CAROLE KUNKLE-MILLER, PH.D. & ASSOCIATES
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CONFIDENTIAL INTAKE INFORMATION

Please Print Clearly

Patient's Name: _____ Social Security # _____
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

Main Contact Number: □_____ Cell Phone: □_____ Cell phone provider_____

Email Address: _____ (for billing purposes)

Do you give permission to receive a reminder call or text for your appointments? YES NO

Age: _____ Date of Birth: _____ Sex: M F Person responsible for insurance: _____

Patient's Employer/School: _____ Patient's Employer/School Status: _____

Marital Status (please circle one): Single Married Separated Divorced Domestic Partnership Widowed

Primary Care Physician: _____ Phone: _____

Date of last physical exam: _____ Allergies: _____

Previous psychological or psychiatric contacts: _____

Have you been seen in this private practice previously? Y/N

Person to contact in an emergency: _____ Phone: _____

Who referred you to our practice?_____

INSURANCE INFORMATION

Insurance Company: _____ Plan Name: _____

Policy Subscriber's Name:_____ Relationship to Subscriber: _____

Policy Subscriber's Date of Birth: _____ Subscriber's Employer: _____

Policy Subscriber's Social Security #: _____ Employment Status: (full, part time, retired)_____

Patient ID Number: _____ Group Number: _____

_____ _____
Signature of Responsible Party Date

CONSENT FOR TREATMENT; PHI may be used and disclosed to carryout treatment, payment, or health care operations.

(Continue to next page)

Patient Name:_____

FINANCIAL RESPONSIBILITY AND FEE AGREEMENT

Thank you for choosing Carole Kunkle-Miller, Ph.D. and Associates. In order to better serve you we ask you to understand and agree to the following. The fee for service is $300.00 for initial visit and $200.00 for Individual and Family visits. Except for brief phone contacts, you will be charged for phone therapy, report writing, emails or other professional services (letters, phone, and faxes to outside parties) at the rate of $200.00 per hour. Your insurance company will not reimburse for these services. Legal testimony fees differ from the therapy fees.

To pay for these services, you may select one of the following payment plans:

☐ Payment in full after each session. Our providers do not participate in all insurance plans, under these plans, payment is required in full at the time of service. You may request a receipt to submit to your insurance company.

☐ Payment by insurance company. Your health insurance may cover a portion of the fee**. Deductible and co-payment amounts are your responsibility and are due at each session.** Due to variation from one policy to another, we cannot guarantee insurance reimbursement. You are responsible for any fees not covered or not paid by insurance regardless of the reason and for denied claims that exceed your benefit limit. Your signature below grants our office permission to file claims and collect payments on your behalf.

Members Responsibilities:

- Pay Co-payments and deductible at the time of service.
- Give at least 24 hours' notice of cancellation of an appointment
- Contact your insurance company to determine your benefit limitations and financial obligations (co-payment, deductibles, authorizations, limit of number of visits per year, etc) and to verify that the provider participates with your insurance.
- Obtain authorization for office visits. If your insurance requires a pre-authorization at the time of your visit, we must have it on record. If you fail to obtain proper authorization, you are responsible for payment of any denied claim.
- Notify this office immediately of any changes in the status of your insurance coverage to ensure proper billing.

IMPORTANT OFFICE POLICIES AND PROCEDURES

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure required by law.

Cancellations/No Shows

A minimum of 24 hours' notice is required (48 hours' notice is preferred) of ANY appointment that you need to cancel. You will be charged $50.00 for appointments forgotten or cancelled without 24 hours advanced notice. Insurance companies will not reimburse for missed appointments; therefore you will be responsible for the total fees.

_____INITIAL

Payment

Please understand that prompt payment for our services is a necessary part of your treatment plan. Payments may be made in cash, check or credit card. A fee of $35.00 will be charged for each returned check. Accounts left delinquent more than 90 days could result in the account being turned over to a professional collection service. Bills may be sent electronically through email. We have employed safeguards to protect your privacy; however it is always possible that any email can be unencrypted. If you choose paper billing, there will be a $5 fee.

_____ INITIAL

Minor Patients/Divorced Parents

The adult patient must pay at the time of services regardless of who the responsible party is. We cannot become involved in mediation of financial arrangements. Unaccompanied minors should be provided with payment for their visit and will be expected to be responsible for scheduled appointments.

Contact/Emergencies

Due to our schedules, the telephone is answered by voice mail or an answering service. Patients with emergencies should call the answering service at 412-571-5989, and ask the operator to page YOUR therapist. We will get back in touch with you as soon as possible.

I CERTIFY THAT I HAVE READ THE ABOVE AND AGREE TO MY FINANCIAL RESPONSIBILITIES.

_____ _____

Responsible Party Signature Clinician Signature

_____ _____

Date Date

Patient Name:_____

MEDICAL HISTORY

Have you had any hospitalizations, operations or serious medical problems in the past year? Please specify:

_____

_____

Have you or any blood relatives had the following:

	Self	Mother	Father	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Brothers	Sisters	Children	Other
Alcoholism											
Drug Addiction											
Anemia											
Asthma											
Cancer											
Diabetes											
Epilepsy											
Heart Disease											
High Blood Pressure											
Low Blood Pressure											
Stroke											
Hepatitis											
Kidney Disease											
Hospitalized for Psychiatric Treatment											
Suicide Attempts											
Depression											
Manic Depression											
Anxiety, Fears, Phobias											
ADHD, ADD											
Learning Disabilities											
Other (List)											

MEDICATIONS

Prescribing Physician: _____Telephone: _____

Physician Address:_____

Start Date	**Name of Medication**	**Dosage**	**Patient Response**

Patient Name:_____

It is important to the success of your evaluation and treatment that your therapist understands as much about you as possible. Please complete the following form so we can learn more about you. Please answer the questions as honestly as you can and feel free to explain or add any information. If a question does not apply to your situation, please answer "no" or write N/A. This information, as all other information you give to us, is confidential.

PRESENTING PROBLEM

Who referred you to the office at this time? _____

For what reason have you been referred? _____

Do you believe that you have a problem related to stress, emotional adjustment or mental health? Yes No

Does some other person in your life (spouse, friend, etc.) believe that you have a problem? Yes No

If so, who? _____

Please describe the difficulty that you and/or someone else believe that you have: _____

_____

Please state (days, weeks, months, etc.) how long this problem has been going on:_____

Why are you seeking treatment or an evaluation now? _____

_____

Have you ever been hospitalized for a psychiatric or emotional problem? Yes No

If so, when, where, and for what reason?_____

_____

FAMILY OF ORIGIN

Where were you born? _____Describe your ethnic background: _____

Do you think that your ethnic/cultural background has played an important role in your life? Yes No

If so, please explain: _____

_____

What city/area were you raised in? _____

Are your parents still living? Mother: Yes No Father: Yes No

If living, how is your mother's health?_____Your father's? _____

Were your parents married when you were born? Yes No Are they still together? Yes No

What is (was) your perception of your parents' marriage (or relationship)? _____

_____

Did your family have financial problems? Yes No

Did your family move frequently during your childhood? Yes No

Did members of your family use alcohol or drugs in a problematic way while you were growing up? Yes No

If so, who and what impact did it have on you? _____

Has anyone in your family of origin received treatment for alcohol or drug problems? Yes No

If so, who? _____

Has anyone in your family of origin had mental health or emotional problems? Yes No

If so, who?_____Please describe these problems_____

_____

Did he/she receive treatment for these problems? Yes No

Are there medical illnesses that seem to run in your family? Yes No

Specify: _____

To whom are you closest in your family now? _____

Are members of your family of origin supportive of you getting treatment for your problem? Yes No

If not, why? _____

MARRIAGE (OR SIGNIFICANT RELATIONSHIP) AND CHILDREN

Please list the first names and dates of all marriages or significant relationships you have had:

Name of Partner	Date of Marriage (or when became committed)	Date of Divorce (or when relationship ended)	Reason for split

If currently married or in a significant relationship, give first name of partner and describe the quality of that relationship:

Name: _____Quality: _____

Please list the names, ages, occupations (or levels in school), and locations of your children:

Name	Age	Occupation/level in school	Location	Biological/adoptive/step

How do you get along with your children? _____

Are your children experiencing any problems in school, at home, or with the legal system? Yes No

If so, explain: _____

PERSONAL DEVELOPMENT

Are you aware of any major medical/social/emotional difficulties during your mother's pregnancy with you or the time of your birth? Yes No Please describe: _____

_____

Did you have any of these as a child? (please indicate age)

_____ frequent temper outbursts
_____ frequent nightmares
_____ sleepwalking
_____ thumb sucking
_____ stuttering
_____ other (please specify):_____
_____ excessive fears
_____ bed wetting
_____ fire setting
_____ excessive shyness
_____ nail biting

As a teenager, did you have any of these problems? (please indicate age)

_____ trouble with the police
_____ trouble with authorities at school
_____ unwanted pregnancy (self or girlfriend)
_____ frequent cigarette use
_____ criminal acts without getting caught
_____ gang membership or participation
_____ involvement with guns, knives or other weapons
_____ alcohol use
_____ gambling
_____ truancy from school
_____ running away from home
_____ involvement with drugs
_____ cult membership or participation

Patient Name:_____

As a teenager, did you have close friends? Yes No

As a child or teenager, did you belong to any formal groups or organizations? Yes No

If so, describe: _____

_____

Did your family participate in organized religious activities when you were growing up? Yes No

Did you participate? Yes No

Have you lost anyone close to you through death or separation? Yes No

If so, please describe what happened and the effects on yourself and your family: _____

_____

Have you ever experienced an extremely traumatic event (involved in a violent accident or a violent crime such as a rape or assault, witnessing an injury, death, or disaster)? Yes No

Were you ever the victim of rape, physical/sexual/emotional abuse, neglect, incest, molestation, or domestic violence? Yes No

Do you consider yourself: _____ Heterosexual _____Gay/Lesbian _____Bisexual _____Unsure

Do you have any sexual problems which concern you at the present time? Yes No

Do you practice safe sex in terms of disease prevention? Yes No

SOCIAL AND SPIRITUAL SUPPORT

Do you have a "best friend"? Yes No If so, who? _____

Whom do you trust the most in your life right now? _____

Do you consider your social support system to be adequate at the present time? Yes No

Explain: _____

Are your friends supportive of your getting help? Yes No

Do you believe in God or other higher power? Yes No

Do you attend religious services on a regular basis? Yes No

If so, what religion? _____

EDUCATION

What were your grades like in school? _____

Did you participate in extracurricular activities? Yes No

If so, what kinds? _____

Did you get along with your teachers and your classmates? Yes No

Do you recall ever being told that you had a learning disability or other educational or learning problems? Yes No

If so, what kind? _____

Were you ever in a special education class? Yes No

What is your highest grade completed in school: _____

Did you receive a high school diploma? Yes No GED? Yes No

Are you currently in school? Yes No

If so, describe: _____

If graduated from college or graduate school, what were your degrees and majors:

_____

Patient Name:_____

EMPLOYMENT AND FINANCIAL SITUATION

Do you work at the present time? Yes No If yes, where? _____

Job title: _____ Hours per week:_____

Job duties: _____ Are you satisfied with your work?_____

Do you want to be working? Yes No

Have you had any trouble on the job such as disciplinary actions or warnings as a result of the problem(s) which bring you to treatment? Yes No

Have you ever been fired from a job? Yes No

How many employers have you had in the past 5 years?_____

Have you had military experience? Yes No

If so: Branch _____ Time served: _____
Rank _____ Location of tour(s)_____
Circumstances of discharge_____ Status of discharge_____
Did you see combat? _____

Are you currently having significant financial problems? Yes No

Have you had money problems in the past such as bankruptcy or repossessions? Yes No

PHYSICAL HEALTH

Do you have any significant injuries, illnesses, or medical problems at the present time? Yes No

If so, please specify: _____

Do you have a history of any significant illnesses, injuries, or medical problems (as a child or an adult)? Yes No

If so, please specify: _____

Have you ever been hospitalized for medical reasons? Yes No

If so, when and for what reason? _____

Have you ever had surgery? Yes No

Have you ever had any type of head injury? Yes No

If so, when and what type of injury: _____

Have you ever lost consciousness as the result of an accident or injury? Yes No

If so, explain: _____

When did you last see a physician? _____

Whom did you see?_____Results: _____

Do you have (or have you ever had) what might be considered an eating disorder? Yes No

If so, explain: _____

Do you have any significant problems with sleep? Yes No

Do you have any significant problems with vision, hearing, or speech? Yes No

If so, explain: _____

Do you have any significant physical limitations or disabilities? Yes No

LEGAL

Are you currently involved in any legal action? Yes No

If so, please describe:_____

Have you ever been arrested? Yes No

If so, please explain: _____

Have you ever been convicted of a crime? Yes No

If so, what crime: _____What penalty or sentences were you given? _____

Do you have any past or present legal problems related to alcohol or drug use (such as DUI)? Yes No

If so, explain: _____

LIFESTYLE

Do you smoke cigarettes? Yes No If so, indicate how many per day:_____

Do you drink caffeine? Yes No If so, indicate how many servings per day: _____

Do you drink alcohol? Yes No If so, how many drinks you have per week:_____

Do you use drugs recreationally? Yes No

If yes, please indicate the type of drug and how often it is used:_____

Do you exercise? Yes No

Do you practice stress relieving strategies such as meditation? Yes No

If yes, please indicate the type of activity and times per week that you engage in the activity: _____

_____

Do you have what you consider to be a weight or eating problem? Yes No

If so, please describe:_____

Do you have any hobbies or special interests? Yes No

If yes, please indicate what type and the amount of time per week spent engaged in this interest:_____

_____

How do you typically spend your free time? _____

_____

_____

_____

Is there anything else you would like us to know about you and your situation? _____

_____

_____

_____

What is your primary goal for treatment here? _____

_____

_____

_____

_____ _____

Date **Signature of person completing form**