INTAKE INFORMATION

The following information describes our business practices and professional services. Please read it carefully. If you have questions, it is important that you clarify them with your therapist prior to signing.

Appointments & Fees:

PLEASE NOTE THE FOLLOWING LIST OF OUR PROFESSIONAL FEES:

Master level therapists – 1st Session $140, follow-up sessions $125 - $135; *Group Sessions* – $60;
Doctorate level therapists – 1st Session $150, follow-up sessions $135-$145; *Couples or Family Session* – $135 (Masters Level), $145 (Ph.D Level). *Nurse Practitioner* – 1st Session $240- $375, follow-up sessions $90- $160

In the event that you must cancel an appointment, please call your therapist at least 24 hours in advance. Failure to give adequate notice may result in your being billed a full appointment fee (excluding Medicaid covered clients). Insurance companies cannot be billed, nor will they reimburse for this cost. **Please Initial Here:**_____

Insurance Coverage and Billing: We are happy to bill your insurance company directly. It is your responsibility before your first visit to check your coverage for our mental health services, including any deductible, copay, or coinsurance. We may collect full payment for services at the time of visit until we have confirmation of your insurance coverage.

Miscellaneous Service Charges: Please be advised that therapist time spent on client-related professional services outside of the therapy session is not billable to insurance. Non-billable services will be charged to the client. Also, additional billable charges may apply in some follow up sessions with the Nurse Practitioner.

Confidentiality: There is legal and ethical protection for the information that you share with your therapist and it cannot be released without your express written consent. This also covers our written record. There are also exceptions to privacy/confidentiality, which may include, but are not limited to when Networks Inc. clinicians provide collegial case coverage and case consultation. Other exceptions to confidentiality that include but are not limited to: when there is reason to believe that you intend to harm yourself or another person; when a child, elder or disabled adult has been or might be abused or neglected; or if information is requested by court order.

Confidentiality and Insurance Companies: If you have benefits under a managed care plan including Medicaid and Medicare, Networks may be required to provide information related to your case to the managed care reviewer and your primary physician, in writing and verbally. Networks Inc. will follow these procedures unless otherwise notified by you in writing. I acknowledge the use of the Networks internal billing services to bill for those charges to be submitted to my insurance company. These claims may be submitted electronically. I acknowledge that Networks' billing staff will be given a copy of my "Registration Form" in order to process these claims and/or to maintain a record of my account. If necessary, I authorize the Networks billing staff to contact my insurance company to check on claims submitted for payment for services.

If your insurance coverage, address or phone number changes, you are responsible for immediately notifying Networks.
Person responsible for charges not covered by insurance: _____

Mental Health Emergencies: If you are having a mental health emergency, please call 911, go to your nearest Hospital Emergency Department or call crisis services at 1-802-488-7777.

Consent for Treatment: I voluntarily consent to clinical evaluation/ treatment for myself or my minor child. I understand that there are both benefits and risks involved with engaging in psychotherapy and/or psychiatric treatment that there are no guarantees about the outcome. ***My signature below indicates that I have had an opportunity to ask and have my questions answered about the above information and I have read, understand and agree to abide by all of the above outlined terms.***

Would you like a copy of this page for your records? Yes ☐ No ☐

Signature: _____ _____ Date: _____
Client Signature Print Name of Client

Signature: _____ _____ Date: _____
Parent/Legal Guardian Signature Print Name of Parent/Legal Guardian

Signature: _____ _____ Date: _____
Witness Signature Print Name of Witness

Name: _____ Date: _____ DOB: _____

What are your reasons for seeking therapy/ treatment at this time? _____

_____

_____

_____

Section 1: Overall Quality of Life

Please **circle a number** for the answer that best applies to you for each statement below.

I feel that I am able to do the things I want to do…

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I am happy with the state of my emotional wellbeing…

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Section 2: Living Situation and Relationships

Please list members of present household

Full-Name	Age	Gender	Relationship	Comments

Description of living situation: _____

_____

_____

_____

Name: _____ Date: _____ DOB: _____

Section 3: Family of Origin (Childhood Family): Include all

Full-Name	Age	Gender	Relationship	Comments

Description of living situation: _____

_____

_____

Section 4: Demographics

Ethnicity (Optional): ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Hispanic ☐ Native Hawaiian / Other Pacific Islander ☐ White or European American ☐ Other ☐ Declined

U.S. Citizen: Yes ☐ No ☐ Native Language: _____

Gender Identity (optional): _____ Pronouns (optional): _____ Sexual Orientation (optional): _____

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Comments: _____

Highest level of education: ☐ Grade School ☐ Some high school ☐ High school graduate ☐ GED ☐ Technical school ☐ Some college ☐ College graduate ☐ Some post-graduate ☐ Graduate/prof. degree

Area of Study: _____

Current Student: Yes ☐ No ☐ Comments: _____

Military Veteran: Yes ☐ No ☐ Comments: _____

Employment status: ☐ full time ☐ part time ☐ seasonal ☐ unemployed ☐ looking for work ☐ retired ☐ disabled ☐ Other: _____

Employer: _____

Description of career, employment, work history: _____

_____

Financial concerns: Yes ☐ No ☐ If yes, describe: _____

Current Legal Issues: Yes ☐ No ☐ If yes, describe: _____

History of legal issues: Yes ☐ No ☐ If yes, describe: _____

Name: _____ Date: _____ DOB: _____

Section 5: Childhood Developmental History (check all that apply)

☐ Complications your mother had while pregnant with you (for example diabetes, hypertension, toxemia, serious illness or infection, extreme stress, drug/alcohol abuse, smoked, serious injury)

☐ born premature

☐ growth problems

☐ serious health issues or injuries

☐ psychological evaluations

☐ trouble making and/ or keeping friends

☐ behavior problems

☐ learning challenges/ disability

☐ special education services (Individual Education Plan [IEP] or 504 plan)

☐ gifted and talented services

☐ skipped any grades in school

☐ held back any grades in school

☐ parental separation or divorce

☐ death of a loved one

☐ frequent moves

Delays you experienced with any of the following (check all that apply)

☐ Walking ☐ Talking ☐ Toilet training ☐ Riding a two wheeled bicycle

☐ Other (describe): _____

Comments: _____

Section 6: Mental Health History:

History of abuse: ☐ emotional/ verbal ☐ physical ☐ sexual

If yes, please explain: _____

_____

History of self-harm: ☐ yes ☐ no If yes, explain: _____

_____

History of suicidal thoughts: ☐ yes ☐ no If yes, explain: _____

_____

Have you ever attempted suicide ☐ yes ☐ no If yes, explain: _____

_____

Family history of suicide? ☐ yes ☐ no If yes, explain: _____

_____

Have you ever thought of harming others? ☐ yes ☐ no If yes, explain: _____

_____

Name: _____ Date: _____ DOB: _____

Section 6: Mental Health History (cont).

Treatment History

Psychologist/Therapist/Counselor: _____ Dates_____

_____ Dates_____

_____ Dates_____

Psychiatric provider (MD, NP, PA): _____ Dates_____

_____ Dates_____

Hospitalizations, intensive day treatment, drug/alcohol rehab: _____ Dates_____

_____ Dates_____

_____ Dates_____

Family history of mental health issues, suicide, drug dependency and/or alcohol problems (include parents, grandparents,siblings, aunts, uncles and cousins). Yes ☐ No ☐ If yes, explain: _____

_____

Any family history of psychiatric hospitalizations? Yes ☐ No ☐ If yes, explain: _____

_____

_____

Continue to Next Page (Feel free to use this blank space for comments or additional important detail)

Name: _____ Date: _____ DOB: _____

Section 7: Substance Use

Substance	*Age of First Use*	*Age of Last Use*	*Heaviest Used*	*Current Used*	*Route of Admin.*
Caffeine					
Tobacco/Nicotine					
Marijuana/Cannabis					
Alcohol					
Over the counter (Robitussin, Sudafed, Advil)					
Prescription pain medications					
Heroin					
Other opioids					
Cocaine/Crack					
Stimulants					
Hallucinogens (LSD, PCP, mushrooms)					
Inhalants					
Sedatives, Barbiturates					
Other (bath salts, steroids, qat, beetlenut, ecstasy, synthetic cannabinoids, etc.)					

Have you ever felt that you should cut down on your drinking or use of drugs? Yes☐ No ☐

Have people ever annoyed you by criticizing your drinking or use of drugs? Yes☐ No ☐

Have you ever felt bad or guilty about your drinking or use of drugs? Yes☐ No ☐

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get over a hang-over? (an eye-opener) Yes☐ No ☐

Section 8: Physical Health

Current medical conditions (s): _____

_____

_____

Allergies (drugs, food, environment): _____

Primary Care Provider: _____

Address: _____ Tel #: _____

Current nutritional habits/issues: _____

Current sleep habits/issues: _____

Eating disorder history: _____

Name: _____ Date: _____ DOB: _____

Section 8: Physical Health (continued)

List all medications or supplements you are **currently** taking (**including psychiatric, medical and over the counter):**

Drug	Dose	Start Date	Condition Treated

Who is currently prescribing your medications: _____

Address: _____ Tel #: _____

List **only psychiatric medications you have tried in the past** and how you responded to them:

Drug	Psychiatric Condition Treated and Response

Section 9: Social and Spiritual Assets

What are your strengths? _____

Exercise/ recreational activities/ hobbies: _____

Social groups: _____

Religious affiliation: _____

Spiritual beliefs/higher power concepts: _____

_____

*** * * If client is a child, please complete child addendum. ***