read and understand about the authorization process.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Patient's Informed Consent

I have chosen to receive treatment services. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that I may be contacted by my insurance company to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

I have read the basic rights of patients. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that my therapist may disclose any and all records pertaining to my treatment to my insurance company (and to my primary care physician), if such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

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Signature of Patient, or Parent (if applicable)

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Date

## NOTICE OF PRIVACY PRACTICES

**This notice describes how medical (including mental health) information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

During the process of providing services to you, Charis Counseling and Psychological Services (CCPS) will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below. The purpose of this Notice is to describe how we may use and disclose your protected health information. CCPS is required to abide by the terms of this Notice, or any amended Notice that may follow.

### **Our Obligations**

CCPS is required by State and Federal law to maintain the privacy of protected health information. CCPS is required by law to provide clients with notice of our legal duties and privacy practices with respect to protected health information. There are circumstances where state law is more stringent (strict) than federal law, and in such cases, we will follow state law with respect to the limitation on uses and disclosures of your information.

Uses and Disclosures: CCPS may use and disclose protected health information without your consent in the following ways.

Treatment: We will use your health information to provide, coordinate, or manage health care (including mental health care) and related services. For example, staff involved with your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

Payment: We will use your health information for payment purposes. For example, we will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

Health Care Operations: Health Care Operations refers to activities undertaken by CCPS that are regular functions of management and administrative activities. For example, we may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning, and accreditation, certification, licensing and credentialing activities.

Contacting the Client: We may contact you to remind you of appointments; and to tell you about treatments or other services that might be of benefit to you.

Required by Law: CCPS will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when a client is a danger to self or others or gravely disabled; (e) when required to report certain communicable diseases and certain injuries; and (f) when a Coroner is investigating a client's death.

Health Oversight Activities: CCPS will disclose protected health information to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs, or determining compliance with program standards.

Crimes on the premises or observed by CCPS personnel. Crimes that are observed by our staff, which are directed toward staff, or occur on CCPS's premises will be reported to law enforcement.

Business Associates: Some of the functions of are provided by contracts with business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. Business associates are required to enter into an agreement maintaining the privacy of protected health information.

Research: CCPS may use or disclose protected health information for research purposes if the review board has granted a waiver of the authorization requirement.

Involuntary Clients: Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

Family Members: Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

Emergencies: In life threatening emergencies we may disclose information necessary to avoid serious harm or death.

## **State Limitations**

There are circumstances where state law is more stringent (strict) than federal law, and in such cases, we will follow state law with respect to the limitation on uses and disclosures of your information.

## **Authorizations**

CCPS may not use or disclose protected health information in any way other than described in this Notice without a signed authorization or written consent. When you sign an authorization, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent we have already taken action in reliance thereon.

## **Your Privacy Rights.**

You have rights with respect to your protected health information. To exercise any of these rights, contact the CCPS Office Manager at (469) 467-7595.

Access to Your Information: You have the right to inspect and obtain a copy of the protected health information we maintain about you. There are some limitations to this right, which will be explained to you at the time of your request, if applicable.

You have the right to receive a listing of all disclosures of any PHI for the previous six years in which the information has been maintained as of 10/1/02. Individuals have the right to receive one free accounting per twelve-month period. For each additional accounting, a \$25.00 fee will be incurred.

Amendment of Your Record: You have the right to request that CCPS amend (correct) your protected health information. We are not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be explained to you at the time of your request, if relevant, along with the appeal process available to you.

Accounting of Disclosures: You have the right to know when we have disclosed your information without your consent for purposes other than treatment, payment, and health care operations. There are other exceptions that will be explained to you, if applicable.

Request Restrictions: You have the right to request additional restrictions on the use or disclosure of your health information. We do not have to agree to that request unless, except as otherwise required by law, the request is to limit disclosure to a health plan and the purpose is related to payment or health care operations and the information pertains solely to a health care item or service for which you paid in full.

Confidential Communications: You have the right to request that we communicate with you by alternative means or at alternative locations. For example, if you do not want us to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be explained to you at the time of the request process, if applicable.

Copy of this Notice: You have a right to obtain another copy of this Notice upon request.





# LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your background. In therapeutic work, records are necessary, since they permit a more thorough dealing with one's problems. By completing these questions as fully and accurately as you can, you will facilitate your therapeutic program. You are requested to answer these questions in your own time instead of using up your actual consulting time.

It is understandable that you might be concerned about what happens to the information about you because much of this information is highly personal. Case records are strictly confidential. No outsider is permitted to see your case record without your permission.

If you do not wish to answer any questions, merely write, "do not care to answer."

\*\*\*\*\*

## 1. General

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Who referred you? \_\_\_\_\_ Chief Complaint: \_\_\_\_\_

Race (optional): \_\_\_\_\_

### Family members you reside with:

Name	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you live in a house, apartment, hotel, etc? \_\_\_\_\_

**Marital Status:** (Circle One): Never Married    Engaged    Married    Remarried

Separated    Divorced    Widowed    Cohabiting

If married, spouse's name, age, and occupation: \_\_\_\_\_

Religious Affiliation:    a) In childhood: \_\_\_\_\_

b) As an adult: \_\_\_\_\_

**2. Clinical**

Presenting Problem (include onset, duration, intensity):

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

Precipitating Event (why treatment now): \_\_\_\_\_

**Target Symptoms:**

Symptom                      Frequency/Duration                      Degree of Impairment

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

**Previous Medical History:**

Allergies (adverse reactions to medications/food/etc.) \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Findings: \_\_\_\_\_

Physical Illness:            Asthma            High Blood Pressure            Heart Disease            Diabetes

Thyroid Problems            Seizure Disorders            Other: \_\_\_\_\_

Hospitalizations/Surgeries (include dates, complications, adverse reactions to anesthesia, etc.):

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

**Current medications:**

Name	Dosage	Date of original RX	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Past Psychiatric History**

\_\_\_ Mental Health

\_\_\_ Chemical Dependency

Have you ever attempted suicide? \_\_\_ When? \_\_\_\_\_ Method \_\_\_\_\_

Outpatient Therapy: (Include previous practitioners, dates of treatment, previous treatment interventions, including responses to medications, and the source(s) of clinical data collected):

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

List the major life changes, stresses and/or losses you have had in the last 5 years:

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

**Psychosocial Information:**

Support Systems: \_\_\_\_\_

School/Work Life: \_\_\_\_\_

Marital History: \_\_\_\_\_

Legal History: \_\_\_\_\_

Military History: \_\_\_\_\_

Spiritual Beliefs: \_\_\_\_\_

**Substance Abuse History:**

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>Duration</u>	<u>1<sup>st</sup> Use</u>	<u>Last Use</u>
Caffeine	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____
Opioids/Narcotics	_____	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____	_____
Hallucinogens	_____	_____	_____	_____	_____
Others:	_____	_____	_____	_____	_____

**3. Personal Data**

a) Underline any of the following that apply to you in the last 12 months:

- headaches      dizziness      fainting spells      palpitations      stomach trouble
- anxiety      fatigue      no appetite      angry outbursts      bowel disturbances
- sedative use      insomnia      mood swings      obsessions      compulsive behaviors
- hot flashes      thyroid problems      auditory/visual hallucinations
- binging/purging food      nightmares      feel panicky      alcoholism      feel tense
- conflict      tremors      depressed      suicidal ideas      drug use
- unable to relax      sexual problems      over ambitious      shy with people      lonely
- financial problems      excessive sweating      can't keep a job      memory problems
- can't make friends      physically abused      unable to have a good time
- frequent use of pain killers      concentration      difficulties      bad home conditions

b) Present interests, hobbies, and activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c) **Sex Information**

1. Parental attitudes toward sex (e.g. was there sex instruction or discussion in the home?)

2. When and how did you derive your first knowledge of sex?

3. When did you first become aware of your own sexual impulses?

4. Did you ever experience any anxiety or guilt feelings arising out of sex or masturbation?  
If yes, please explain.

5. Any relevant details regarding your first or subsequent sexual experience?

6. Is your present sex life satisfactory? \_\_\_\_\_ If not, please explain:

**4. Menstrual History (if applicable)**

Age at first period? \_\_\_\_\_

Were you informed or did it come as a shock? \_\_\_\_\_

Are you regular? \_\_\_\_\_ Duration? \_\_\_\_\_

Do you have pain? \_\_\_\_\_ Date of last period: \_\_\_\_\_

Do your periods affect your mood? \_\_\_\_\_

**5. Marital History**

How long did you know your marriage partner before engagement? \_\_\_\_\_

How long have you been married? \_\_\_\_\_ Age of your spouse? \_\_\_\_\_

Occupation of your spouse? \_\_\_\_\_

Personality of your spouse (in your own words): \_\_\_\_\_

\_\_\_\_\_

In what areas is there compatibility? \_\_\_\_\_

\_\_\_\_\_

In what areas is there incompatibility? \_\_\_\_\_

\_\_\_\_\_

How do you get along with your in-laws? (Including brothers and sisters in law)

\_\_\_\_\_

\_\_\_\_\_

Do any of your children present special problems? \_\_\_\_\_

\_\_\_\_\_

Any relevant details regarding miscarriages or abortions? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comments about any previous marriage(s) and brief details: \_\_\_\_\_

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**6. Family Data**

a) Father: Living or deceased? \_\_\_\_\_ If deceased, your age at the time of his death? \_\_\_\_\_

Cause of death? \_\_\_\_\_ If alive, father's present age? \_\_\_\_\_

Occupation? \_\_\_\_\_ Health: \_\_\_\_\_

b) Mother: Living or deceased? \_\_\_\_\_ If deceased, your age at the time of her death? \_\_\_\_\_

Cause of death? \_\_\_\_\_ If alive, mother's present age? \_\_\_\_\_

Occupation? \_\_\_\_\_ Health: \_\_\_\_\_

c) Siblings: Number of brothers \_\_\_\_\_ Brother's ages: \_\_\_\_\_

Number of sisters \_\_\_\_\_ Sister's ages: \_\_\_\_\_

Relationship with brothers and sisters:

Past: \_\_\_\_\_

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Present: \_\_\_\_\_

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d) Give a description of your father's personality and his attitude toward you (past & present)

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e) Give a description of your mother's personality and her attitude toward you (past & present)

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f) In what ways were you punished/disciplined by your parents as a child? \_\_\_\_\_

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g) Give an impression of your home atmosphere (the home in which you grew up). Mention the state of compatibility between parents and between parents and children.

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h) Were you able to confide in your parents? \_\_\_\_\_

i) Did your parents understand you? \_\_\_\_\_

j) Basically, did you feel loved and respected by your parents? \_\_\_\_\_

k) If you have a step-parent, give your age when your parent remarried: \_\_\_\_\_

How did you adjust to this person? \_\_\_\_\_

l) Give an outline of your religious training: \_\_\_\_\_

m) If you were not brought up by your parents, who did bring you up, and between what years?  
\_\_\_\_\_ and why? \_\_\_\_\_

n) Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.?  
\_\_\_\_\_

o) Who are the most important people in your life? \_\_\_\_\_

p) Does any member of your family suffer from alcoholism, epilepsy, or anything which can be  
considered a "mental disorder" or "chemical dependency"? \_\_\_\_\_

q) Are there any other members of the family about whom information regarding illness, etc.,  
may be relevant? \_\_\_\_\_

r) Recount any tearful or distressing experiences not previously mentioned: \_\_\_\_\_  
\_\_\_\_\_

s) Have you ever lost control (i.e. temper, crying, aggression?) If so, please describe:  
\_\_\_\_\_

t) Please add any information not tapped by this questionnaire that may help your therapist in  
understanding and helping you.

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

**7. Therapeutic Expectations**

a) What personal characteristic do you think the ideal therapist should possess?

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b) How would you describe an ideal therapists' interactions with his/her clients?

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c) What do you think therapy will do for you and how long do you think your therapy should last?

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d) Prior to this, I have attempted to help myself with:

self help reading     individual therapy     support group     bio feedback

group therapy     relaxation training     other \_\_\_\_\_

e) In therapy, I need/want to work on (rank with #1 being most important):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_