Intake Form
Today's Date:

Personal Information

Patient:

Responsible Party:

Date of Birth:

Responsible Party's SSN:

Address:_____

City:

State:_____

Home Phone: _____

Work Phone: _____ _____

Cell Phone:

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self_____ Spouse_____ Child_____ Other _____

Relative or friend in case of emergency _____
Name: Phone #:
Relationship:

Source of referral: _____ Reason for referral: _____

Financial

I understand that Delanie Isaacs, LPCC does not accept insurance. If requested, I will be given a receipt/Superbill that I may submit to my insurance for possible reimbursement. **As well, I understand that if I cancel within 24 hours or do not show up for an appointment I will be billed the entire amount of the session.** I have been given the opportunity to ask questions regarding this statement.

Signature of Responsible Party:

Printed Name:

Date:

FAMILY INFORMATION

NAME	M/F	AGE	DATE OF BIRTH	RELATIONSHIP TO PATIENT &/or MARITAL STATUS	EDUCATION	OCCUPATION
Patient(s)						
1.						
2.						
Parent (s)						
1.						
2.						
Children/Step Children/Siblings						
1.						
2.						
3.						
4.						
5.						
6.						
Others Living in Household						
1.						
2.						
3						
4						
5						
6						

MEDICAL INFORMATION

Patient Name

Have you ever been treated for emotional difficulties before (When and Where?)

Physician Name/Practice:

Address:

Phone: _____

Date of last physical exam:

How is your general health now:

Medications:

Are you presently being treated by a physician for any physical condition?

Have you had any serious illness? (List) _____

Have you ever had any surgery? (List)

PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)

___Anger	___Grief	___Paranoia
__ Anxiety	___Guilt	___Physical Aggression
___Behavior Problems	___Hallucinations	___School/Work Problems
___Changes in Appetite/Eating Habits	___Hopelessness	___Self Abusive Behavior
___Criminal Activity	___Hyperactivity	___Sleep Disturbance
___Decreased Energy	___Impulsiveness	___Somatic Complaints
___Delusions	___Interpersonal	___Suicidal
___Depressed Mood	Conflicts	Thoughts/Attempt
___Disruption of Thought Process/Content	___Irritability	___Weight Gain
___Emotional/Physical/Sexual Trauma	___Manic	___Weight Loss
___Excessive Crying	___Mood Swings	___Worthlessness
___Family Conflicts	___Oppositional	___Other (Specify)
	___Panic Attacks	

You are about to become involved in counseling or psychotherapy with a trained and licensed therapist. I wish to take this opportunity to welcome you and also to state some basic principles I believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:

a) Type of therapy needed (individual, group, medication referral, etc.)
b) Frequency of therapy sessions (weekly, biweekly, etc.)
c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment is approximately 50-55 minutes. At the end of each appointment we can discuss future appointments. **Please note that your case will be closed if there is no contact for 30 days.** However, I am happy to schedule returning clients who wish to resume therapy with me, as long as I have the availability.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that I can schedule people that are on my waiting list. **You will be personally charged for your appointment if not canceled at least 24 hours in advance.**

4. PAYMENTS: You are responsible for payment in full for each office visit when you come for your appointment. I accept payment for sessions through Ivypay using credit card or HSA card, cash, or check. Please make checks out to "Delanie Isaacs". If using Ivypay, following your initial appointment you will receive a text message from Ivypay requesting your credit card or HSA card information. Once you've entered this information, I am able to bill you for future sessions without any work on your part, other than entering updated information should the card on file expire. Charges for services in addition to therapy may be levied (i.e., involvement in client litigation, document preparation, letter writing, etc.). I am a treating clinician, not an expert witness in regards to custody hearings or any other legal proceedings. Therefore, you are discouraged from requesting my participation in legal proceedings. If you become involved in legal proceedings and do request my participation, you will be expected to pay for my time, including preparation and transportation costs, even if I am called to testify by another party. The rate for this participation is $2000/day, paid in advance. Given the unpredictability of timing and duration of court appearances, any day that I am expected to appear in court is a day that I am unable to schedule other clients. Therefore, any court appearance will be billed at the full $2000 rate. If I am required to write letters, complete paperwork, speak to attorneys, etc., I will bill at my $150/50 minute rate.

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. I do not directly participate with insurance plans, but many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. Payment is required at the time of service, but upon your request, I am happy to provide you with a receipt called a Superbill that you may submit to your insurance company for reimbursement. Payments for services received from Delanie Isaacs, LPCC are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the preauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gatekeeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges.

6. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained by Delanie Isaacs, LPCC and is considered confidential within the office unless specified by you in writing. I follow HIPAA and maintain confidentiality. I am bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

□ Yes □ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

□ Yes □ No I have received a copy of the Privacy Practices Form.

Signature:
Printed Name:
Date:

CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS

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4. PAYMENTS: You are responsible for payment in full for each office visit when you come for your appointment. Charges for services in addition to therapy will be levied (i.e., involvement in client litigation, document preparation, etc.). I accept cash and check. Please make checks out to "Delanie Isaacs".

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. I will assist you in any way possible by providing a receipt, called a superbill. I currently do not directly participate with insurance plans. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. The hourly rate will apply. Payments for services received from Delanie Isaacs, LPCC are your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gatekeeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges.

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If more than one adult patient, each person should check and initial boxes.

□ Yes □ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

□ Yes □ No I have received a copy of the Privacy Practices Form.

Patient(s):
Signed: _____
Date: