John Paul Jones, Ph.D.
Licensed Psychologist

606 N. Court Avenue
Gaylord, Michigan 49735

Telephone: (989)732-6488
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CLIENT INTAKE INFORMATION SHEET

Date:_____ Referred By:_____ Emergency:_____Yes _____No

Client Name:_____If Child, Parent's Name:_____

Address:_____City, State, Zip:_____

Telephone: (Home) (_____)_____(Work) (_____)_____

Services Requested:_____

Assigned To:_____First Appointment Time_____

Client D.O.B.:_____S.S.N._____Driver's License:_____

Name of Employer or School:_____

Which is Best to Call: Home Work
When Best to Call: Morning Afternoon Evening

In Emergency, Contact:_____Phone# (_____)_____

INSURANCE INFORMATION

DIAGNOSIS CODE: _____

Primary Carrier

Insurance Company:_____

Telephone #: (_____)_____

Subscriber Name:_____

Subscriber's Date of Birth:_____

Relationship to Client:_____

Employer:_____

Policy/Contract #:_____

Group #:_____

Deductible: $_____

Coverage:_____Co-Pay:_____

Maximum/Year:_____

Credentials Accepted:_____

Verified By:_____Date:_____

Secondary Carrier

Insurance Company:_____

Telephone #: (_____)_____

Subscriber Name:_____

Subscriber's Date of Birth:_____

Relationship to Client:_____

Employer:_____

Policy/Contract #:_____

Group #:_____

Deductible: $_____

Coverage:_____Co-Pay:_____

Maximum/Year:_____

Credentials Accepted:_____

Verified By:_____Date:_____

JOHN PAUL JONES, Ph.D.
LICENSED PSYCHOLOGIST

Fee Agreement

	Intake	Individual
Initial Intake or Individual	$_____	$_____
Deductible Not Met	$_____	$_____
Estimate Insurance Amount	$_____	$_____
Client Co-Payment Amount	$_____	$_____
Professional Courtesy	$_____	$_____

Deductible:_____ **EAP:** Yes No

Total Charge Per Hour	**Intake**	**Individual**
	$220.00	$135.00

These are estimated amounts and are not a guarantee of benefits. Responsibility for payments remains with the client. **The above fee schedule takes effect after the deductible is met.** I understand that adjustment is in conjunction with the Professional Disclosure Statement.

Client Signature Date

Therapist Signature Date

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IMPORTANT POLICY INFORMATION

Please be aware **late cancellation** of a scheduled appointment and **no show** for scheduled appointments **may be charged to you.** Your insurance policy will not pay for these late cancellation and no show of appointments.

You must cancel **24 hours prior to your appointment time** to avoid a late cancellation charge.

We do not charge for an emergency situation beyond your control.

My signature below indicates I have been made aware of this policy.

_____ _____
Client Date

_____ _____
Witness Date

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LICENSED PSYCHOLOGIST

HIPAA Summary

Welcome to our practice. The following is a summary of the HIPPA rules and regulations that we must provide you with by law. If you wish not to read the attached this summary will provide you with the key points. Please sign below after reading. Thank you.

This clinic is private and is not funded with any government money. Expenses have to be met by our resources; therefore most clients pay for services through insurance benefits. Most insurance companies pay for part of the fee. Any portion of the fee not covered by insurance benefits is the responsibility of the client. We will be glad to assist you in verifying insurance coverage's and in our office will submit insurance claims on your behalf.

Unless other arrangements are made this clinic's fee is $ 220.00 per hour for the initial consultation (first hour) and $135 .00 per hour for an individual consultation. Co-pays and deductibles are collected at each session. A typical session begins on the hour and terminates ten minutes to the hour (i.e. 5:00-5:50). Fees for other services (i.e. psychological testing, medication reviews) are discussed with clients prior to them being initiated. Our office has a 1.5% interest rate for all balances over 60 days past due. If appointments are not canceled 24 hours prior to the scheduled time the client will be charged for that appointment.

All client information is confidential, but this clinic adheres to professional ethics and legal standards. Legal limits on confidentiality are in effect in cases involving: potential suicide, potential homicide, court orders and in cases of child abuse or neglect.

You may examine and/or receive a copy of your clinical record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. HIPAA provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your clinical records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records.

Professional counselors, psychologists and social workers in Michigan are regulated by the Department of Licensing, Regulation and Health Investigation Division, P.O. Box 30018. Lansing, Michigan 48909, 989-373-1737

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form as described above.

_____ _____

Client Date

_____ _____

Witness Date

*If you would like a copy of the full HIPAA Compliance Laws, please feel free to ask the receptionist.

GENERAL SYMPTOMS

Patient Name:_____ Date:_____

Check off any of these symptoms which have been most bothersome or have occurred frequently during the last 8 weeks.

____Repetitive senseless thoughts
____Repetitive senseless behaviors
____Fainting or feeling faint
____Tremors, trembling or shakiness
____Seizures
____Skin rash
____Violent behavior/Thoughts
____Constant worry
____Irritability
____Tension
____Headaches
____Feeling in a dreamlike state
____Fearful feelings
____Fear of losing control
____Jumpiness
____Restlessness
____Sweating
____Dizziness/Lightheadedness
____Keyed up/On edge
____Agitation
____Nervousness
____Trouble concentrating
____Insomnia/Trouble sleeping
____Decrease in sex drive
____Frequent thoughts about sex
____Trouble making decisions
____Sad/Depressed/Down in the dumps
____Lack of/Loss of interest in things
____Having suicidal thoughts
____Fatigue/Lack of energy
____Weakness
____Increase or decrease in appetite
____Increase or decrease in weight
____Frequent crying or weeping
____Frequent thoughts of death or suicide
____Excessive feelings of guilt
____Increased feelings of self-importance
____Feeling life is not worth living
____Racing thoughts
____Excessively high mood
____Frequent negative thinking
____Memory problems
____Fear of doing something uncontrollable
____Fear of dying
____Chills
____Seeing or hearing things that are not real
____Fear of going crazy
____Fear that someone is out to get me
____Feeling worthless
____Feeling hopeless
____Feeling useless
____Feeling helpless
____Feeling discouraged
____Feeling sad
____Feeling mad/angry
____Lack of self-esteem
____Having panic attacks
____Having flashbacks of a trauma situation
____Muscle tension
____Tingling sensation (hands, feet, etc.)
____Feeling paranoid
____Eating problems
____Feeling jealous
____Withdrawing from people
____Having mood swings
____Loss of motivation
____Had a closed head injury
____Suffered from a lot of physical pain
____Drinking too much
____Abusing drugs
____Abusing prescription drugs
____Hyper/ Can't relax
____Obesity/Overweight
____Shy/Avoid social situations

If you have any other symptoms that you would like to list, please list them in the area below:

_____

_____

_____