**Psychological and Life Skills Associates, PC**
13885 Hedgewood Drive, Suite 245, Woodbridge, VA 22193
601 Jefferson Davis Highway, Suite 101, Fredericksburg, VA 22401
2960 Chain Bridge Road, Suite 200, Oakton, VA 22124
(703) 490-0336

# Adult Intake Questionnaire

Referred by:_____

Name_____ Today's Date_____
Date of Birth_____ Place of Birth_____ Gender: Male/Female_____
Home Address_____ City_____ Zip Code_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Level of Education_____
Occupation_____ Employer_____
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed
Spouse Name_____ Spouse Phone_____

**Current Family Structure:** (residing in the home)

| Name | Age | Relationship | Job/School |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Other Children: (not in home)

| Name | Age | Relationship | Job/School |
|---|---|---|---|
| | | | |
| | | | |

**Family of Origin Structure:** Include parent/caregivers, step-parents, medical/mental history (substance abuse, cancer, depression).

| **Parents** Name | Relationship | Age | **M**arital Status | Job/ Occupation | Medical/Mental History |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Client Name:**_____

| **Siblings** Name | Relationship | Age | Marital Status | Job/ Occupation | Medical/Mental History |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Current Symptoms:** Please check if you currently experience any of these symptoms:

☐ Irritability
☐ Aggression
☐ High activity level
☐ Staring spells
☐ Trouble expressing self (please explain)_____
_____
__ Frequent fatigue
__ Low energy level
☐ Trouble falling asleep
☐ Trouble getting up in the morning
__ Frequent awakenings during the night
__ Easily frustrated
☐ Recent weight gain/loss
☐ Recent changes in appetite
☐ Excessive fears/worries
☐ Lack of interest in sexual relationships
__ Social isolation
☐ Depressed mood
__ Mood swings

☐ Hopelessness
☐ Anxiety
☐ Rage/Anger
☐ Guilt
☐ Grief/Mourning
☐ History of sexual abuse
☐ History of physical abuse
☐ coping with pain (please explain)_____
_____
__ Aches and pains (please explain)_____

☐ Suicidal thoughts/actions (please explain)_____
_____
☐ Desire to hurt someone else (please explain)
_____
_____

__ Self-harm (please explain)
_____
_____
__ Problems in thinking (please explain)_____
_____
__ Problems with memory (please explain)_____
_____
__ History of traumatic event(s) (please explain)_____
_____
_____
__ Recent legal charges/police involvement (please explain)
_____
_____
__ Other (please explain)_____
_____
_____

**Relevant Health and Mental Health History:**
Physician Name_____ Physician Phone_____
Medical or mental health conditions_____
History of substance abuse problems_____

**Client Name:**_____

Frequency of use of the following: Alcohol_____Caffeine_____Nicotine_____
Other Substances (e.g., marijuana, cocaine, sleeping pills) _____
Previous hospitalizations and date(s)_____

| Current Medications: | Medication | Dose | Treating Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| History of Psychotherapy: | Previous Therapist | Dates | Issues Addressed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

What in your life are you grateful for?_____
_____

My goals for therapy are _____
_____

I will know I've reached them when _____
_____

Client Signature_____

Date_____

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## NOTICE OF OUR PRIVACY PRACTICES

***UNDERSTANDING YOUR HEALTH RECORD & INFORMATION:*** Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

***YOUR HEALTH INFORMATION RIGHTS:*** Unless otherwise required by law your health record is the physical property of Psychological and Life Skills Associates, P.C. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your mental health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your mental health record. You may obtain an accounting of disclosures of your mental health information, request communications of your mental health information by alternative means or at alternative locations, revoke your authorization to use or disclose mental health information except to the extent that action has already been taken.

***OUR RESPONSIBILITIES:*** Psychological and Life Skills Associates, P.C. is required to maintain the privacy of your mental health information, and in addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected mental health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. We will not use or disclose your mental health information without your authorization, except as described in this notice.

***EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS***

***We will use your mental health information for treatment*:** Information obtained by your therapist will be recorded in your record and used to determine the course of treatment that should work best for you.

***We will use your mental health information for payment.*** For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, relevant history, and treatment given.

***Law enforcement:*** We may disclose mental health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your mental health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public. We will attempt to contact you first to see if you consent to such release.

***Child Abuse:*** If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services. We will discuss this with you as appropriate.

***Abuse of Elderly or Incapacitated Adults:*** When we have reason to suspect that an incapacitated adult (e.g. someone who is not able to advocate for himself or herself) is being abused, neglected or exploited, we are required by law to make a report and provide relevant information to the Virginia Department of Social Services. You will be notified of this action unless your therapist believes that it would put you at risk of serious harm.

***Health Oversight:*** The Virginia Board of Health Professions, including the Boards of Psychology, Social Work, and Counseling, has the power to subpoena relevant records should we be the focus of an inquiry.

***Judicial or Administrative Proceedings (Court Orders):*** If you are involved in a court proceeding and a request is made for information about your treatment, we will not release information without your written authorization. If we receive a Subpoena for your records (of which you have been served, along with the proper notice required by state law) we are required to respond. We will attempt to contact you first to see if you consent to such release. If you object, you may file a motion, with the clerk of the court to move to quash (block) the subpoena. If you pursue this, notify your therapist as soon as possible. We are then required to place your records in a sealed envelope and provide them to the clerk of the court so that the court can determine whether the records should be released.

***Serious Threat to Health or Safety of Others:*** If you communicate to us a specific and immediate threat to cause serious bodily injury or death to an identified or to a readily identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect the threatened person.

***Danger to Self:*** Your therapist can break confidentiality if you (or your child) are in imminent danger of hurting yourself, in order to keep you (or your child) safe. This may include notifying emergency personnel.

***Worker's Compensation:*** If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant PHI to you, your employer, the insurer, or a certified rehabilitation provider.

***Debt Collection:*** Your name can be reported to a collection agency and/or a credit bureau if you fail to pay your bill. You will be notified before such a report is made.

***Legal Defense:*** Disclosure may be made if a therapist must arrange for legal consultation if a patient takes legal action against a therapist.

**Effective Date:** This notice will be effective on April 14, 2003

***Modification & Amendment:*** This notice may be modified or amended by other documents, upon notification from your healthcare provider.

**To obtain more information, or if you have any questions about this form, please contact our privacy officer:**

***Dr. Christopher T. Haley***
***13885 Hedgewood Drive #245***
***Woodbridge, VA 22193***
***(703)490-0336***

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## Acknowledgement of Notice of Privacy Practices

**I acknowledge the review and/or receipt of the Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.**

**I understand that my therapist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me upon a written request to the Privacy Officer.**

**I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to my therapist. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my mental health information. Written revocation of consent must be sent to our office.**

**I understand that I have the right to request that the practice restricts how my individually identifiable mental health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.**

**Signed:_____ Date:_____**

**If you are not the patient, please specify your relationship to the patient_____.**

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# Our Financial Policy

Welcome to the office of Psychological and Life Skills Associates, P.C. In order to ensure the efficiency of our practice, we wish to explain our policy with regard to financial responsibility for sessions with the psychotherapists from this office.

**All payments are due prior to each session.** If we are in network with your insurance carrier, a copay/coinsurance is expected. Our office will then file to your insurance carrier for the remaining amount owed. Benefits quoted by your insurer are not a guarantee of payment. Ultimately, you are responsible for all charges incurred. If we are out of network with your insurance carrier, payment in full is expected. As a courtesy we will file to your insurance. If you have out of network benefits they will reimburse to you directly. During office hour's payment may be given to your psychotherapist or the office staff. After hours, payment is due to your therapist at the time of service. With so many insurance carriers, policies, and various benefit packages available, we will help you with your insurance filing but we cannot guarantee payment or accept responsibility for negotiating your claim(s). It is important that you understand the provisions of your insurance policy.

## Our Late Cancellation/No-Show Policy

If you are unable to keep a scheduled appointment, you are required to give us at least a 24-hour notice. Late cancellations (with less than 24 hour notice) and No Shows (missing a scheduled appointment) are charged $75 each time, regardless of the reason. For all group sessions, you will be charged $25. This fee cannot be billed to insurance. _____(initial)

## Statement Fee

All payments are due at the time of service. If a balance is owed and a statement is mailed to you, you will be charged a $5.00 statement fee for each statement sent to you.

## Collections Services

We are contracted with collection services to recover any money owed to Psychological and Life Skills Associates.

## Outstanding Balance Policy

Payment is due at the time of session. Account balances that exceed $250 must make payment before further appointments can be scheduled.

## Returned Checks

The return of a check (electronic or paper) issued to Psychological and Life Skills will result in a $25.00 returned check fee being placed on the account of the patient, or individual, on whose behalf the check was presented for each returned check, no matter the reason.

## Consent for Release and Use of Confidential Information

I, _____hereby give my consent to Psychological and Life Skills Associates, P.C. to use for the purpose of payment, all information contained in the patient record of:_____.

***The undersigned has read, understands, and agrees to the above terms and conditions.***

_____ _____
Signature of Person Financially Responsible Date

_____ _____
Address (if other than patient's) Signature of Therapist/Witness

_____
Date of birth of financially responsible party

## Insurance Information

Ins. Co. (Name/Address):_____

Policy Holders Name:_____DOB:_____SSN and Insurance ID:_____

If Military (Active/Retired):_____

Any secondary insurance? (if so, name of company)_____

Policy Holders Name (if different from above):_____DOB:_____

SSN and Insurance ID:_____

NOTE: Tricare Options Standard please alert your therapist if you have used any of your mental health benefits since October 1.
Name of Referring Provider:_____

***All Payments are Due at the Time of Your Appointment***
***You Must Agree to One of the Following (please initial one):***

_____
*Initial here*

**I agree to pay my session fee/co-pay in full at the time of service using one of the methods below.**

1. BY CASH: We will gladly accept cash payments and will provide you with a receipt of payment.

2. BY CREDIT: We accept all major carriers. We can also accept credit card payments by phone. You can reach our office staff Monday-Friday from 10 am to 5 pm by calling 703-490-0336 x 0.

3. BY CHECK: Please make checks payable to ***Psychological and Life Skills Associates, PC***. You may give the check to your therapist or the office staff.

4. BY PAYPAL: Visit our website, Psychlife.net, and click on "Make a Payment." Then, follow the Paypal prompt.

_____
*Initial here*

**I request that my credit or debit card be charged for each session at the time of service. (please complete below)**

**NAME OF CLIENT** _____
Card # _____
Exp. date _____
Sec code _____
Billing zip _____
Name of Cardholder _____
Signature _____
Address (if different than above)
_____
_____

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# Charges for Ancillary Services

Please be aware that it is our policy to charge for non-clinical services. Such services include, but are not limited to, telephone consultations with other providers or schools, writing letters on behalf of clients, completing paperwork at the request of clients (eg. filling out disability paperwork), and fielding emergency calls. Charges will reflect the time needed to complete the service and is billed in 15 minute increments at a rate of $150/hour.

***Please note that advance notification will be sent before additional charges are applied.**

For example:

15 minutes = $37.50

30 minutes = $75.00

45 minutes = $112.50

60 minutes = $150.00

# Charges for Medical Records

Searching and Handling Fee - $10
Pages 1 - 50: $0.50 per page
Pages 51+: $0.25 per page

I have read, understand, and agree to the above office policy.

_____ _____

Signature of Patient Date