Psychological and Life Skills Associates, PC
13885 Hedgewood Drive, Suite 245, Woodbridge, VA 22193
601 Emancipation 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: __________
Email Address:______________________________

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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Good Faith Estimate

In order to comply with the No 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 $180

Individual/Family/Marital session $160

Group session $80

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 $160/hour. For example:

15 minutes = $40.00

30 minutes = $80.00

45 minutes = $120.00

60 minutes = $160.00

Charges for Medical Records

Searching and Handling Fee - $10

Pages 1 - 50: $0.50 per page

Pages 51+: $0.25 per page

Charges for Court-related Services

We require a signed Retainer Agreement and $6,000 retainer prior to any court-related activities, including consulting with attorneys. Additionally, we bill $400/hour for these services. Please see the Retainer Agreement and consult with your therapist for more information on this.

Charges for Audio/Videotaping sessions

It is essential that confidentiality be maintained for all our clients, including minors. We therefore do not allow, at any time, any audio or videotaping of sessions with us. Should you (or your child) choose to record any sessions, you will be billed $2,500 for each session that a recording has occurred. Additionally, you may be reported to local and/or state authorities as this act may be illegal under the Virginia Rules of Professional Conduct (please refer to Virginia Codes § 19.2-62, § 19.2-61, and § 19.2-69). Violation of these Virginia laws is a felony, punishable by imprisonment and fine.

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