Marcia S. Gibson PsyD & Associates, P.C.

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

Sex: _____ Birth date: _____

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

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Policy ID#: _____ Group #: _____

Phone: _____ Employer Name: _____

Insured's Name: _____

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: _____

Marcia S. Gibson PsyD
& Associates, P.C.

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: _____

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: _____

Marcia S. Gibson PsyD
& Associates, P.C.

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

Marcia S. Gibson PsyD & Associates, P.C.

Child/Adolescent 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 full fee for the session***.
- 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 $25.00 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**.
- Parent is required to either send child/adolescent with check or credit card or a credit card MUST be on file to pay for co-pays, co-insurances, and deductibles.
- Balances of $200.00 or more, must be paid in full before next appointment is made.

Signed: _____ Date: _____

_____

Signature of Parent, Guardian or Personal Representative* Date

Marcia S. Gibson PsyD & Associates, P.C.

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.

Marcia S. Gibson PsyD & Associates, P.C.

Child/Adolescent Intake Form

Name: _____ Date: _____

Guardian Name: _____ Relationship to Client: _____

In your own words, tell us why you are seeking care through Marcia S. Gibson PsyD & Associates, P. C.: _____

What is/are your goal(s) for seeking care through Marcia S. Gibson PsyD & Associates, P. C.: _____

What have you tried that has helped your child? _____

Are the custodial parents divorced? ☐ Y ☐ N

If Yes, are both parents aware of the child participating in therapy? ☐ Y ☐ N

If not, please explain: _____

Marcia S. Gibson PsyD
& Associates, P.C.

Name: _____ Date: _____

Child Intake Symptom Check List:

☐ Financial difficulties ☐ Legal problems ☐ Depression ☐ Anxiety ☐ Problems sleeping ☐ Perfectionism
☐ Voices in my head ☐ Suicidal thoughts ☐ Suicide attempts ☐ Crying Spells ☐ Hyperactivity ☐ Picky eater
☐ Difficulty with relationships ☐ Loneliness ☐ Anger ☐ Loss of appetite ☐ Trauma or abuse ☐ Sibling rivalry
☐ Weight gain ☐ Weight loss ☐ Eating disorder ☐ Self-injury ☐ Mood swings ☐ Nightmares ☐ Sexting
☐ Memory loss ☐ Agitation ☐ Poor concentration ☐ History of delayed development ☐ Fire-starting ☐ Gambling
☐ Thoughts of hurting myself ☐ Thoughts of hurting someone else ☐ Hallucinations ☐ Accident-prone ☐ Bullying
☐ Difficulties at school ☐ Problems using or understanding nonverbal communication ☐ Viewing pornography
☐ Difficulty with social interactions or situations ☐ Poor impulse control ☐ Poor grades ☐ Cruelty to people or animals
☐ School refusal or truancy ☐ Vandalism or stealing ☐ Problems separating from parents/family ☐ Victim of bullying
☐ Other – please describe: _____

_____

Mental Health History:

If your child has received mental treatment/hospitalization in the past, please tell us:

Provider: _____ When Seen: _____ Helpful? ☐ Y ☐ N

Provider: _____ When Seen: _____ Helpful? ☐ Y ☐ N

Provider: _____ When Seen: _____ Helpful? ☐ Y ☐ N

Provider: _____ When Seen: _____ Helpful? ☐ Y ☐ N

Please list any mental health diagnoses given to your child in the past: _____

_____

_____

_____

Please list any mental health medications that your child has taken in the past: _____

_____

_____

_____

Please list all your child's current medications (including herbs and over the counter medicines): _____

_____

_____

Marcia S. Gibson PsyD & Associates, P.C.

Child/Adolescent Intake Form

Name: _____ Date: _____

Medical History:

Primary Care Physician/Pediatrician: _____ Date of last exam: _____

Medication Allergies: _____

Food/Environmental Allergies: _____

Please list any conditions that your child has been diagnosed with or takes medication for: _____

_____

_____

_____

Medical History Check List:

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

☐ Hospitalizations ☐ Surgeries ☐ Prematurity ☐ Asthma ☐ Head trauma ☐ Seizures ☐ Fainting

☐ Heart murmurs ☐ Heart palpitations ☐ Birth control pill or injections

☐ Use of tobacco, alcohol, recreational drugs, or pills (including one-time use)

☐ Sexual activity in the past 3 years

☐ Other: _____

Birth and Development:

Were there complications during the pregnancy? ☐ Y ☐ N
If so, what happened? _____

Was there tobacco, alcohol, drug, or toxin exposure during the pregnancy? ☐ Y ☐ N
If so, what exposure occurred? _____

Were there any complications during the delivery? ☐ Y ☐ N
If so, what happened? _____

Birth weight: _____ ☐ Full term ☐ Premature (_____ weeks early) ☐ Other: _____

Did you leave the hospital within 2-3 days of birth? ☐ Y ☐ N
If not, why was there a delay? _____

Please tell us when your child:

Spoke his/her first word(s): _____ Began using 2-3-word phrases: _____

Began sitting unassisted: _____ Began walking: _____

Completed toilet training: _____

Marcia S. Gibson PsyD & Associates, P.C.

Child/Adolescent Intake Form

Name: ______________________________ Date: ______________

Has your child ever regressed or unexpectedly lost developmental milestones? ☐ Y ☐ N

If so, what skills were affected: ______________________________

Does your child have any current problems with wetting or soiling him/herself? ☐ Y ☐ N

If so, please explain: ______________________________

Social History:

Child's Father: Living? ☐ Y ☐ N Date of death: __________ Cause: ______________

Age: ________ Occupation: ______________ Education: ______________

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Child's Mother: Living? ☐ Y ☐ N Date of death: __________ Cause: ______________

Age: ________ Occupation: ______________ Education: ______________

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Child's Parents Status:

☐ Never Married ☐ Married ☐ Separated since: ________ ☐ Divorced since ________

Child's Siblings: (If additional room is needed for siblings, please use the back of this page.)

Name: ______________________ Age: ________ Gender: ☐ M ☐ F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Name: ______________________ Age: ________ Gender: ☐ M ☐ F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Name: ______________________ Age: ________ Gender: ☐ M ☐ F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Name: ______________________ Age: ________ Gender: ☐ M ☐ F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Name: ______________________ Age: ________ Gender: ☐ M ☐ F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Please tell us who lives in the home with your child: ______________________________

____

Family Religion/Belief System: ______________________________

Marcia S. Gibson PsyD & Associates, P.C.

Name: _____ Date: _____

Name of Child's School: _____ Grade Level: _____

Does your child receive any of the following services?

☐ IEP ☐ Special education ☐ Speech therapy ☐ Physical therapy ☐ Occupational therapy

Do the school system/teachers report any concerns? If so, please explain: _____

_____

_____

Family History:

Is there any family history of:

☐ ADHD ☐ Bipolar disorder ☐ Anxiety ☐ Depression ☐ OCD ☐ Heart Problems
☐ Schizophrenia/Psychosis ☐ Autism/Asperger's/PDD ☐ Cognitive/Learning Disabilities
☐ Legal problems or incarceration ☐ Alcoholism ☐ Drug Abuse ☐ Gambling ☐ Seizures
☐ Mental health hospitalizations ☐ Emotional abuse ☐ Suicide attempts ☐ Suicide completion
☐ Physical abuse ☐ Sexual Abuse ☐ Domestic Violence

Please list any other mental or medical illnesses that occur in the family: _____

_____

_____

Is there anything else that you would like your child's provider to know? _____

_____

_____

_____

_____