



MARGARET ANN JESSOP, PSYD

Psychological, Counseling, and Consulting Services

53700 Generations Drive, Suite 200 • South Bend, IN 46635

Phone: (574) 245-0077 • Fax: (574) 258-6310

Email: meganajessop@gmail.com

ADULT INTAKE FORM

Thank you for completing the attached intake information form. Please feel free to ask any questions you might have regarding the nature of therapy and/or to share your expectations and goals.

Personal Information

For Scheduling

For Newsletter

Date: _____ Email: _____

Name: _____

Last

First

M.I.

Date of Birth

Address: _____

Number

Street

City

State

Zip Code

Home Phone: _____ Marital Status: _____

Previous number of marriages for: _____ Husband: _____ Wife: _____

Spouse's Phone: _____ Spouse's Date of Birth: _____

Spouse's Address: _____

(If different)

Number

Street

City

State

Zip Code

Children:

| Name | Birth Date | Biological | Adopted | Other |
|------|------------|------------|---------|-------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Emergency Contact: _____

Name

Address

Phone

(Continued on page 2)

Work Information

Employer: _____ Address: _____

Work Phone: _____ Okay to call at work? Yes No

Alternate (Cell, etc.) Phone: _____

Spouse's Employer: _____ Address: _____

Medical Information

Family Physician: _____
Name *Address*

Current Medications (Name, dosage, and frequency): _____

Current Health Issues: _____

Known Allergies: _____

Previous Therapist: _____
Name *Address*

Psychiatric Hospitalization: _____
Faculty *Date(s)*

Referred by: _____

Current Symptoms or Situation: _____

Check any of the following which currently, or in the past six (6) months, apply to you. Asterisk(*) those of most concern. If you are a couple, delineate by initials whichever is relevant to each of you.

| | | |
|--|---|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fears |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Divorce | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Self-control | <input type="checkbox"/> Unhappiness |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Stress | <input type="checkbox"/> Work |
| <input type="checkbox"/> Relaxation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Tiredness |
| <input type="checkbox"/> Legal matters | <input type="checkbox"/> Memory | <input type="checkbox"/> Motivation |
| <input type="checkbox"/> Too much energy | <input type="checkbox"/> Spending money | <input type="checkbox"/> Decision making |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Education | <input type="checkbox"/> Career choices | <input type="checkbox"/> Health problems |
| <input type="checkbox"/> Temper | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Children | <input type="checkbox"/> Appetite problems | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Parenting | <input type="checkbox"/> Troublesome thoughts |
| <input type="checkbox"/> Family | <input type="checkbox"/> Moodiness | <input type="checkbox"/> Urge to repeat actions |
| <input type="checkbox"/> Other | | |

Psychotherapy is a very personal, and, by ethical standards, a confidential process. However, often it can be helpful for your therapist to discuss treatment with your family physician. This is especially true when there are physical symptoms, or you are taking medication. If you wish to give permission for your therapist to discuss your care with your family physician, or another healthcare provider, please identify that provider and sign below.

Name of Provider

Address

Phone

Signature of responsible party

Date



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INSURANCE INFORMATION AND RELEASE

If you want me to file insurance for you, please complete the information below and sign to give me permission. You must provide the identifying information, including name of insured and address for claims.

Identifying Information

Name of Insured: _____

Name of Patient: _____

Insured's Employer: _____

Insurance Company: _____ ID#: _____

Policy Number: _____ Group Number: _____

Claims Office Address: _____

Phone Number: _____

Pre-authorization required? Yes No **Authorization obtained?** Yes No

PATIENT OR AUTHORIZED PERSON SIGNATURES

I authorize the release of any medical information, including diagnosis and dates of service, necessary to process claims.

Signed: _____ Date: _____

I authorize payment of any medical benefits for the services provided to the physician or supplier of services.

Signed: _____ Date: _____

PLEASE NOTIFY MARGARET ANN JESSOP, PSYD OF ANY CHANGES IN YOUR INSURANCE.



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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have, so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you; and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one, 55-minute session (one

appointment hour of 55 minutes duration) per week, at a time we agree on—although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it, unless:

- you provide one-day's advance notice of cancellation, or
- unless we both agree that you were unable to attend due to circumstances beyond your control.

If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is \$210–\$160. If we meet for more than the usual time, I will charge accordingly.

In addition to weekly appointments, I charge this same hourly rate for other professional services you may need—although I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing; telephone conversations lasting longer than 10 minutes; attendance at meetings with other professionals you have authorized; preparation of treatment summaries; and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. (I charge \$250 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of \$.10 per page for records requests.)

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise, or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested. (In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.)

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. (If such legal action is necessary, its costs will be included in the claim.)

In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience, and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by the insurance contract.

CONTACTING ME

I am often not immediately available by telephone. Though I am **usually in my office between 9 AM and 3 PM**, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call on the same day you make it—with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available.

In emergencies, you can try me at my cell number. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNICATION POLICY

EMAIL COMMUNICATIONS AND TEXT MESSAGING

I use email communication and text messaging only with your permission, and only for administrative purposes, unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. Please do not email me about clinical matters, because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone, or wait so we can discuss it during your therapy session. The telephone, or face-to-face context, simply is much more secure as a mode of communication.

SOCIAL MEDIA

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

WEBSITES

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

WEB SEARCHES

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person, and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional

with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to disrupt our ability to work together.

CONFIDENTIALITY (for adult patients)

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it; and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I may be required to make a report to the appropriate state agency, and I will follow all applicable state regulations.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.



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HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

My signature below acknowledges that I have received a copy of *Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information,** as required by new federal legislation (HIPAA).

**Located at Front Desk*

(Client Signature)

(Date)

OUTPATIENT SERVICE CONTRACT SIGNATURE PAGE AND CONSENT FOR MENTAL ILLNESS SERVICES

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

(Client or Guardian Signature)

(Date signed)

CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned, agree and consent to participate in the mental health services offered and provided by _____, a mental health service provider or psychologist, as defined by Indiana Law.

I understand that I am consenting and agreeing only to those mental health services that the above named provider is qualified to provide within:

- a) The scope of the provider's license, certification and training; or
- b) The scope of the license, certification and training of those mental health providers directly supervising the services received.

Client signature _____ Date _____

Parent/Guardian signature _____ Date _____

Witness _____ Date _____

Note: This page will be removed from the previous 9 pages and kept in your Clinical Chart. You may keep the rest of the documents for your records.