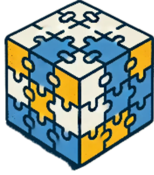

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5665 NEW NORTHSIDE DR., SUITE 500
ATLANTA, GA 30328
(404) 256-9325

ADULT INTAKE QUESTIONNAIRE

Name: ____ Today's Date: ____________

Age: ______________ Date of Birth: ____________________

Address: ____

____

Home phone: __________________________ Ok to leave message? Yes No

Work phone: __________________________ Ok to leave message? Yes No

Cell phone: __________________________ Ok to leave message? Yes No

Email: ____

Referred by: ____

May we acknowledge the referral? ________________

Reason you are seeking services:

____

____

____

____

____

____

____

____

Present psychological difficulties – please check any that apply to you at this time.

______ Generalized Anxiety (across many situations)
_____ Specific fears/phobias (list): ______________________________
_____ Panic attacks
_____ Social Anxiety
_____ Obsessive thinking or compulsive behaviors
_____ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
_____ Sadness or Depression
______ Emotionally overwhelmed
_____ Frequent crying
_____ Loss of energy
_____ Loss of pleasure in life
______ Self-injurious / Self-harm behavior
_____ Thoughts of suicide
_____ Problems with eating
______ Problems falling asleep
______ Problems sleeping through the night (middle of the night waking or early morning waking)
______ Trouble waking up
______ Fatigue/tiredness during the day
______ Nightmares
_____ Problems with attention or concentration
_____ Racing thoughts
______ Problems making or keeping friends
_____ Problems controlling temper
_____ Relationship/Marriage problems
_____ Problems with intimacy
_____ Problems with job
______ History of abuse (emotional, physical, sexual)
______ Alcohol/drug use/abuse
_____ Financial problems
_____ Legal situation

Other:

____

____

Describe any previous mental health services you have received.

Dates of treatment	Type of service*	Provider name	Any diagnoses	Length of service

*please note whether this was an evaluation, outpatient therapy, partial hospitalization/day treatment, hospitalization, residential placement, or other type of mental health service

Please provide copies of any previous psychological evaluation reports.

What do you wish to accomplish (what are your goals) in seeking services at this time?

____

____

____

FAMILY INFORMATION

Marital Status: Single Cohabitating Married Separated Divorced Widowed

Rate quality of present relationship/marriage (if applicable):

___ very good ___ good ____ fair _____ poor ____ very poor

Your occupation: ____

Occupation of Spouse/Partner: ____

Children and ages: ____

____

If divorced, what are the custody arrangements? ___________________________

____

Who currently resides in your home? ______________________________________

____

GENERAL HEALTH

Your current health: ______ excellent ______ good _____ fair ______ poor

Primary Physician and address: ____

____

Physician phone and email: ____

When was your last physical exam? Any relevant findings? ______________________

____

____

Are there any other physicians you see on a regular basis? ______________________

____

____

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (surgeries, etc.).

____

____

____

Describe any sleep difficulties: ____

____

Describe any eating difficulties: ____

____

Please rate the overall level of stress in your life:

_____Very Low _____Low _____Average _____High _____Very High

What do you consider to be the greatest source of stress at this time?

____

Rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY). _______

List your medications. Include prescriptions, over the counter medicines, vitamins, and supplements.

Medication and dosage	Physician prescribing	For what symptoms	How long taken

Describe any caffeine use (type and frequency)____

____

Describe any tobacco use (type and frequency)____

____

Describe any alcohol use (type and frequency)____

____

Describe any marijuana use (type and frequency)______________________________________

____

Describe any other recreational drug use (type and frequency)___________________________

____

Other comments about your health, if any: ____

____

FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

Yes	Condition	Family Member
________	Alcohol / Substance Abuse	________________________
________	Attention-Deficit / Hyperactivity / Impulsivity	________________________
________	Autism Spectrum / Asperger's Disorder	________________________
________	Depression	________________________
________	Generalized Anxiety (across many situations)	________________________
________	Genetic Disorder (e.g., Down Syndrome, Fragile X)	________________________
________	Intellectual Disability	________________________
________	Learning Problems / Disabilities	________________________
________	Manic-Depression / Bipolar Disorder	________________________
________	Obsessive-Compulsive Disorder	________________________
________	Phobias	________________________
________	Schizophrenia or other psychosis	________________________
________	Seizures or other neurological disorder	________________________
________	Sleep disorders	________________________
________	Social Anxiety	________________________
________	Speech or Communication Disorder	________________________
________	Suicide attempts / Suicide	________________________

Other: ____

____

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:

____

____

____

____

EDUCATIONAL HISTORY

Your highest level of education completed: ______________________________

Any problems with attention, learning, or behavior in school? ______________________________

____

____

Grades repeated and reason: ______________________________

____

____

Any special education services in school? ______________________________

____

____

LEGAL HISTORY

Have you every filed or been involved in any litigation? Please explain

____

____

Is there anything else that you would like your clinician to know that was not covered by this form?

____

____

____

____

____

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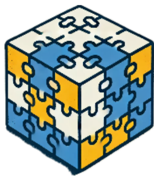

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NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

Welcome to the Behavioral Institute of Atlanta (BIA). This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your clinician about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY

Communication between you and your clinician is considered privileged and confidential. We will not release any information without your written authorization. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes. The only exception to these conditions may occur in situations such as child abuse, danger to life, or workers' compensation where by law other action is permitted. Please discuss this with your clinician. If you would like us to work collaboratively with other professionals, such as physicians, teachers, other therapists, attorneys, etc., you may sign a release of information form authorizing this.

OFFICE HOURS

The office staff are typically available from 9:00 a.m. to 5:00 p.m. Monday through Friday. When the office staff is not available, you may leave a voice message for your clinician or email the clinician directly. We will assist you as soon as possible, but we do not provide 24 hour, on-call, emergency services. In these situations, you may seek help through a hospital emergency room, urgent care center, or by calling 911. If your clinician is out of town or unavailable for some other scheduled reason, one of our other clinicians will be available to help you. The first priority and our primary concern is your well-being.

SCHEDULING APPOINTMENTS AND APPOINTMENT LENGTH

An appointment can be scheduled by either your clinician or our office staff. Adult intake appointments are typically 50-60 minutes and include an interview about your current difficulties and a review of the history of the problems.

Individual, couples, and family therapy are typically 45-50 minutes long. If an appointment runs longer, there is a charge for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

Appointments for psychological and psychoeducational testing may run 2-4 hours each, with 2-3 appointments needed in addition to the parent intake appointment. Results conferences following testing typically last 60-90 minutes depending on the extent of the testing.

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from seeing someone else in need. **Therefore, except in the case of an acute emergency, we require a 24 hour notice of any cancellation; otherwise, your account will be charged.** In addition, because insurance will not pay or reimburse for missed appointments, you will be held financially responsible for these charges. If our office is closed, leave a voice message for the front office staff and

contact your clinician directly by voice mail or email to inform us of your cancellation so the time may be used appropriately.

FEES AND INSURANCE REIMBURSEMENT:

Payment for professional services are due and payable at the time they are rendered. All clients are expected to take care of their fees at the time of the appointment. Any other arrangement is considered a special arrangement and must be discussed in advance with your therapist. We accept all major credit cards and checks. Many clients choose to have a credit card "on file" that is charged at the time of each appointment. Delinquent accounts may be referred to a collection agency.

All of our clinicians are "out of network" providers from the standpoint of insurance companies. If your insurance policy offers out-of-network mental health coverage, you may receive reimbursement from your insurance company if you choose to seek this yourself. Our office generally does not file insurance claims or accept payment from insurance companies. However, we can email you a statement for insurance reimbursement, called a "superbill," so that you may file claims. Many of our clients receive reimbursement for some or all of the costs of their services. Superbills and claims must be submitted to insurance companies in the same year as the services were provided, and some companies require claims to be submitted even sooner, such as within 30-90 days of the service. Check with your insurance company to see what will be required.

ASSESSMENT AND/OR TESTING**:**

Testing is billed on the basis of the types of tests and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with information about the types of tests and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. The written report, if requested, is generated after payment in full for testing services is received.

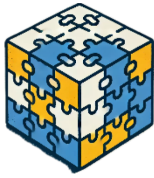
WRITTEN REPORTS, SUMMARIES, AND LETTERS:

Clinicians sometimes provide written reports, treatment summaries, and letters for clients. These are billed as separate procedures if they are done outside of a comprehensive psychological evaluation. Clinicians typically bill at their same hourly rate for writing as they do for providing psychological testing or therapy.

I have read and understand these policies. I acknowledge responsibility for all fees incurred.

Client name (print): ____

Client signature: ____ Date: ___________________



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INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES

I hereby voluntarily apply for and consent to psychological services from____________________________________.
(Clinician's name)

This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of receiving psychological services may include obtaining a professional opinion, reduction of psychological symptoms, and an increased understanding of psychological issues. I understand that potential risks may include possible disagreement with the professional opinions offered, possible emotional distress when addressing my child's difficulties, and limitations in the ability to make predictions based on results of psychological assessments (when applicable). I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with my services.

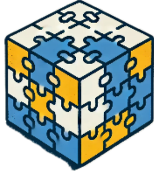
I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

1. where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. where the validity of a will of a former patient is contested
3. where such information is necessary for the clinician to defend against a malpractice action brought by the client
4. where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the clinician
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order.

I hold ____ harmless for releasing information under these conditions.
(Clinician's name)

Client name (print): ____

Client signature: ____ Date: ____________________



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CONSENT FOR TELEHEALTH SERVICES

1. I understand that my clinician is providing telehealth services which may include telephone or video conferencing.

2. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

3. I understand that my clinician will take measures to protect the confidentiality of our telehealth appointments. At the same time, there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

4. I understand that my clinician or I can discontinue the telehealth appointment if it is felt that the telephone or video connections are not adequate for the situation.

5. I have had the opportunity to ask my clinician questions about telehealth. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me so that I understand them.

6. I understand that telehealth is NOT an Emergency Service and in the event of an emergency, I will call 911 or other appropriate agency providing emergency services.

7. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

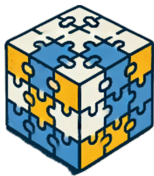
By signing this form, I certify that I have read or had this form read and/or had this form explained to me, that I fully understand its contents including the risks and benefits of the procedure(s), and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. I understand I can revoke this consent at any time by written request.

____

Client name (printed)

____ ____________________

Client signature Date



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PERMISSION TO RELEASE AND OBTAIN INFORMATION

Complete this form if you want your clinician to consult with other individuals regarding your care.

I hereby authorize ____ to release and discuss the results of my
(Clinician's name)

_________ Psychological Evaluation/Testing

_________ Treatment/Therapy

with the following individuals. I give those listed below my permission to release and discuss information regarding

my care to ____.
(Clinician's name)

This release of information is valid from _____________________ (date) to ________________________ (date).

Individual and Agency	Phone or email
1.	
2.	
3.	
4.	
5.	

____
Client name (printed)

____ ______________________
Client signature Date