Marcia S. Gibson PsyD
& Associates, P.C.

CLIENT INFORMATION

Today's Date: _____ Clinician: _____

First Name: _____ Middle: _____ Last: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ OK to Leave message? ☐ Yes ☐ No

Cell Phone: _____ OK to Leave message? ☐ Yes ☐ No

Sex: _____ Birth date: _____

Email Address: _____ OK to email sensitive info? ☐ Yes ☐ No

Select one: ☐ Married ☐ Divorced ☐ Single ☐ Widow/er ☐ Separated

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Policy ID#: _____ Group #: _____

Phone: _____ Employer Name: _____

Insured's Name: _____

Insured's birthdate: _____

Insured's Address: _____ City, State, Zip: _____

Patient's Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Marcia S. Gibson PsyD & Associates, P.C.

AUTHORIZATION/ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process this claim. I also request payment of insurance benefits to Marcia S. Gibson PsyD & Associates, P. C.

Signed: _____ Date: _____

I authorize payment of medical benefits to Marcia S. Gibson PsyD & Associates, P. C. for services provided.

Signed: _____ Date: _____

I give permission to Marcia S. Gibson PsyD & Associates, P. C. to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will be responsible for any unpaid balances including copayments, deductibles, and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed to me at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signed: _____ Date: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

If the guarantor is different than the patient, please complete and sign:

Guarantor Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship to Patient: _____

E-mail Address: _____

As the responsible party, I understand that I am responsible for payment of any outstanding charges on this account.

Signed: _____ Date: _____

Marcia S. Gibson PsyD
& Associates, P.C.

AUTHORIZATION

PERMISSION TO RECEIVE PRERECORDED APPOINTMENT REMINDER PHONE CALLS, TEXTS, OR EMAILS

As a service to our clients, we now offer appointment reminder calls, texts, and/or reminder emails. In order to authorize receiving the calls, texts, or email messages, please fill out the information below and provide the phone number and/or email where you wish to receive these messages.

By providing your phone number and/or email below, you consent to receiving appointment reminder calls, texts, or emails. You do not need to sign this authorization; however, if you do not sign this authorization, we will not be able to provide you with the courtesy reminder calls and/or emails.

Name of Client: _____

_____ _____

Signature of Client Date

_____ _____

Signature of Parent or Guardian (if client is a minor) Date

Phone number authorized by client to receive reminder calls: _____

Phone number authorized by client to receive reminder texts: _____

Email Authorized by client to receive reminder appointments: _____

Please indicate your preference:

□ Phone Call Reminder □ Text Reminder □ Email Reminder

Marcia S. Gibson PsyD & Associates, P.C.

Adult Intake Form

Name: _____ Date: _____ Date of Birth: _____

OFFICE POLICIES

Confidentiality:

- Information in my sessions is confidential EXCEPT if I am threatening to hurt myself or someone else, or if I tell of a child or an elderly person being abused. In any of these cases, the clinician will have to act upon this information to protect me or someone else.

Appointments:

- Psychotherapy sessions are typically **50-55 minutes long**.
- There is a 24 hour cancellation fee. When I schedule an appointment, the clinician reserves that time for me and ***if I cannot attend a session I must give 24 hours notice or I will be charged the full fee for the session***.
- The initial visit is considered to be an evaluation only and not a guarantee that treatment will be the result of said visit.

Payments and Billing:

- Payment at time of service is expected unless other arrangements have been made. If health insurance covers my sessions, Marcia S. Gibson PsyD & Associates P. C. will help me seek reimbursement from the insurance company. **ANY unpaid balance after insurance is MY responsibility to pay.**
- I agree that Marcia S. Gibson PsyD & Associates P. C. may release to my insurance company any information needed to secure payment for service.
- If I do not pay my account, then it may be turned over to collections.
- In the event that any check I write is returned NSF (insufficient funds) I agree to pay ***a $25.00 service fee***.
- Balances of $200.00 or more, must be paid in full before next appointment is made.

The parent accompanying the child to session is responsible for any payment unless other arrangements have been made with the office manager in charge of billing.

Signed: _____ Date: _____

Marcia S. Gibson PsyD & Associates, P.C.

404 W. Boughton Road, Suite A

Bolingbrook, IL 60440

Credit Card Authorization

For internal use only.

I, _____, authorize Marcia S. Gibson PsyD & Associates, P. C. to keep my signature on file and to charge my credit card listed below for:

All copays and coinsurances owed at each session, if applicable.

All patient balances (less than $250) for services rendered once the claim has been processed by my insurance company.

I understand that Marcia S. Gibson PsyD & Associates, P. C. will contact me by telephone for all patient balances exceeding $250 prior to charging my card.

I authorize recurring charges for services rendered for the following family members:

Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____

Check One: Visa _____ Master Card _____ Discover _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____

CVV: _____ (3 numbers on the back of the card)

Cardholder Signature: _____ Date: _____

Cardholder preferred contact number: _____

I have the right to terminate this authorization at any time and agree to do so by contacting Marcia S. Gibson PsyD & Associates P. C. at (630)759-4000.

Marcia S. Gibson PsyD & Associates, P.C.

Name: _____ Date: _____ Date of Birth: _____

AUTHORIZATION TO DISCUSS MY MEDICAL INFORMATION AND ACCOUNT:

You may discuss my **medical** information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

You may discuss my **appointment** information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

You may discuss my **account** information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signed: _____ Date: _____

CONSENT TO TREATMENT: I hereby authorize and voluntarily consent to all care, treatment, and other related services that may be ordered, requested, directed, or provided by Marcia S. Gibson PsyD & Associates, P. C. Further, **I understand and agree to the above policies and I authorize my clinical and account information to be discussed as indicated above.**

_____ _____

Signature of Patient/Client Date

_____ _____ _____

* Signature of Parent, Guardian, Relationship/Authority Date

Marcia S. Gibson PsyD
& Associates, P.C.

Name: _____ Date: _____

Problems are you seeking help with today: _____

_____

Current Symptoms:

☐ Depression ☐Mood swings ☐Anger/Irritability/Temper ☐Thoughts of death/dying ☐Suicidal thoughts

☐Crying spells ☐Loss of enjoyment/interest ☐Loss of Motivation ☐Hopelessness/Worthlessness

☐Withdrawal/Avoidance ☐Fatigue/No energy ☐Increase energy ☐Sleep Problems ☐Self-injury

☐ Racing thoughts ☐Worry ☐Anxiety or Panic attacks ☐Agitation ☐Impulsivity ☐Increase in risky behavior

☐Suspiciousness ☐Hearing voices ☐Seeing things ☐Change in libido ☐Appetite Change ☐Homicidal thoughts

☐Problems with attention/concentration/focus ☐ADHD ☐Problems with memory

☐Other – please describe: _____

_____

SUICIDE RISK ASSESSMENT:

Have you had thoughts that you don't want to live? ☐No ☐Yes Do you have those thoughts now? ☐No ☐Yes

Have you ever tried to kill yourself? ☐No ☐Yes Number of times ____ When was most recent attempt? _____

Has anyone in your family died by suicide? ☐No ☐Yes Who? _____

PAST TREATMENT HISTORY:

Have you received treatment in the past for mental health problems? ☐No☐ Yes

Type of treatment: ☐ Talk therapy ☐Medications ☐Inpatient: # times? _____ When most recent _____

Past Diagnosis, if known: _____

FAMILY PSYCHIATRIC HISTORY:

Please check if family members have (or might have) of any of the following problems:

☐ Depression: _____ ☐ Schizophrenia: _____

☐ Bipolar: _____ ☐ Addictions: _____

☐ Anxiety: _____ ☐ PTSD: _____

☐ ADHD/ADD: _____ ☐ Other: _____

SUBSTANCE USE/ADDICTION HISTORY:

Do you use tobacco products? ☐No ☐Yes What do you use, and how much? _____

Do you have problems with alcohol, drugs, or prescription drugs? ☐No ☐Yes – Describe _____

_____

Marcia S. Gibson PsyD & Associates, P.C.

Adult Intake Form

Name: _____ Date: _____

Have you been treated for problems with alcohol or drugs? ☐No ☐Yes -Describe: _____

_____

SOCIAL HISTORY:

Where did you grow up? _____ Quality of childhood ☐Great ☐Adequate ☐Difficult

Raised by _____ # Brothers _____ # Sisters _____

Abuse in the home? ☐ No ☐ Yes - check all that apply: ☐ Physical ☐ Emotional ☐ Sexual ☐ Neglect

Marital Status: ☐ Single, never married ☐ Married/Partnered for _____ years ☐ Divorced ☐ Widowed

past marriages? _____ Relationship with spouse/partner: ☐Great ☐Adequate ☐Difficult

Do you have children? ☐ No ☐ Yes – what are their ages: _____

Highest Education Level? _____ How did you do in school: _____

Occupation: ☐ Employed _____ ☐ Not working by choice ☐ Unemployed ☐ Retired ☐ Disabled

Military History: ☐ No ☐ Yes: Branch_____ When_____ Type discharge_____

Legal History: Have you ever been arrested ☐ No ☐ Yes: describe _____

Current legal issues? ☐ No ☐ Yes Describe: _____

_____

_____

MEDICAL HISTORY:

Primary Care Physician: _____Approximate Date of last exam: _____

How would you describe your physical health?_____

Please check any of the following health conditions for which you are being treated:

□ High blood pressure □ Diabetes □ Liver Disease □ Heart Disease □ Thyroid Problem

□ Stomach/Intestinal □ High Cholesterol □ Seizures □ Sleep Apnea □Stroke

□ Headache/Migraines □ Seizures □ Pain where: _____

□ Asthma □ COPD/Bronchitis □ Cancer - type: _____

Medical problems not included above: _____

Past surgeries: _____

_____

_____

Allergies (medications or other): _____

Current Medications: _____

_____

_____

Marcia S. Gibson PsyD & Associates, P.C.

Adult Intake Form

Name: _____ Date: _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between your Marcia S. Gibson PsyD & Associates P. C. clinician and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date is specified.

I, _____ _____

Patient/Client (PRINT) Date of Birth

Please check one:

☐ I agree to release mental health/substance abuse information to my Primary Care Physician.

☐ I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name: _____

Physician Address: _____

Physician Phone: _____ Fax: _____

_____ _____

Signature of Patient/Client Date

_____ _____ _____

* Signature of Parent, Guardian or Personal Representative Relationship/Authority Date

Information for PCP:

The above-named individual was seen on _____ for _____

Date Diagnosis

by _____

Clinician