ADULT INTAKE SHEET

Thank you for completing the attached intake information form. Please feel free to ask any questions you might have regarding the nature of therapy and/or to share your expectations and goals.

Date _____ Email_____

Name _____
Last First M.I. Date of Birth

Address _____
Number Street City State Zip

Home Phone _____SS # _____

Marital/Partner Status _____

Previous Marriages/Partnerships for Yourself _____ Spouse/Partner _____

Partner Spouse SS # _____ DOB _____

Partner/Spouse Address _____
(If different) Number Street City State Zip

CHILDREN:

Name	Birth Date	Biological	Adopted	Other

Emergency Contact_____
Name

_____
Address Phone

Employer_____ Address_____

Work Phone _____ OK to call at work? ___ Yes ___ No

Alternate (Cell, etc.) Phone_____

Spouse's Employer _____ Address_____

Family Physician_____
Name Address

Current Medications (Name, dosage & frequency) _____

_____

Current Health Issues _____

_____

Known Allergies _____

Previous Therapist_____
Name Address

Psychiatric Hospitalization _____
Facility Date(s)

Referred by _____

Current Symptoms or Situation _____

Check any of the following which currently or in the past six (6) months apply to you. Asterisk those of most concern. If you are a couple, delineate by initials whichever is relevant to each of you.

Nervousness	Depression	Fears
Shyness	Sexual problems	Suicidal thoughts
Separation	Divorce	Finances
Drug use	Alcohol use	Relationships
Anger	Self-control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal matters	Memory	Motivation
Too much energy	Spending money	Decision making
Loneliness	Inferiority feelings	Concentration
Education	Career choices	Health problems
Temper	Nightmares	Marriage
Children	Appetite problems	Stomach trouble
Bowel problems	Parenting	Troublesome thoughts
Family	Moodiness	Urge to repeat actions

Psychotherapy is a very personal and by ethical standards, a confidential process. However, often it can be helpful for your therapist to discuss treatment with your family physician. This is especially true when there are physical symptoms or you are taking medication. If you wish to give permission for your therapist to discuss your care with your family physician, or another healthcare provider, please identify that provider and sign below.

_____
Name of Provider Address Phone

_____
Signature of responsible party Date

RIVERWALK ASSOCIATES
Psychological, Counseling and Consulting Services

53700 Generations Drive • Suite 200 • South Bend, IN 46635
(574) 258-6300 Fax (574) 258-6310

CONSENT FOR RELEASE OF PSYCHOLOGICAL INFORMATION

Name of Client(s) Requesting the Release of Information: _____

_____

I, the undersigned, agree to the exchange of information, regarding the psychological treatment, for myself or the minor for whom I am responsible, between _____, and the following person, school or associated organization:

School or Associated Organization: _____

Name: _____

Address: _____

Telephone Number: _____ Fax: _____

Info to be Released: _____

Purpose of Release: _____

I further understand and agree that the providers exchanging information should ethically respect the confidentiality of the information being exchanged. This consent will remain in effect for 90 days or at my written request that my consent for release of psychological information be terminated.

I understand and agree to the above statements and will inquire about anything which is unclear or with which I disagree.

Client(s) or Legal Guardian Signature: _____ Date: _____

Spouse: _____

and/or

Verbal Authorization given on

RIVERWALK ASSOCIATES
Psychological, Counseling and Consulting Services

53700 Generations Drive • Suite 200 • South Bend, IN 46635
(574) 258-6300 Fax (574) 258-6310

PRIVACY NOTICE ACKNOWLEDGEMENT

My signature below acknowledges that I have received a copy of "Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information", as required by new federal legislation (HIPAA).

Located at Front Desk — Yellow Paper in Binder

_____ _____
(Client signature) (Date)

PSYCHOTHERAPIST-PATIENT SERVICE AGREEMENT SIGNATURE PAGE AND CONSENT FOR MENTAL HEALTH SERVICES

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____
(Client or Guardian signature) (Date signed)

CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned agree and consent to participate in the mental health services offered and provided by _____ a mental health service provider or psychologist, as defined by Indiana law.

I understand that I am consenting and agreeing only to those mental health services that the above named provider is qualified to provide within:

a) The scope of the provider's license, certification and training; or

b) The scope of the license, certification and training of those mental health providers directly supervising the services received.

Client signature_____Date _____

Parent/Guardian signature_____Date _____

Witness _____Date _____

Note: This page will be removed from the previous 7 pages and kept in your Clinical Chart. You may keep the rest of the documents for your records.

INSURANCE INFORMATION AND RELEASE

If you want us to file insurance for you, please complete the information below and sign to give us permission. You must provide the identifying information, including name of insured and address for claims.

Identifying Information

Name of Insured: _____

Name of Patient: _____

Insured's Employer: _____

Insurance Company: _____ ID#: _____

Policy Number: _____ Group Number: _____

Claims Office Address: _____

_____

_____

_____

Phone Number: _____

Pre-authorization required? ___Yes ___No Authorization obtained? ___Yes ___No

PATIENT OR AUTHORIZED PERSON SIGNATURES

I authorize the release of any medical information, including diagnosis and dates of service, necessary to process claims.

Signed: _____ Date: _____

I authorize payment of any medical benefits for the services provided to the physician or supplier of services.

Signed: _____ Date: _____
(Insured or Authorized Person)

PLEASE NOTIFY THIS OFFICE OF ANY CHANGES IN YOUR INSURANCE