Grace C. Graham, Psy.D.
Charis Counseling and Psychological Services
2301 Ohio Dr., Suite 138A
Plano, TX 75093
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PATIENT INTAKE FORM
(17yrs. and up)

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: _____Republic Title_____

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), and 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 and 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 $65.00 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 and/or text messages, 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 and a copy of your credit card is required in advanced. For deposition or court appearances you will be billed in increments of either half of a day (4 hrs. x $350/hr. = $1400.00) or a whole day (8 hrs. x $350/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. If you retain me for half of a day but I am not released at the end of the four hours, you will give me permission to bill you for 4 additional hours at the rate of $350/hr. 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.

_____

Printed name of Signer Relationship to patient

_____

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.

_____ _____

Signature of Patient, or Parent (if applicable) 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.

Complaints

If you believe CCPS has violated your privacy rights, you have the right to file a complaint with CCPS. To file your complaint, call the CCPS Office Manager at (469) 467-7595. You may also complain to Dr. Graham at (214) 536-6888, or the United States Secretary of Health and Human Services.

Changes to this Notice

This Notice is effective November 1, 2012. CCPS reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in CCPS website.

By signing below, I _____ _____ am indicating that I have been given the opportunity to read this "Notice Of Privacy Practices" and that I agreed to the terms and conditions of the Privacy Practices of CCPS.

Print Patient's Name	Relationship to Patient	Date

Signature	Please print your name here if signing for a minor

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
Easily distracted	at all times	completely

_____

_____

_____

_____

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: _____

Substance	Amount	Frequency	Duration	1st Use	Last Use
Caffeine					
Tobacco					
Alcohol					

Marijuana _____

Opiods/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 over ambitious depressed conflict
sedative use insomnia mood swings obsessions compulsive behaviors bad home conditions
hot flashes thyroid problems auditory/visual hallucinations lonely tremors drug use
binging/purging food nightmares feel panicky alcoholism feel tense suicidal ideas
shy with people unable to relax sexual problems concentration difficulties
financial problems excessive sweating can't keep a job memory problems physically abused
can't make friends unable to have a good time frequent use of pain killers

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: _____

_____

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: ____good_____

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: _____good_____

c) Siblings: Number of brothers _____ Brother's ages: _____

Number of sisters _____ Sister's ages: _____

Relationship with brothers and sisters:

Past: _____

Present: _____

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

_____

_____

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

_____

_____

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

_____

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.

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 stepparent, 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, an 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: ___a lot_____

_____

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?

_____

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

_____

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

_____

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. _____