Intake Form

INTAKE FORM

PATIENT INFORMATION

This is the information for the patient we will be seeing, if you have not filled out our "Start Here" form then please go back to our forms page and do that first.

Patient Name*

Application Date*

Date

Patient Address*

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Home Phone/Cell Phone*

Please enter a valid phone number.

Work Phone

Please enter a valid phone number.

Date of Birth*

Date

Email

example@example.com

Marital Status of Patient*

Single Married/Domestic Partnership Divorced Separated Widowed

I authorize messages to be left on answering machine, voicemail, and/or email*

Yes No

I authorize a summary of my visit to be sent to my physician upon request

Yes No

Physician Name

Physician Address
- Street Address
- Street Address Line 2
- City State / Province
- Postal / Zip Code

Referred By

Referred to Dr./Group

Notify in case of emergency*

FINANCIALLY RESPONSIBLE PERSON

If you will be paying the bill or invoices you must complete this section completely, if you are NOT the financially responsible person, then this section may be skipped. We require at least ONE financially responsible party in order to see any patient.

Name

Relationship

Please Select ▼

Address
- Street Address
- Street Address Line 2
- City State / Province
- Postal / Zip Code

Date of Birth

Date

Eligible for Medicare or Medicaid Benefits*

Yes No

I understand and agree that any amounts owed by me are subject to 1.5% per month (18% per year) interest, which will be added to any outstanding bill. Fees are based upon how much time is spent on activities associated with the client needs, at an hourly rate.I understand that I am financially responsible for my entire bill, and the fees are due at the time of service. We ask that all patients pay at the beginning of their appointment for services scheduled.

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The Nicholls Group does not provide Medicare or Medicaid services; therefore, if I am a Medicare or Medicaid beneficiary, I understand that a separate private contract will need to be signed and I wil be fully responsible for payment of all services provided.

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Therapy/consultation hours are 50 minutes long and are billed at the hourly rate. This procedure is required because of the additional time needed to write up session notes.Psychological evaluations are charged at a rate that is one and one-half times the direct face-to face contact time. This procedure is required because of the additional time needed to score and interpret psychological testing. Report preparation is charged according to the time required.We are happy to correspond with you by phone or by email, as we understand that you may have questions in between sessions or after a feedback session. Please note if that time exceeds 15 minutes, you will be billed for that time. Charges will be billed 15 minute intervals.I understand that the providers in this office do not submit claims to any insurance companies, I understand that I will be informed about the administrative procedure and upon request I will be given diagnostic codes, which I may submit to my insurance company at my own discretion; and that I am responsible for any prior authorization or pre-certification required for services. Please note that The Nicholls Group cannot correspond with your insurance company via phone/mail without written consent from the client or guardian.

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Cancellation Policy:

- The Nicholls Group requires a 72-business hour cancellation for all evaluations. If my appointment is not cancelled within 72 hours. I understand that I will be charged for the time scheduled.
- For therapy and/or consultation, the Nicholls Group requires a 48-business

hour notice. If my appointment is not cancelled within 48 hours, I understand that I will be charged for the time scheduled.

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I understand that insurance companies do not reimburse or cover missed or late cancel expenses.

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Policies for Children with Divorced Parents:

- In all therapy and evaluation cases, where the child's parents are divorced, we will need to have a full copy of the divorce decree for our records to keep on file to ensure our office is maintaining the most legal ethical practice.
- We ask that both parents provide consent before an assessment or treatment begins with a minor. We also ask that both parents are involved in your child's treatment and/or evaluation, including the progress of treatment, in order to maintain the most ethical practice. The exception to these stipulations is in the case of alleged child abuse and/or an on-going investigation, or services provided under a court order.
- It is important to note that unless it is otherwise stipulated by the court or law, both parents are entitled to equal access to information (spoken or written) concerning his/her child's psychological treatment and/or evaluation.
  In order to release any records to a third party, both parents' written consent must be obtained. Additionally, in the case of family therapy or parenting consultation, in which both parents are present to discuss their child/children, written consent from both parties is required to release records to either client or to a third party.
- In many divorce cases there are court agreements that states the payment schedule for each parent; as either an amount or percentage. Please note The Nicholls Group is not responsible for collecting divided payments from each parent, and that the bill is due at the time of the service. In the case of an evaluation, each parent is responsible for the entirety of his or her portion of the bill PRIOR to the evaluation being performed.

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Important Notices:

- Emergency contact with The Nicholls Group may not be immediatley available and will be unavailable on weekends or nights. In case of emergency please dial 911 or go to your closest Emergency Room. The crisis network hotline is 480-787-1500 (EMPACT) or 1-800-631-1314 (crisis

response network).
- The Nicholls Group does not provide custody evaluations.

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The Nicholls Group trains postdoctoral fellow and graduate students in Clinical Psychology from multiple universities who are practicing in our office as part of their training. These individuals are not yet licensed in psychology and therefore are working under the supervision of one of our Licensed Psychologists. If you are meeting with one of our trainees and have any concerns, please consult with the supervising provider prior to your first appointment.

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The Nicholls Group engages in professional and scientific research, and reviews data gathered in the performance of our evaluations and therapies. Unless you specifically state that you do not wish us to use the information about yourself or your child, you give us permission to include such information in our research projects. Please note that all information so used is de-identified and anonymous. There is no method that you or your child's identity could be determined.

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Confidentiality: I understand consultation, therapy, and psychological evaluations are confidential and that I must give my consent to release information to a third party. Exceptions to confidentiality include the following:

- There is reason to believe a child under 18 has been the victim of abuse or neglect.
- The client expresses the intent to harm themselves or is gravely disabled.
- The client communicates a serious threat of imminent harm to a clearly identified victim(s).
- There is a court order for records signed by a judge.
- The evaluation is an independent educational evaluation requested by and paid for by the school and consented to by the parent.
- For the purposes of professional consultation.

I authorize the Clinical Psychologist or member of The Nicholls Group to record a video, voice record, or take a photo of myself/ my child for the use of evaluation and professional education. Any use outside of direct clinical service will have all identifiable information removed.

Consent: I acknowledge that I have had access to read over The Nicholls

Group’s “Psychologist-Patient services Agreement,” (Found under the “Patient Forms” page at www.thenichollsgroup.com) and accept responsibility for reading this document and asking any questions that I may have regarding services provided to me. I hereby certify that I have legal authority to seek requested services and consent for the identified staff member(s) at The Nicholls Group to provide psychological services to me and/or the person for whom I am a legal guardian. I have had an opportunity to ask questions about any concerns I have regarding the above.

Signature of Client or Parent/Legal Guardian*

Clear

Relationship (if not client)*

Email
example@example.com

Email
example@example.com

Submit