CLIENT INFORMATION

Today's Date: ______________________________ Clinician: ____

First Name: ________________________________ Middle: ______ Last: ____

Address: ____

City, State, Zip: ____

Home Phone: ____ OK to Leave message? ☐ Yes ☐ No

Cell Phone: ____ OK to Leave message? ☐ Yes ☐ No

Social Security Number: ______________________________ Sex: __________ Birth date: __________________________

Email Address: ____ OK to email sensitive info? ☐ Yes ☐ No

Select one: ☐ Married ☐ Divorced ☐ Single ☐ Widow/er ☐ Separated

PRIMARY INSURANCE INFORMATION

Insurance Company: ____

Policy ID#: ____ Group #: ____

Phone: ____________________________________ Employer Name: ____

Insured's Name: ____

Insured's SS#: ____________________________________ Insured's birthdate: ____

Insured's Address: __________________________________ City, State, Zip: ____________________________________

Patient's Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________________

AUTHORIZATION/ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process this claim. I also request payment of insurance benefits to Marcia S. Gibson PsyD & Associates, P. C.

Signed: ____ Date: ____

I authorize payment of medical benefits to Marcia S. Gibson PsyD & Associates, P. C. for services provided.

Signed: ____ Date: ____

I give permission to Marcia S. Gibson PsyD & Associates, P. C. to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will be responsible for any unpaid balances including copayments, deductibles, and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed to me at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signed: ____ Date: ____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

If the guarantor is different than the patient, please complete and sign:

Guarantor Name: ____ DOB: _____________________________

Address: ____ City/State/Zip: ____

Home Phone: ____________________________________ Cell Phone: ____

Soc Sec Number: _________________________________ Relationship to Patient:__________________________________

E-mail Address: ____

As the responsible party, I understand that I am responsible for payment of any outstanding charges on this account.

Signed: ____ Date: ____

AUTHORIZATION

PERMISSION TO RECEIVE PRERECORDED APPOINTMENT REMINDER PHONE CALLS, TEXTS, OR EMAILS

As a service to our clients, we now offer appointment reminder calls, texts, and/or reminder emails. In order to authorize receiving the calls, texts, or email messages, please fill out the information below and provide the phone number and/or email where you wish to receive these messages.

By providing your phone number and/or email below, you consent to receiving appointment reminder calls, texts, or emails. You do not need to sign this authorization; however, if you do not sign this authorization, we will not be able to provide you with the courtesy reminder calls and/or emails.

Name of Client: ____

______________________________________ ____________________________

Signature of Client Date

______________________________________ ____________________________

Signature of Parent or Guardian (if client is a minor) Date

Phone number authorized by client to receive reminder calls: ______________________________

Phone number authorized by client to receive reminder texts: ______________________________

Email Authorized by client to receive reminder appointments: ______________________________

Please indicate your preference:

□ Phone Call Reminder □ Text Reminder □ Email Reminder

Adult Intake Form

Name: ____ Date: _______________ Date of Birth: _________

OFFICE POLICIES

Confidentiality:

- Information in my sessions is confidential EXCEPT if I am threatening to hurt myself or someone else, or if I tell of a child or an elderly person being abused. In any of these cases, the clinician will have to act upon this information to protect me or someone else.

Appointments:

- Psychotherapy sessions are typically **50-55 minutes long**.
- There is a 24 hour cancellation fee. When I schedule an appointment, the clinician reserves that time for me and ***if I cannot attend a session I must give 24 hours notice or I will be charged the fee service charge for the session***. _____________ initials
- The initial visit is considered to be an evaluation only and not a guarantee that treatment will be the result of said visit.

Payments and Billing:

- Payment at time of service is expected unless other arrangements have been made. If health insurance covers my sessions, Marcia S. Gibson PsyD & Associates P. C. will help me seek reimbursement from the insurance company. **ANY unpaid balance after insurance is MY responsibility to pay.**
- I agree that Marcia S. Gibson PsyD & Associates P. C. may release to my insurance company any information needed to secure payment for service.
- If I do not pay my account, then it may be turned over to collections.
- In the event that any check I write is returned NSF (insufficient funds) I agree to pay ***a $15.00 service fee***.

The parent accompanying the child to session is responsible for any payment unless other arrangements have been made with the office manager in charge of billing. _____________ initials

Signed: ____ Date: ____________________________

404 W. Boughton Road, Suite A

Bolingbrook, IL 60440

Credit Card Authorization

For internal use only.

I, ____, authorize Marcia S. Gibson PsyD & Associates, P. C. to keep my

signature on file and to charge my credit card listed below for:

All copays and coinsurances owed at each session, if applicable.

All patient balances (less than $250) for services rendered once the claim has been processed by my insurance company.

I understand that Marcia S. Gibson PsyD & Associates, P. C. will contact me by telephone for all patient balances exceeding $250 prior to charging my card.

I authorize recurring charges for services rendered for the following family members:

Patient Name: ____ DOB: ________________________
Patient Name: ____ DOB: ________________________
Patient Name: ____ DOB: ________________________
Patient Name: ____ DOB: ________________________

Check One: Visa ___________ Master Card ___________ Discover ______________

Billing Address: ____

City: ____ State: ________________ Zip: _________________________________

Credit Card Number: ____ Expiration Date: _______________________

CVV: _________________________ (3 numbers on the back of the card)

Cardholder Signature: ____ Date: ________________________________

Cardholder preferred contact number: ____

I have the right to terminate this authorization at any time and agree to do so by contacting Marcia S. Gibson PsyD & Associates P. C. at (630)759-4000.

Adult Intake Form

Name: ____________________________________ Date: _____________ Date of Birth: _________

AUTHORIZATION TO DISCUSS MY MEDICAL INFORMATION AND ACCOUNT:

You may discuss my **medical** information with:

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

You may discuss my **appointment** information with:

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

You may discuss my **account** information with:

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Signed: ____________________________________ Date: _________________________

CONSENT TO TREATMENT: I hereby authorize and voluntarily consent to all care, treatment, and other related services that may be ordered, requested, directed, or provided by Marcia S. Gibson PsyD & Associates, P. C. Further, **I understand and agree to the above policies and I authorize my clinical and account information to be discussed as indicated above.**

____ ______________________________

Signature of Patient/Client Date

____________________________________ ________________________ __________________

* Signature of Parent, Guardian, Relationship/Authority Date

Adult Intake Form

Name: ____ Date: ________________________

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between your Marcia S. Gibson PsyD & Associates P. C. clinician and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date is specified.

I, ___________________________ _________________ ____________________________

Patient/Client (PRINT) Date of Birth Social Security Number

Please check one:

☐ I agree to release mental health/substance abuse information to my Primary Care Physician.

☐ I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name: ____

Physician Address: ____

Physician Phone: ______________________________ Fax: ____________________________________

____ ____

Signature of Patient/Client Date

____ _________________ _________________

* Signature of Parent, Guardian or Personal Representative Relationship/Authority Date

Information for PCP:

The above-named individual was seen on ________________ for _____________________________________

Date Diagnosis

by ____________________

Clinician

Adult Intake Form

Name: ______________________________ Date: ______________________

Problems are you seeking help with today: ____

____

Current Symptoms:

☐ Depression ☐Mood swings ☐Anger/Irritability/Temper ☐Thoughts of death/dying ☐Suicidal thoughts

☐Crying spells ☐Loss of enjoyment/interest ☐Loss of Motivation ☐Hopelessness/Worthlessness

☐Withdrawal/Avoidance ☐Fatigue/No energy ☐Increase energy ☐Sleep Problems ☐Self-injury

☐ Racing thoughts ☐Worry ☐Anxiety or Panic attacks ☐Agitation ☐Impulsivity ☐Increase in risky behavior

☐Suspiciousness ☐Hearing voices ☐Seeing things ☐Change in libido ☐Appetite Change ☐Homicidal thoughts

☐Problems with attention/concentration/focus ☐ADHD ☐Problems with memory

☐Other – please describe: ____

____

SUICIDE RISK ASSESSMENT:

Have you had thoughts that you don't want to live? ☐No ☐Yes Do you have those thoughts now? ☐No ☐Yes

Have you ever tried to kill yourself? ☐No ☐Yes Number of times ____When was most recent attempt? _________

Has anyone in your family died by suicide? ☐No ☐Yes Who? ____________________________________

PAST TREATMENT HISTORY:

Have you received treatment in the past for mental health problems? ☐No☐ Yes

Type of treatment: ☐ Talk therapy ☐Medications ☐Inpatient: # times? ______________ When most recent ____________________

Past Diagnosis, if known: ____

FAMILY PSYCHIATRIC HISTORY:

Please check if family members have (or might have) of any of the following problems:

☐ Depression: ______________________________ ☐ Schizophrenia: ______________________________

☐ Bipolar: ______________________________ ☐ Addictions: ______________________________

☐ Anxiety: ______________________________ ☐ PTSD: ______________________________

☐ ADHD/ADD: ______________________________ ☐ Other: ______________________________

SUBSTANCE USE/ADDICTION HISTORY:

Do you use tobacco products? ☐No ☐Yes What do you use, and how much? ______________________________

Do you have problems with alcohol, drugs, or prescription drugs? ☐No ☐Yes – Describe ______________________

____

Adult Intake Form

Name: ____ Date: ________________________

Have you been treated for problems with alcohol or drugs? ☐No ☐Yes -Describe: ___________________________
____

SOCIAL HISTORY:

Where did you grow up? _____________________________ Quality of childhood ☐Great ☐Adequate ☐Difficult
Raised by ____ # Brothers _________ # Sisters _________

Abuse in the home? ☐ No ☐ Yes - check all that apply: ☐ Physical ☐ Emotional ☐ Sexual ☐ Neglect

Marital Status: ☐ Single, never married ☐ Married/Partnered for __________ years ☐ Divorced ☐ Widowed

past marriages? ______________ Relationship with spouse/partner: ☐Great ☐Adequate ☐Difficult

Do you have children? ☐ No ☐ Yes – what are their ages: _______________________________________

Highest Education Level? ____________________________ How did you do in school: _______________________

Occupation: ☐ Employed ________________ ☐ Not working by choice ☐ Unemployed ☐ Retired ☐ Disabled

Military History: ☐ No ☐ Yes: Branch______________ When_____________ Type discharge________________

Legal History: Have you ever been arrested ☐ No ☐ Yes: describe _____________________________________

Current legal issues? ☐ No ☐ Yes Describe: ____
____
____

MEDICAL HISTORY:

Primary Care Physician: _____________________________________ Approximate Date of last exam: ___________
How would you describe your physical health?____
Please check any of the following health conditions for which you are being treated:

☐ High blood pressure ☐ Diabetes ☐ Liver Disease ☐ Heart Disease ☐ Thyroid Problem
☐ Stomach/Intestinal ☐ High Cholesterol ☐ Seizures ☐ Sleep Apnea ☐Stroke
☐ Headache/Migraines ☐ Seizures ☐ Pain where: ____
☐ Asthma ☐ COPD/Bronchitis ☐ Cancer - type: ____

Medical problems not included above: ____
Past surgeries: ____
____
____

Allergies (medications or other): ____
Current Medications: ____
____
____

Adult Intake Form

Name: ____ Date: ________________________

	For Each of the following questions indicate "Yes" or "No"	Yes	No
1	Do you feel you are a normal drinker ("Normal" – drink as much or less than most people)		
2	Have you ever awakened in the morning after drinking the night before and found you couldn't remember a part of the evening?		
3	Does any near relative or close friend ever worry or complain about your drinking?		
4	Can you stop drinking without difficulty after one or two drinks?		
5	Do you ever feel guilty about your drinking?		
6	Have you ever attended and Alcoholics Anonymous (AA) meeting?		
7	Have you ever gotten into physical fights when drinking?		
8	Has drinking ever caused problems between you and a near relative or close friend?		
9	Has any family member or close friend gone to anyone for help about your drinking?		
10	Have you ever lost friends because of your drinking?		
11	Have you ever gotten into trouble at work because of your drinking?		
12	Have you ever lost a job because of drinking?		
13	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
14	Do you drink before noon fairly often?		
15	Have you ever been told you have liver trouble such as cirrhosis?		
16	After heavy drinking have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?		
17	Have you ever gone to anyone for help with your drinking?		
18	Have you ever been hospitalized because of drinking?		
19	Has your drinking ever resulted in your being hospitalized on a psychiatric ward?		
20	Have you ever gone to any doctor, social worker, clergy, or mental health clinic for help with any emotional problems in which drinking was a part of the problem?		
21	Have you ever been arrested more than once for drinking under the influence of alcohol?		
22	Have you ever been arrested, even for few hours, because of other behavior while drinking?		

Adult Intake Form

Name: ____ Date: ________________________

At what age did you have your first drink? __________ At what age did you first try a drug? ______________

Please complete the following for each drug you have used: if not applicable, please skip this page.

Drug	Age of 1st use	When was your last use	Type of use (e.g. Heavy, recreational)
Alcohol			
Cocaine			
Methamphetamine			
Other Amphetamines (e.g. Ritalin)			
Bath Salts			
Hallucinogens (e.g. LSD, Mushrooms, PCP, salvia, ketamine)			
Heroine			
Prescription Pain Pills			
Benzodiazepines (Xanax, Valium, Klonopin, etc.)			
Other Prescription Medications			
Inhalants			
Cold Medicines			
Marijuana			
K2/Spice ("Synthetic Marijuana")			
MDMA (Ecstasy/Molly)			
Other Club Drugs			
Steroids (Anabolic)			
Other:			