FAMILY PSYCHOLOGICAL CENTER, P.A.
CHARLES NICHOLS, PSY.D.
623 NORTH WALNUT ST · HARRISON, ARKANSAS 72601
PHONE: (870) 743-6225 · FAX: (870) 743-6006
www.fpc-pa.com

ADULT INTAKE FORM

(This form should be updated with any information changes. Please complete all items.)

Today's Date: ______-_____-_______
Month Day Year

PATIENT INFORMATION

Patient's Name: ____
First Middle Last

Date of Birth: _____-_____-____________ **Age:** ________ **Social Security Number:** _______-_______-________
Month/Day/Year

Home Address: ____
Street Apt No. City State Zip

Home Phone: (_____)_____-________ **Cell Phone:** (_____)_____-________ **Work Phone:** (_____)_____-________

Sex: ☐M ☐F **Race** (check all that apply): ☐Asian ☐American Indian ☐Black ☐Hispanic/Latino ☐White ☐Native Hawaiian ☐ Other _________

Marital Status: ☐ Single (Never Married) ☐Married ☐Divorced ☐Separated ☐Widowed

OTHERS LIVING IN PATIENT'S HOME	DATE OF BIRTH	RELATIONSHIP TO PATIENT (wife , mother, stepfather, aunt, brother, stepsister, etc.)

GUARANTOR INFORMATION

Name of Responsible Legal Party/Guarantor: ____
First Middle Last

Guarantor's Relationship to Patient:____________________________ **Guarantor's Social Security Number:** _______-_______-_________

Guarantor's Date of Birth: ______-______-_________ **Age:** _________
Month/Day/Year

Guarantor's Address: ____
Street Apt. No. City State Zip

Guarantor's Home Phone: (_____)_____-________ **Guarantor's Mobile Phone:** (_____)_____-________

Gender: ☐ M ☐ F **Guarantor's Employer's Name:** ____

Guarantor's Work Address: ____
Street City State Zip

Guarantor's Work Phone: (_____)_____-________

REFERRAL SOURCE

How did you hear about us?
____

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HEALTH INFORMATION

Your Physician___________________________ **Physician's Address:** ____
Street City State Zip Code

Describe any medical health problems you now have.____

____

CURRENT MEDICATIONS	DOSE/FREQUENCY	WHEN STARTED? (DATE)	WHO PRESCRIBES MEDICATION?

Describe any serious *PAST* medical illnesses and injuries have you had with approximate dates. ____

____

List any prior surgeries with dates.____

Have you had prior mental health assessment or therapy? ☐ Yes ☐ No **If yes, list all dates/periods of treatment below.**

Mental Health Treatment Dates (Begin/End)	Facility/Treatment Provider	Type of Treatment (Medication, Therapy, Hospitalization)	Reason for Treatment/Diagnosis	Was Treatment Successful?

Have you ever been hospitalized for psychiatric treatment? ☐ Yes ☐ No **If yes, how many times and when?** ______________________________

What was/were the reason(s) for your mental health hospitalization(s) (if applicable)? ____

____

SERVICES REQUESTED

Please indicate the type of services you are interested in (check all that apply):

☐ Psychological Testing ☐ Individual Treatment/Counseling ☐ Couples/Marital Therapy ☐ Family Therapy
☐ Learning Assessment ☐ Personality Assessment ☐ Court Assessment for Legal Issues ☐ Diagnostic Clarification

Please describe your primary reason for seeking services. ____

____

CURRENT SYMPTOMS

Rate the degree which you have experienced the following symptoms and how long each has occurred.

0 = None, Not at All 1=Mild, Rarely a Problem 2=Moderate, Sometimes It's Difficult 3=Severe, I Can Barely Stand It

Symptom	0-3	How Long?
Prolonged Sadness or Depression		
Loss of Energy		
Loss of Sex Drive		
Sleep Too Much/Too Little *(circle one)*		
Negative View of Future/Hopelessness		
Weight Loss/Gain (circle one)		
Difficulty Making Decisions		

Symptom	0-3	How Long?
Alcohol Misuse		
Drug Misuse		
Decreased Work Performance		
Decreased Academic Performance		
Conflict (spouse, child, parents, supervisor) *(circle)*		
Parenting Problems		
Excessive Sex Drive		

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Appetite Increase/Decrease *(circle one)*		
Excessive Joy or Grand Feelings		
Risky Behaviors (splurges, drive fast, stealing) *(circle)*		
Racing Thoughts		
Pressure to Talk More than Usual		
Abnormally High Physical Activity or Energy		
Prolonged Anxiety/Nervousness		
Fear of Being Criticized in Public		
Muscle Tension		
Forgetfulness (losing things, forget appointments)		
Difficulty Relaxing		
Panic or Anxiety Attacks		
Nightmares		
Memories of Traumatic Event(s)		
Fear of Objects or Situations		
Constant and Disturbing Worries		
Ritualistic/Compulsive Behaviors		
Nervous in Public/Avoid Groups		
Problems with Finding Words/Speaking Difficulty		
Confusion/Becoming Lost *(circle those that apply)*		
Forgetting How to Do Common, Everyday Tasks		

Hallucinations (hearing voices, seeing things) *(circle)*		
Physical Violence		
Suspicious Thoughts/Difficulty Trusting Others		
Temper Problems/Rage		
Physical Problems that Increase with Stress		
Fear of Having a Disease		
Short Attention Span		
Difficulty Completing Tasks		
Poor Organization		
Difficulty Following Directions		
Difficulty Sitting Still/Restlessness		
Excessive Talking		
Not Thinking Ahead about Consequences		
Legal Problems/Probation *(circle those that apply)*		
Twitches/Tics *(circle those that apply)*		
Worry about Gaining Weight/Restricting Calories		
Purging/Inducing Vomiting		
Self-Mutilation		
Side Effects from Medication(s)		
Other:		
Other:		

INSURANCE AND WORK INFORMATION

A copy of all your active insurance card(s) is (are) required to confirm your insurance benefits and file claims.
Please bring your card(s) when you return this form.

Do you plan to use insurance? If so, please complete information below using your insurance card(s).

PRIMARY Insurance Company: ______________________________

Name of Insured on Card: ______________________________
First Middle Last

Group Number:______________________ **Member Number:** ______________________

SECONDARY Insurance Company: ______________________________

Name of Insured on Card: ______________________________
First Middle Last

Group Number:______________________ **Member Number:** ______________________

Who is Responsible for Payment of Services? ______________________________
First Middle Last

Relationship of Responsible Party to Patient: ______________________________

Employer and Address: ______________________________
Company Street City State Zip

Landlord: ______________________________ **Phone #:** (_____)_______-__________

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ______________________________**, hereby authorize** ______________________________
Name of Insured/Responsible Party Name of Insurance Company

to pay and hereby assign directly to Family Psychological Center all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred, including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services, and I hereby authorize the release of pertinent healthcare information to insurance carriers. I understand and agree that I am ultimately responsible for the balance of my account, regardless of my insurance status. I have read all the information on these sheets and have completed all of the answers that apply to me and/or the patient. I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in the above information, including my address, employment, and insurance status. I further acknowledge that any insurance benefits, when received by and paid to Family Psychological Center, P.A. will be credited to my account, in accordance with the above said assignment.

______________________ ______________________ ______________
Signature of Insured/Responsible Party Printed Name of Insured/Responsible Party Date

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MEDICARE RECIPIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Family Psychological Center, P.A. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine benefits or the benefits payable for related services.

______________________________ ______________

Signature of Patient or Legal Representative Date

NOTICE OF OFFICE POLICIES FOR ADULTS

CONFIDENTIALITY

Confidentiality is a fundamental priority. The information you disclose remains confidential except when you provide signed consent to release it (such as to your physician) or when legal or ethical principles apply. Confidentiality must be breached if any form of abuse involving a child, elder, or other incapacitated person is disclosed. Other instances include suicidal intentions, a specific harm against an identified person, or a court order. You should openly verbalize any concerns about confidentiality with your treatment professional. By signing below, you acknowledge receiving a copy of the "Patient Notice of Privacy Practices" from the Family Psychological Center, P.A. Which can be obtained from our office or our website at www.fpcharrison.com.

TRAINING INSTITUTION

FPC, P.A. provides doctoral internship training accredited by the American Psychological Association. As such, some staff members are doctoral interns or postdoctoral residents. If your therapist is an intern or resident, your treatment information will be confidentially reviewed by your therapist and his or her licensed clinical supervisor, a psychologist on staff at Family Psychological Center, P.A. This confidential review will occur on a frequent basis with the purposes of enriching your treatment and providing quality training.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier(s) to assign all health care benefits, if applicable, to Family Psychological Center, P.A. I also authorize release of health care information necessary to process all insurance claims. I agree to provide full and complete information for all my active insurance policies on this form and will update Family Psychological Center, P.A. if changes to my insurance coverage occur.

PAYMENT POLICY

Co-payments are to be collected at the time of your appointments, before sessions begin. We accept cash and checks only **(no credit cards or debit cards)**. All mental health services provided are directly charged to the patient or responsible party. If your provider is contracted with your insurance carrier(s), we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Some billable services may be required that are not reimbursable by insurance but are time consuming for your provider (e.g., writing letters if requested, testing more than allowable hours, court testimony—if in a legal case). We do not bill insurance for court-related evaluations and therapy; services provided in a legal context must be paid in full before services are provided. If non-billable services are requested or required, you will be advised beforehand, if possible. Your payment is expected in full at the time of the service.

CANCELLATION POLICY

Our office requires that if you need to cancel or reschedule appointments, we must receive notice from you **at least 24 hours** before the appointment. This allows us time to contact another client and schedule them in your vacated appointment slot. We reserve the right to charge an **$80.00 fee** for a "no show" appointment or an appointment canceled less than 24 hours in advance, which must be collected before your next appointment is scheduled. Cancellations must be made in person or by phone, *not email*. Voicemails must be left on our office line (870-743-6225) if the phone is not answered at the time you call to reschedule or cancel an appointment.

I GIVE CONSENT TO TREATMENT AFTER READING, UNDERSTANDING, AND FULLY AGREEING TO ABIDE BY THE ABOVE RELEASE OF HEALTHCARE INFORMATION, PAYMENT ARRANGEMENTS, CANCELLATION POLICY AND FEES, AND ALL OTHER OFFICE POLICIES.

Signature of Responsible Party: ______________________________ Date: ___________

Printed Name of Responsible Party: ______________________________

First Middle Last

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CONSENT TO CALL

With permission, we remind patients by phone about appointments. If patients are not available, we do not leave messages unless the patient or authorized representative authorizes us to do so. Initial the methods of contact you will permit.

______ I consent and authorize Family Psychological Center, P.A. to call my residence for appointment reminders.
______ I consent and authorize Family Psychological Center, P.A. to leave a message at my residence for appointment reminders.
______ I consent and authorize Family Psychological Center, P.A. to call my cell phone for appointment reminders.
______ I consent and authorize Family Psychological Center, P.A. to leave a message on my cell phone for appointment reminders.
______ I consent and authorize Family Psychological Center, P.A. to call my place of employment for appointment reminders.

I understand and allow Family Psychological Center, P.A. to contact me by means of the initialed methods above. I understand that phone contact may become known by anyone with access to my phone or caller ID systems.

______________________________ Patient Name

______________________________ Date of Birth

______________________________ Signature of Patient or Authorized Representative

______________________________ Date

PATIENT NOTICE OF PRIVACY PRACTICES

The undersigned hereby acknowledges receiving a copy of the "Patient Notice of Privacy Practices" from Family Psychological Center, P.A. This is available from our office or at www.fpcharrison.com.

______________________________ Patient's Name

______________________________ Date of Birth

______________________________ Signature of Patient or Authorized Representative

______________________________ Date

We appreciate your interest in our professional services and look forward to working with you!

***Remember:** Present all active insurance cards when you submit this form.*

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OFFICE USE ONLY

Date Received ______________________________

Received By ______________________________

Incomplete Sections ______________________________

Notes______________________________