David Cummins Ph.D., Licensed Psychologist

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Please complete this as honestly and accurately as possible so that I can help you more effectively. Feel free to use the back of the paper if there is not enough room for your answers.

Last Name _____ First Name _____ Birth date _____

Home Phone _____ Cell Phone _____ Email Address _____

Home Address _____

Please place a check next to areas you wish to discuss.

- ☐ Depression
- ☐ Stress
- ☐ Anxiety
- ☐ Drug/Alcohol
- ☐ Other Addictions
- ☐ Pornography Usage
- ☐ Sexual Concerns
- ☐ History of Abuse or Neglect
- ☐ Unwanted Sexual Experiences
- ☐ Traumatic Experiences
- ☐ Thoughts of Harming Myself
- ☐ Thoughts of Harming Others
- ☐ Family Issues
- ☐ Hallucination or Delusions
- ☐ Health (Sleep, Physical Problems)
- ☐ Eating Issues
- ☐ Body Image
- ☐ Relationships
- ☐ Grief
- ☐ Other: _____
- ☐ Other: _____

Please describe the concerns for which you are seeking help, including how long you have had these concerns:

What would you like from our meeting and how would you know therapy was successful for you?

Have you been having suicidal thoughts? _____ Yes _____ No

Have you ever attempted suicide before? _____ Yes _____ No

Who referred you?_____

What are your spiritual beliefs and experiences?

Do you have a history of or are you currently experiencing any medical problems, please list below along with any medication, including herbal/vitamin supplements you are taking:

Primary Physician:_____

Psychiatrist:_____

Who do you live with and what are the relationships and living conditions like?

Do you have a romantic relationship? What is it like? What are your other relationships like?

What is your history with alcohol and drugs? What role does it currently play in your life?

Give details of family members with mental health and substance issue.

What are your strengths? And, how have you coped effectively with your problems?

_____ _____

Signature Date

What You Should Know about Therapy and Confidentiality

In therapy, I will treat you and what you tell me with great care. My main role in working with you is to help you to live a happier and healthier life. This takes place in different ways due to the complexity of people's presenting issues, their histories, and how they work best within their world. I am committed to gaining the best understanding possible of your particular situation, create an environment of trust and security, and work to help you identify the most effective means of achieving your goals in therapy. I believe that most every one of my clients who has worked diligently in and out of therapy has made substantial gains in the areas of life that they wish to improve.

I strive to make myself available to my clients in times of crisis and emergency. However, **there are times when I am not available** due to being out of town, working in other capacities, etc. If any emergencies take place and you are unable to contact me, please leave a message on my phone and use your resources (families, friends, etc.), call 911, and/or go to the nearest hospital emergency room. I will try to respond to you as soon as possible.

Confidentiality plays a very important role in therapy. With the exception of certain specific exceptions described below, you have the right to confidentiality. You may direct me to share information with whomever you chose, and you may revoke permission at any time. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission to do so. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the "confidentiality" of therapy. But I cannot promise that everything you tell me will *never* be revealed to someone else. **There are some circumstances when the law requires me to disclose information you may share with me to others.** You need to be aware of these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret. These are very important issues, so please read the following carefully and keep a copy for yourself. At our next meeting, we can discuss any questions you might have.

1. **When you or other identifiable persons are in physical danger (including suicidality and homicidality) or you are unable to reasonably take care of yourself,** the law requires me to tell others about it to ensure your and other peoples' safety.

2. **Disclosure of information that indicates that child (or elderly) abuse and/or neglect has occurred by an identifiable person or situation that has not been previously reported or investigated.**

3. **I may sometimes consult (talk) with another professional to ensure that I am giving you the best treatment possible**. I promise to keep your identity as anonymous as possible if I consult about your case. This other person is also required by professional ethics to keep your information confidential.

4. **In regard to billing and money matters:**
   A. I am employed with North End Wellness, LLC and do all billing and work practices through them. All North End Wellness, LLC employees are HIPAA compliant in protocol. These employees are only privy to information needed for billing and insurance and do not have any access to clinical information.
   B. Some insurance companies may require diagnoses and other treatment information about your therapy for billing purposes.
   C. If problems arise with your billing and/or payment a North End Wellness, LLC billing agent may contact you through email, mail, or by phone to help in resolving the matter.
   D. If payment is not made in a reasonable amount of time, I have the right to report the billing for collection purposes.
5. **Record keeping:** All records are stored in a designated area and under lock and key at all times.
6. **Electronic Submissions**: You are also protected under the provisions of the Federal Health Insurance HIPPA Act. This law ensures the confidentially of all electronic transmissions of information about you. When I transmit information about you electronically (sending bills or faxing information) it is done with safeguards in place to insure confidentiality

If any of the above situations occur that would warrant me having to share information with others, I would take reasonable attempts to empower you as much as possible so that you can make the best decision for your loved ones and yourself. I promise to reveal only the information that is needed to protect you, other persons, or for billing requirements.

The signatures here confirms that you have read, understand, and agree to abide by the points presented above.

_____	_____	_____
Printed Name	Signature of client (or person acting for client)	Date

Insurance and Billing

I am "fee for service" and expect full payment at time of service. However, if you have insurance, you may be able to receive some reimbursement for your counseling sessions. I am more than happy to have my billing manager submit your claims to your insurance company as an out-of-network therapy provider to help reduce your costs. If you would like this service, please complete the insurance information portion of the intake forms and my billing manager will submit all of your sessions to your insurance company for you. Your insurance company will mail you a check for any portion of our counseling sessions that are covered by your plan. As far as payment goes, I only accept payment at time of service in the form of cash, check, or HSA cards at time of service.

Last Name: _____ First Name: _____ MI: ____

Birth date: ____/____/__ ___ ____ Gender: M ☐ F ☐

Address: _____

Phone: ( ) _____ -_____ Email:_____

Primary Insurance:	**Secondary Insurance:**
Insurance Company:_____	Insurance Company:_____
Primary card holder:_____	Primary card holder:_____
Policy/ID Number:_____	Policy/ID Number:_____
Group Number: _____	Group Number: _____
Policy Holder Name: _____	Policy Holder Name: _____
Policy Holder Date of birth: _____	Policy Holder Date of birth: _____
Ins Ph# on back of card:_____	Ins Ph# on back of card:_____

- Please check circle if you <u>do not want</u> appointment reminders texted to you.
- Please check circle if you <u>do not want</u> to be on an email list sharing my helpful articles.

_____ _____

Signature Patient or Guardian Date

Fees and Services*

Payment will be paid in full at time of service.

Please check one of the following:

☐ I agree to pay $200 for each hour of service.

☐ I understand I am responsible for paying all fees in cash, check or HSA.

☐ I understand that I cannot use credit or debit card as form of payment.

Cancellations/Missed Appointments

If an appointment is missed or canceled with less than one business days' notice, you will be directly billed $100. Emergencies and illnesses occasionally happen to cause missed sessions. If this is the case please let us know as soon as possible so this fee can be waived and so that accommodations can be made.

I have read the above and agree to the terms set forth for fees, missed appointments, and late cancellations.

Client's or Guardian's Signature Today's Date