Dutch Fork Psychological Services LLC
7313 College Street, Irmo, SC 29063
(803) 407-7099

CONFIDENTIAL INTAKE FORM

PERSONAL INFORMATION

Name_____ Responsible Party (if different)_____

Address_____ Address (if different)_____

_____Zip_____ _____Zip_____

Phone (H)_____(W)_____ Phone (H)_____(W)_____

Cell _____ May we contact you by phone? Y N

FAMILY INFORMATION (continue on back if necessary)

NAMES	M/F	AGE	BIRTH DATE	EDUCATION	OCCUPATION
Client:					
Partner					
Children/stepchildren/others:					
1.					
2.					
3.					

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder_____

Address (if different)_____

_____

Insurance Company_____

Address_____

_____

Phone_____

Policy Holder's Member #_____

Group # _____

Employer_____

Employer's Address_____

_____

SECONDARY INSURANCE

Policy Holder_____

Address (if different)_____

_____

Insurance Company_____

Address_____

_____

Phone_____

Policy Holder's Member #_____

Group #_____

Employer_____

Employer's Address_____

_____

MEDICAL INFORMATION

Physician_____ Phone#_____

Describe any health problems you have._____

What medications do you take?_____

What serious illnesses have you had? _____

List any prior surgeries._____

Have you had prior counseling or therapy? Y N When?_____

What was the concern?_____

Who was the counselor?_____

Have you ever been hospitalized for psychiatric treatment? Y N When?_____

Where were you hospitalized?_____ For how long?_____

What brings you to counseling now?_____

How long have the current problems existed?_____

Describe your present concerns: (Circle one) Mild Moderate Moderately Severe Severe A Crisis

How did you learn about us?_____

Emergency Contact Person_____
(Name) (Relationship) (Phone)

PLEASE MARK ALL THAT APPLY:

_____crying spells
_____unable to have fun
_____feelings easily hurt
_____lacking in confidence
_____constipation
_____feeling irritable
_____always tired
_____poor appetite
_____depressed
_____trouble sleeping
_____feeling lonely
_____loss of weight
_____not enjoying things
_____suicidal thoughts
_____feeling inferior
_____loss of sexual interest
_____no one understands me
_____worried about health
_____can't concentrate
_____can't "get going"
_____feeling angry
_____don't like being alone
_____lack energy

_____panic attacks
_____always worried
_____frequent sweating
_____dizziness
_____shaky hands
_____stomach trouble
_____nightmares
_____feeling tense
_____cold feet and hands
_____feeling panicky
_____diarrhea
_____shy with people
_____muscle twitching
_____nausea or vomiting
_____can't make decisions
_____can't make friends
_____headaches
_____fainting spells
_____unable to relax
_____feeling fearful
_____overly sensitive
_____anxious inside
_____weight gain

_____money problems
_____relationship concerns
_____work difficulties
_____sexual problems
_____can't hold a job
_____excessive drinking
_____excessive medication use
_____excessive drug use
_____problems with children
_____problems with parents
_____poor physical health
_____fighting and quarreling
_____dislike my body
_____full of energy
_____overly ambitious
_____easily excited
_____quick tempered
_____impatient with people
_____binge eating
_____very restless
_____feel like hurting someone
_____feel like smashing things
_____excessive overeating

DUTCH FORK PSYCHOLOGICAL SERVICES, LLC

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We welcome to our practice and we look forward to working with you. We believe the following information will be helpful in establishing a good therapy relationship between us. Please read this information carefully, and ask any questions you may have. When you have read both pages, please sign the statement below.

Professional Background Bill Haxton, Ph.D. is a Licensed Clinical Psychologist (#654), having earned a Doctorate in Clinical Psychology from Georgia State University in Atlanta where he specialized in child and family psychology and developmental neuropsychology. Dr. Haxton earned his undergraduate degree in Psychology at the University of North Carolina at Chapel Hill, and a master's degree in Counseling at Trinity Evangelical Divinity School in Chicago. He completed his clinical residency at the Medical College of Georgia. Dr. Haxton is a member of the South Carolina Psychological Association and the American Psychological Association. He has over 20 years experience working children, adolescents, and adults.

Beth Nowell-Haxton, Ph.D. is a Licensed Clinical Psychologist (#700) who completed her Doctoral degree at the University of Tennessee in Knoxville and her clinical residency at the Medical College of Georgia. She earned her undergraduate degree in Psychology at the University of Tennessee, Knoxville. With over 15 years of clinical experience, her background includes the treatment of children, adolescents, and adults using a variety of assessment and counseling techniques. Dr. Nowell-Haxton is a member of the South Carolina Psychological Association and the American Psychological Association.

Initial Appointment The initial appointment is considered a diagnostic interview. From the information you share with me on this first visit, we will decide together whether I am the right therapist to help you attain your goals. If we decide to work together, we will discuss the type of therapy needed (individual, couple, family, etc.), the frequency of therapy sessions (weekly, bi-weekly, etc.), and schedule your next appointments.

Appointments Each therapy session lasts 45-50 minutes. All appointments are scheduled directly with me, in person or by phone. If you find that you need to cancel an appointment, please give as much notice as possible. You will be personally charged for appointments not canceled at least 24 hours in advance, except for emergency reasons. Insurance companies do not pay for unattended appointments.

Payments The fee for your initial visit is $150 and for each therapy session thereafter is $125. (The fee for psychological evaluations is contracted separately.) Most insurance companies will pay for a portion of outpatient mental health services. With your approval by signature, I will bill your insurance company, and have the payments sent directly to me. You will be responsible for paying all deductibles and co-pays in full at each visit by cash or check. Because payment for your services is ultimately your financial responsibility, you should check carefully with your insurance company to find out the specific requirements of your coverage.

Confidentiality All information regarding the specific nature of your therapy is considered confidential unless specified by you in writing. However, I do reserve the right to consult with other clinicians at times to help ensure I am providing the best possible service. In such instances I will

take measures to conceal your identity. All consultations will be noted in your case notes. Other issues related to confidentiality are discussed in more detail in our Notice of Privacy Practices.

Termination As you reach your goals in therapy, a gradual tapering of sessions typically occurs. It is helpful for you to discuss your wish to end counseling at least one or two sessions prior to your last session. A final session to process your therapy, settle any unfinished concerns, and say goodbye has proven to be beneficial.

Emergencies Our confidential voicemail (803-407-7099) is always available for leaving messages when I am in session or out of the office. If an emergency arises when I am not available to speak with you, please call the National Lifeline (1-800-273-8255), which provides 24-hour crisis intervention services. The emergency room of the nearest hospital is also another resource in time of crisis.

I encourage you to ask any questions you may have concerning the above policies, either now or as they occur. More comprehensive information is available in our Psychologist-Patient Service Agreement.

Please circle:

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 this form, the Service Agreement and privacy practices brochure.

YES NO I authorize the release of any medical information necessary to process my insurance claims.

YES NO I authorize benefits to be paid directly to my psychologist or to Dutch Fork Psychological Services, LLC.

YES NO I consent to the exchange of treatment information between my psychologist and my primary care physician.

_____ _____

Signature Date