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:**_____

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: Privacy and confidentiality are important to the relationship between client and therapist. 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. Additionally, in the event that your therapist is unavailable, a colleague will be covering. There are 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 has been requested by court order. If you have any questions about confidentiality, please raise them with your therapist.

Confidentiality and Insurance Companies: If you will be using 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. When technology permits, these claims may be submitted electronically. I acknowledge that the Networks billing department will be given a copy of my "Registration Form" page (included in this intake packet) in order to process these claims and/or to maintain a record of my account. If necessary, I authorize the Networks billing department 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 of the change.

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 _____
Signature of Parent or Legal Guardian Print Name of Parent or Legal Guardian

Witness _____ _____ Date _____
Witness Signature Printed Name

Name: _____ Date: _____ DOB: _____

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

_____

_____

_____

Section 1: Living Situation and Relationships

Please list members of present household

Full-Name	Age	Gender	Relationship	Comments

Description of living situation: _____

_____

_____

Section 2: Family of Origin (Childhood Family): Include all

Full-Name	Age	Gender	Relationship	Comments

Description of living situation: _____

_____

_____

Name: _____ Date: _____ DOB: _____

Section 3: 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: _____

Comments: _____

Gender Identity (optional): _____ Pronoun (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 _____

Section 4: 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

Name: _____ Date: _____ DOB: _____

Section 4: (continued)

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 5: 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, describe: _____

_____

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_____

_____

Name: _____ Date: _____ DOB: _____

Section 6: Substance Use

Substance	*First Use*	*Last Use*	*Heaviest Use*	*Current Use*	*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 7: Physical Health

Current medical condition(s): _____

_____

_____

Allergies (drugs, foods, environment): _____

Primary Care Provider: _____

Address: _____ Tel # _____

Current nutritional habits/issues: _____

Current sleep habits/issues: _____

Eating disorder history: _____

Name: _____ Date: _____ DOB: _____

Section 7: 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 all **previous** psychiatric medications and how you responded to them:

Drug	Condition Treated and Response

Section 8: 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. * * ***