Family Psychiatry & Psychology Associates, P.A.

INTAKE FORM

CONFIDENTIAL

Client Information: ***Date:_____***

Last Name: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ Sex:____ M ____ F

Mailing Address: _____

City/State: _____ Zip: _____

Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

Name of Person(s) Financially Responsible: _____

Relationship to Client: _____ SSN: _____

Address (if different than client's): _____

City/State: _____ Zip: _____

School Information:

Name: _____

Occupation:_____Grade:_____

City/State:_____

Education/Degrees: _____

Parent Information:

Name: _____ Phone: (____) _____ - _____

Relationship to client: _____

Employer Name: _____ Phone: (____) _____ - _____

Address: _____ City/State: _____ Zip: _____

Emergency Contact Information:

*In Case of Emergency, Contact _____Relationship to Client:_____

Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

Who can we thank for referring you here today?_____Internet _____Phone Book _____Friend
_____Doctor/Psychologist? (Name)_____ _____Other

Medical History

Client Name:_____

Past Educational, Psychiatric and/or Medical Diagnoses (please give the year):

1) _____

2) _____

3) _____

Current Medications (Include dosage and frequency):

1) _____ 2) _____

3) _____ 4) _____

Known Allergies:

_____

_____

Family Psychiatry and Psychology Associates, P.A.

1400 Crescent Green, Suite 120, Cary, NC 27518 Office: (919) 233-4131 Fax: (919) 233-4168

Seth E. Tabb, M.D.
Amanda S. Dorn, M.D.
Jennifer D. Siddle, M.D.
Lisa Hayutin, Ph.D.
Sheryll A. Daniel, Ph.D.
Daniel Sheras, Psy.D.
Elizabeth A. Hanna, M.Ed.
Kelli A. Fuhrmann, M.S.Ed.
Rebekah A. Reynolds
Erik M. Russ, M.A.

Release of Information

I, _____, consent to allow all clinicians of Family Psychiatry and Psychology Associates, P.A. listed above to release and/or exchange information regarding

_____. _____
(Client) (Date of Birth)

This information will include:

___Psychiatric Records
___Procedures
___Medical Records
___Educational Records
___Discharge Summary
___Psychological Testing
___Therapy Notes
___Laboratory Work
___Other _____
___All of the above

Information can be shared with the following people/agencies (please include address):

_____

_____

_____

I understand that this information will be used in the client's best interests to benefit current psychiatric and psychological evaluation and/or treatment. I understand that the information exchanged will be handled in a professional and confidential manner.

It is the policy of FPPA not to release those materials provided by physicians from outside this office regarding the patient's former or current care. You may obtain second party records by contacting the source directly. Second party records will only be released when such records are no longer available from the original source.

I also understand that I may revoke this consent at any time except to the extent that action based on this consent has already taken place.

Signature: _____Witness: _____

Relationship to Client: _____Date: _____

This consent is valid until _____. If I fail to specify an expiration date, this authorization will automatically expire 12 months from the date of signature.

Rescind Consent: I hereby rescind the prior consent granted to Family Psychiatry and Psychology Associates, P.A. to release and/or discuss any information with the individual(s)/agencies listed above.

Signature:_____ Date:_____

FAMILY PSYCHIATRY and PSYCHOLOGY ASSOCIATES, P.A. **FINANCIAL POLICY**

APPOINTMENTS

The keeping of regular appointments is crucial to achieving success. As schedule permits, we will work out a most convenient time for you for these appointments. The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you. We will charge for telephone, email and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate should your provider deem it appropriate.

_____**Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at the rate of the reserved session. You will be billed directly for this time.**

PAYMENT OF FEES

_____ Payment to FPPA is to be made in full at the time of service. We accept cash, check, MasterCard/Visa, and Discover. Payment of any unpaid balance on an account must be received in full before the close of the month. Payments are non-refundable. You will be charged a $25 service charge for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings. This process includes the addition of a thirty-three and one-third (33 1/3) percent attorney fee to your unpaid balance. Service may be interrupted until payment is made.

CONSENT TO RELEASE OF INFORMATION

_____Client agrees that Educational Specialist may share information with other providers at Family Psychiatry and Psychology Associates, P.A. (FPPA) with regard to his/her case in order to better provide quality treatment. This information will be kept strictly confidential within the confines of FPPA only.

REPORTS, CONSULTATIONS AND OTHER CLERICAL MATTERS

Any reports, emails, phone calls, professional consultations, or clerical tasks (including editing and revising paperwork for client) involving time beyond that of the regular scheduled session will be at a pro-rated charge for the professional or clerical time involved.

READ CAREFULLY AND SIGN

I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

Signature of Patient/Responsible Party Date

Client name: _____ D.O.B._____

CLIENT ACKNOWLEDGEMENT

I understand that the client's information is private and confidential. I understand that Family Psychiatry and Psychology Associates, P. A. works very hard to protect the client's privacy and preserve the confidentiality of the client's personal information.

I understand that Family Psychiatry and Psychology Associates, P.A. may use and disclose the client's personal information to help provide care to the client and to handle billing and payment.

Family Psychiatry and Psychology Associates, P. A. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the client's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice of Privacy Practices". If I ask, Family Psychiatry and Psychology Associates, P.A. will provide me with the most current "Notice of Privacy Practices".

Within the Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my records,; receiving an accounting of disclosures as required by law, and requesting communication be by specified methods of communications or alternative locations.

Family Psychiatry and Psychology Associates, P.A. has established procedures which help them meet their obligations to clients. Their procedures may include other signature requirements, written acknowledgements information, charges for copies and non-routine information needs, etc. I will assist Family Psychiatry and Psychology Associates, P. A. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Family Psychiatry and Psychology Associates, P.A. "Notice of Privacy Practices".

_____

Client or legally authorized individual signature Date Time

_____

Relationship to client if signed by anyone other than the client

1400 Crescent Green, Suite 120
Cary, NC 27518