

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

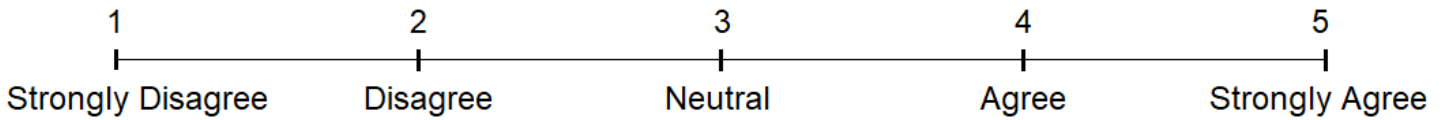
Name: _____ Date: _____ DOB: _____

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

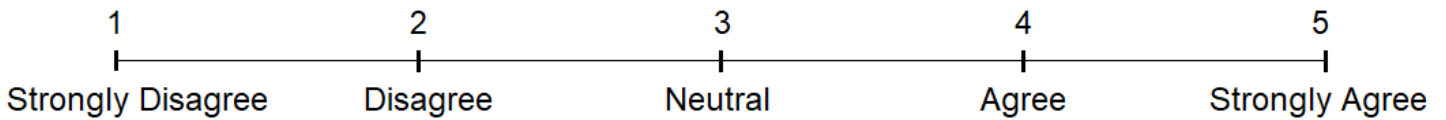
Section 1: Overall Quality of Life

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...



I am happy with the state of my emotional wellbeing...



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)

- | | |
|--|---|
| <input type="checkbox"/> 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) | |
| <input type="checkbox"/> born premature | <input type="checkbox"/> special education services (Individual Education Plan [IEP] or 504 plan) |
| <input type="checkbox"/> growth problems | <input type="checkbox"/> gifted and talented services |
| <input type="checkbox"/> serious health issues or injuries | <input type="checkbox"/> skipped any grades in school |
| <input type="checkbox"/> psychological evaluations | <input type="checkbox"/> held back any grades in school |
| <input type="checkbox"/> trouble making and/ or keeping friends | <input type="checkbox"/> parental separation or divorce |
| <input type="checkbox"/> behavior problems | <input type="checkbox"/> death of a loved one |
| <input type="checkbox"/> learning challenges/ disability | <input type="checkbox"/> 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

<i>Substance</i>	<i>Age of First Use</i>	<i>Age of Last Use</i>	<i>Heaviest Used</i>	<i>Current Used</i>	<i>Route of Admin.</i>
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. ***