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: _____Today's Date: _____

Name: _____
Date of Birth_____ Place of Birth_____ Gender: _____
Home Address_____ City_____ Zip_____
Home Phone_____ Cell Phone _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Level of Education _____ Occupation _____
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	Age	Relationship	Marital Status	Job/Occupation	Medical/Mental History
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Siblings

Name	Age	Relationship	Marital Status	Job/Occupation	Medical/Mental History
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Client Name:_____

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
- ☐ Coping with pain (please explain) _____
- ☐ Recent weight gain/loss
- ☐ Appetite changes
- ☐ Excessive fears/worries
- ☐ Social isolation
- ☐ Depressed mood
- ☐ Mood swings
- ☐ Hopelessness
- ☐ Anxiety
- ☐ Anger/rage
- ☐ Guilt
- ☐ Easily frustrated
- ☐ Sexual abuse history
- ☐ Physical abuse history
- ☐ Suicide thoughts/actions
- ☐ Desire to hurt someone
- ☐ Drug/alcohol use
- ☐ Tobacco use
- ☐ Self-harm
- ☐ Problems in thinking
- ☐ Problems with memory
- ☐ Grief/morning
- ☐ Frequent awakenings during the night

- ☐ Aches and pains (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 _____

Frequency of use of the following: Alcohol _____ Caffeine _____ Nicotine _____

Other Substances (e.g., marijuana, cocaine, sleeping pills)_____

Previous hospitalizations and date(s) _____

Client Name:_____

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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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. _____(Initials)

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

Our Financial Policy

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:_____

All Payments are Due at the Time of Your Appointment Using Your Credit/Debit Card on File. Our company policy is to require a credit/debit card on file to be charged.

_____
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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Acknowledgement of Notice of Privacy Policy

I acknowledge that I may review the Privacy Policy found on Psychlife.net. The Notice of Privacy Policy 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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In order to comply with the Surprises Act of 2020, we are providing you with a list of our fees. This Good Faith Estimate explains our rates for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

Charges for Psychotherapy Services

Initial Intake $175
Individual/Family/Marital session $155
Group session $75

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 letter 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 $155/hour. For example:

15 minutes = $38.75
30 minutes = $77.50
45 minutes = $116.25
60 minutes = $155.00

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

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Electronic Record and Signature Disclosure

From time to time, Psychological and Life Skills Associates, PC, may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically via email. The words "the Company," "we," "us," and "our" refer to Psychological and Life Skills Associates, PC. The words "you and "your" mean you, the individual(s) identified on this intake form. "Communication" means any client agreement, amendments, disclosures, notices, responses, transaction history, privacy policies and all other information related to the service, including but not limited to information that we are required by law to provide to you in writing. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the "I agree" button at the bottom of this document.

Communications in Writing.

All Communications, either electronic or paper format, from us to you will be considered "in writing." You should print or download for your records a copy of this intake form and disclosure that you deem important.

Federal E-Sign Consent
You acknowledge and agree that your consent to electronic Communications is being provided in connection with a intake form and with a transaction that is subject to federal Electronic Signatures in National Commerce Act, and that you and we both intend that the Act apply to the fullest extent possible to validate our ability to conduct services as a business with you electronically.

Acknowledging your access and consent to receive materials electronically.
To confirm to us that you can access this information electronically, which will be similar to other electronic Communications that we will provide to you, please verify that you were able to read this electronic disclosure and that you are also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving Communications exclusively in electronic format on the terms and conditions described above, please let us know by clicking the "I agree" button below.

By clicking the 'I agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC RECORD AND SIGNATURE DISCLOSURES document; and
- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and
- Until or unless I notify Psychological and Life Skills Associates, PC, as described above, I consent to receive electronic means all notices, disclosures, authorizations, acknowledges, and other documents that are required to be provided or made available to me by Psychological and Life Skills Associates, PC during the course of my relationship with you.

☐ I AGREE

_____ _____
PRINT NAME OF PATIENT DATE