Gabrielle Carey, Ph.D., LMFT DATE _____

INDIVIDUAL FORM

Name _____

Address _____

City _____ Zip _____

Phone _____ E-mail _____

Birth Date _____ Age ____ Sex ____ SS #:_____

Occupation _____

Employer _____

Work Address_____

City _____ Zip _____

Work Phone_____ Cell/Pager_____

Who referred you to us? _____

Have you ever been married? Yes _____ No _____

If so, to whom and for how long?

Name _____ Years _____

Please list Children: If no Children list Siblings	Age	Sex	SSN	Birthdate	Living at home Yes	No

Are there any other persons living in your household? Yes ____ No _____

If yes, please give their name(s), ages, and their relationship to your family.

Are your parents living? If yes, please give their names, address(es), and telephone number(s).

_____

_____

_____

If no, give the name, address, and telephone of the nearest relative in case of an emergency.

_____

_____

Emergency contact will be called if suicidal or homicidal ideation is present.

Mother Yes ____ No ____ Father Yes ____ No ____

Emergency contact: _____

Phone # _____

BASIC HEALTH AND COUNSELING HISTORY

Good ____ Fair ____ Poor ____

Date of last physical exam? _____

Name of Physician? _____

Phone _____

Are you taking any prescription medication, over-the-counter medications, allergy medications, herbs, etc.? Yes ____ No ____

If yes,what? _____

_____

_____

Have you ever been hospitalized? Yes ____ No ____

If so, for what? _____

_____

Do you drink alcohol? Yes ____ No ____

If yes, amount? _____

Do you use any illegal drugs? Yes ____ No ____

If yes, what? _____

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes ____ No ____

If yes, what _____

_____

_____

Have you had counseling in the past? Yes ____ No ____

If so, Dates _____

With whom? _____

For what? _____

_____

_____

RATE YOUR CURRENT MENTAL STATUS:

	G = Good	**F = Fair**	**P = Poor**
Comments			
1. Memory/Short	G	F	P
2. Memory/Long	G	F	P
3. Insight/Judgement	G	F	P
4. Attention	G	F	P
5. Concentration	G	F	P
6. Affect/Mood	G	F	P
7. Eye Contact	G	F	P
8. Body Movement	G	F	P
9. Speech	G	F	P
10. Impulse Control	G	F	P

CURRENT REASON(S) FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish to have counseling?

What would you like to see happen as a result of counseling?

POLICY

A counseling session is normally 45-50 minutes. It is customary to pay your therapist after each session. A 24-hour cancellation OR rescheduling notice is required; otherwise the usual **full fee** will be charged. Emergencies will be handled on a case to case basis.

The therapist will maintain strict confidentiality. However, I understand that suicidal threats, homicidal threats, and child or elder abuse will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

I have signed the release of information form for my insurance company (if applicable) and I have been given the information form regarding privacy and confidentiality as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I understand that I have the right to refuse treatment at any time.

Client Signature _____

Psychotherapist
Signature _____

Insurance & Fees

Fees

My standard fees are $200 for the first session and $150 for each subsequent session. If you are using insurance and have met your deductible, you will only be charged the copay or coinsurance amount (check with your insurance company).

Payment is due at the time of the session. I accept cash, checks, Mastercard, Visa, or American Express as payment for my services. If a check is returned for insufficient funds, a $35 charge will be charged to your account. A 24-hour cancellation notice is required or you will be responsible for the full cost of the session.

Insurance

The following insurance plans are accepted.

- Aetna
- Some Blue Cross/Blue Shield Plans
- Ceridian
- Cigna
- Corporate Family Network EAP
- Humana
- Indecs
- Meritain
- Oxford
- Pacificare
- Tricare
- United Behavioral Health
- UBH EAP
- United Healthcare
- Value Options

Individual plans may vary on coverage. Call your insurance company to make sure mental health counseling or family counseling is covered.

If you do not see your company on the list, you may still have coverage. Either call your insurance company or call Dr. Carey.

If you intend to use your insurance, a pre-authorization may be needed before beginning treatment. Dr. Carey will take your information and the get the authorization, just let her know when you schedule. If you will be using an EAP (Employee Assistance Program), you will need to contact them to obtain an authorization.

Map & Directions

CONTACT BUTTON

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