Adult Intake Form
Clinton S. Felker, Ph.D. Psychological Services

Name_____ Date_____

Age_____Date of Birth_____ Social Security_____

Address_____

City, State, Zip_____Bill to this Address? Yes No

If no, Alternate Address_____

Phone(s) Home_____ Cell_____ Work_____

Any Numbers You DO NOT want voice mail or text messages left?
Home Cell Work

Email_____OK to use for appointments? Yes No

Emergency Contact_____Phone_____

Who referred you to Dr. Felker?_____

Relationship Status_____Partner's Name_____

How Long Together?_____Education Self_____Partner_____

Employer_____Position_____ Length_____

Partner's_____Position_____ Length_____

Names and ages of children or others in home_____

_____

Who will pay deductibles, co-pay, self-pay? _____

Primary Insurance _____

Policy Holder_____ Relationship_____

SSN if different from above_____ D.O.B._____

Secondary Insurance _____

Policy Holder_____ Relationship_____

SSN if different from above_____ D.O.B._____

Deductible_____ Met? Y N Copay_____

If using insurance for services, please sign below._____

I hereby grant Dr. Felker and his billing service authorization to release any Protected Health Information (PHI) to my insurance company necessary for the purpose of billing. This typically includes information such as identification, diagnosis, and date and type of service but NOT Psychotherapy Notes which can only be released by my signed release. I authorize my insurance company to send payment directly to Dr. Felker. I authorize Dr. Felker to release claim forms and supporting documentation to the Ohio Department of Insurance if Dr. Felker files a claim against my insurance company under the Ohio Prompt Payment Law. I agree that a photocopy of this authorization shall be as valid as the original.

_____

Signature Date

Adult Problem Checklist

Name_____

How often (days per two weeks)	None 0	Slight 1-2	Mild 4-6	Moderate 7-10	Severe 11-14	Had problem in the past
Being more forgetful (or others tell me).	0	1	2	3	4	_____
Problems with new learning, knowing where I am.	0	1	2	3	4	_____
Hearing things (e.g., voices) when no one is around.	0	1	2	3	4	_____
Feel I or my surroundings are not real.	0	1	2	3	4	_____
Periods of little sleep but still have plenty of energy.	0	1	2	3	4	_____
Starting many projects, doing risky things.	0	1	2	3	4	_____
Staying awake for long periods then crashing.	0	1	2	3	4	_____
Abrupt mood swings with or without reason.	0	1	2	3	4	_____
Little or no pleasure in doing things.	0	1	2	3	4	_____
Not feeling close to others, wanting to withdraw.	0	1	2	3	4	_____
Feeling down, depressed, hopeless.	0	1	2	3	4	_____
Frequent crying.	0	1	2	3	4	_____
Self-harm thoughts or actions.	0	1	2	3	4	_____
Frequently feeling tired.	0	1	2	3	4	_____
Little or no interest in sex.	0	1	2	3	4	_____
Feeling irritated, grouchy, or angry often.	0	1	2	3	4	_____
Frequent arguments with others.	0	1	2	3	4	_____
Losing temper, acting out, hurting others.	0	1	2	3	4	_____
Avoiding places that make me nervous.	0	1	2	3	4	_____
Difficulty with racing thoughts.	0	1	2	3	4	_____
Feeling panicky or frightened.	0	1	2	3	4	_____
Excessive worrying, feeling anxious.	0	1	2	3	4	_____
Feeling driven to repeat actions or mental acts.	0	1	2	3	4	_____
Repeated unpleasant thoughts, urges, or images.	0	1	2	3	4	_____
Can't stop remembering unpleasant past events.	0	1	2	3	4	_____
Nightmares and/or flashbacks about past events.	0	1	2	3	4	_____
Feeling distant from self, body, surroundings.	0	1	2	3	4	_____
Gaps in recent memory of events or location.	0	1	2	3	4	_____
Worry that something is wrong with my body.	0	1	2	3	4	_____
Unexplained aches and pains.	0	1	2	3	4	_____
Problems with sleep quality or amount.	0	1	2	3	4	_____
Problems with diet, weight gain or loss.	0	1	2	3	4	_____
Sexual or gender concerns.	0	1	2	3	4	_____
Difficulty concentrating.	0	1	2	3	4	_____
Forgetting what I'm doing or where I put things.	0	1	2	3	4	_____
Impulsivity, hyperactvity.	0	1	2	3	4	_____
Not recalling something I just read.	0	1	2	3	4	_____

Other Problems_____

_____

Behavioral Health Information

Please note issues and goals you would like to address and any other current or previous information you feel is important to know in working with you:

_____

_____

_____

_____

_____

Previous Experience with Therapists, Psychiatrists, Hospitalization, Substance Abuse Treatment:

Name Date

_____

_____

_____

_____

_____

Physical Medical Information

Primary Care Physician_____Phone_____

Address_____

List all current Medications

Prescription DosageTo Treat Prescribing Physician Start Date

_____

_____

_____

_____

_____

_____

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Health Problems and Surgeries

Current Past

_____

_____

_____

_____

_____

_____

Allergies_____None_____

Amount and Frequency of use:

	Current	Past
Alcohol		
Drugs not Prescribed		
Marijuana		
Other “Street” Drugs		

Clinton S. Felker, Ph.D.
Psychologist, License #6127

Confidentiality, Privacy, and Informed Consent

Healthcare providers' obligations and your rights are governed by "HIPAA", the Health Insurance Portability and Accountability Act. This Federal law regulates the use of your information; requires that its privacy is protected; and that you be informed of office policy about your clinical record. This information can be released to others only if you sign an authorization to release confidential records (see exceptions, below). You may restrict information to your insurance company if paying for services out of pocket.

Your signature on this form is your consent for the following uses and releases of information:

1. Case consultation with other healthcare professionals. This may be a "blind" consultation with a therapist with more experience in a problem area to assist treatment plan and strategy. Personal identification will be avoided. Or, a specific consultation/correspondence with another professional involved in your case (Physician, appropriate school personnel, other therapist). Both types of contact are subject to confidentiality regulations, and will be noted in the case records.

1. For business purposes, the billing agency, insurance companies, or collection agency receive only necessary Protected Health Information (PHI) such as name of the policy holder, plan, account number, diagnostic code, fees, and the date and service provided. Confidentiality is maintained by contract agreement with these agencies.

1. Confidentiality in couples or family therapy is not completely clear. Information will only be released with your written permission unless required by law or court order.
2.

Exceptions: Confidential information may be released or required by law without authorization when:

1. There are indications that a client may hurt themselves or another person, or there are indications that a child or senior citizen has been subjected to abuse.

1. A minor's parent requests case information unless stipulated by court order that a parent does not have access to medical records.

1. A court orders release of case information. Note that an attorney's order to release information is protected by client-psychologist privilege unless signed authorization is provided.

1. Government agencies such as Medicare, Social Security Disability, and Bureau of Workers' Compensation may require case information to assure policy compliance and need for treatment.

1. Complaints or legal action regarding treatment.

In addition to PHI content, your file will include session case notes. These are kept separate and are not to be reviewed or released without specific authorization by you (unless ordered by court). This restriction applies in situations such as file auditing by insurance company, release of medical records requests, etc.

As an extra precaution, most questions involving disclosure of confidential information will be discussed together, and you will have the right to sign authorization or, in some cases, denial to release information. If you have concerns about the privacy of your records or disagree about information being released, you may contact the U.S. Department of Health and Human Services, the governing body for HIPAA.
Addendum: Electronic communication (e-mail or texts) cannot be guaranteed to be entirely secure. As a result, please limit these to requests about appointments. I do not engage social media (Facebook, Twitter) with clients as these are, by nature, not private.

Service and Fee Agreement

Psychological services provided fall into two main categories: psychotherapy for individuals and families; and psychological testing, Billing service codes and related fee schedules are:

90791	Diagnostic Intake/Evaluation:	
90832	Psychotherapy , up to 37 minutes	$ 75
90834	Psychotherapy, 38 to 52 minutes	$120
90837	Psychotherapy, 53 minutes and longer	$170
90847	Family Psychotherapy	$160
96101	Psychological Testing	$130

If you are not using insurance, fees can be negotiated according to income. Billing is conducted through BillPro Management Services (440.854.0209). Contracts with insurance typically have a set fee they allow, with higher amounts to be adjusted off of the balance. Plans vary widely in the portion they cover; you are responsible for any applicable annual deductible and co-payments. Additional charges will apply for sessions not covered by your plan, extended phone consultations, and reports to others such as physicians and attorneys Note: You will be charged for services canceled less than 24 hours in advance and for appointments not kept; these fees are not covered by insurance plans and are your responsibility. There may be reasons to cancel without charge such as illness and family emergencies (but not work changes, baby sitter canceled). All charges should be paid at time of service or within 30 days of receiving a billing statement. As allowed by law, overdue accounts without regular payments made may be charged interest (10% APR) or submitted to a collection agency. When needed, payment plans can be arranged, and you will be notified in the monthly statement when an account is overdue.

By signing this form, you agree to pay fees for services provided not covered by your insurance plan.

I have read this agreement and agree to its terms. I am entitled to a copy after signing.

_____ _____ _____

Client or responsible party; parent or guardian for a minor Witness Date

Revised February 2016