Shari Pescatore, LPC
847 Easton Road
Suite 2300 B
Warrington, PA 18976
(215) 343-3091

Intake Form

Patient's name: _____ DOB: _____

Address: _____

City: _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Referred by: _____ Phone Number: _____

_

Emergency contact: _____

Telephone: _____

Marital status: Spouse's (partner's) Name: _____

Children (names and ages):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Pets: _____

(Use back of form if necessary)

Are you currently taking, or have you ever taken, medications for a psychiatric problem? If yes, please list the name, dosage, and dates of each medication: (Use back of form if necessary):

_____

_____

Please list the name, and telephone number of your Psychiatrist/Physician:

Name: _____ Phone number: _____

May I contact: _____

Have you ever been hospitalized for a psychiatric problem? If yes, please list the hospital(s), date(s), and reason(s):

_____

Are there any medical problems that have resulted in a significant impact on you? If yes, please describe:

_____

Are you currently taking any medications for medical problems? If yes, please list the name and dosage of each medication: (Use back of form if necessary):

_____

_____

Please check each problem below for which you would like help:

___Anxiety ___Depression __ Fear __ Headaches __ Inactivity ___Mood swings
___Regrets ___ Shyness ___Self-esteem ___Marital problems ___ Alcohol abuse
___Suicidal ___ Assertion ___Loneliness ___ Irritable bowel ___ Impulsivity
___Sexual problems ___ Physical complaints ___Difficulty controlling eating
___Substance abuse ___Anger ___Aggression ____Low energy ____Problem solving
____Social skills ____ Insomnia ____ Self-criticism ____ Procrastination ____Conflict resolution ____Decision making _____Violence ____Hopelessness ____Work
____ Friendships _____Overweight _____Underweight _____ Agitation ____ Panic
____Obsessive Thoughts
Please describe): _____

Have you experienced any sources of stress in the past year?
If yes, please describe:

_____

Have you ever experienced a trauma?
If yes, please describe:

_____

Are there any situations or people you avoid because they make you feel anxious?
If yes, please describe:

_____

Do you exercise?
If yes, please describe:

_____

What are your typical recreational activities?

_____

Have you ever had, or do you have, a problem with substance abuse?
If yes, please indicate substance(s) (alcohol, medication, and illicit drugs) and dates of use:

_____

Have you ever had a period of 2 days or more when you experienced any of the following?
____Decreased need for sleep ____Racing thoughts _____Unusual desire to spend money _____Easily distracted _____Very talkative ___ Unusually high self-esteem _____ Driving very fast ____ Very irritable or angry
Is there anything else you would like your therapist to know about you?

FAMILY HISTORY

_____

_____

Please explain why you are seeking therapy:

_____

_____

_____

List some goals you may like to achieve through your counseling experience:

_____

_____

_____

Your signature below indicates that you have read this agreement and agree to its terms during our professional relationship.

Client's Name:

_____

Signature:

_____

Client's Name (partner/spouse in couple's therapy):

_____

Signature:

_____

Signature of Parent (if Child under age 14 years old)

_____

NOTICE OF PRIVACY PRACTICE
Shari Pescatore, LPC
847 Easton Road
Suite 2300 B
Warrington, PA 18976
215-343-3091

This document describes how I, Shari Lynn Pescatore, LPC may use and disclose Psychological, medical and financial information about you (protected health information – PHI) that is in our possession. It also describes how you can access this information. We may change our privacy practices at any time as allowed by state and federal law. If we make a significant change in those practices, we will amend this Notice and make the new Notice available on request. To request a copy of our Notice or for more information about our privacy practices, please contact Shari Pescatore at 847 Easton Road Suite 2300 B Warrington, Pa 18976. Please review this notice carefully.

I. TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Federal law does not require us to obtain consent to use or disclose your PHI for treatment, payment and health care operations. Accordingly, we may use or disclose your to another health care professional to provide treatment to you. We may use or disclose your PHI to obtain payment for services we provide to you or to determine eligibility or coverage for services. We may also use your PHI in connection with
performance and operation of my practice which includes quality assessment, licensure and credentialing activities, training, audits, administrative services, case management and care coordination, among other similar activities.

II. USES PURSUANT TO AN AUTHORIZATION

As permitted by federal and state law, we may disclose your PHI with your consent. You may generally revoke your consent in writing at any time to the extent we have not already relied on that consent. It is understood that such consent may authorize the release of information to which you have not had access or to information that has not been generated at the time of the execution of the release.

III. FURTHER DISCLOSURES

Federal and state law does not require patient consent for the following disclosures:

A. Child abuse: We must report to the local Department of Social Services information that leads us to reasonably suspect child abuse or neglect. We must also comply with a request from the Director of the Department of Social Services to release records relating to a child abuse or neglect investigation.

B. Adult abuse: We must report to the local Department of Social Services information that leads us to reasonably suspect that a disabled adult is in need of protective services.

C. Judicial/Administrative Proceedings: We must comply with an appropriately issued court order or subpoena requiring that we release your PHI.

D. Serious Threat to Health or Safety: We may disclose your PHI to protect you or others from a serious threat of harm.

E. Worker's Compensation: Under certain circumstances, we may disclose your PHI in connection with a Worker's Compensation claim that you have filed.

F. As Required by Law: There may be other instances where either federal or state law requires that we release your PHI.

IV. PATIENT RIGHTS

A. You have a right to request restrictions on certain uses and disclosures of PHI; however, federal law does not require that we comply with all requests.

B. You can request and receive confidential communications of PHI by specified means and at alternative locations.

C. You may inspect or obtain a copy of PHI in certain circumstances. If we deny you that right, you may have this decision reviewed. We will answer your questions concerning the details of the reviewing process.

D. You may request an amendment of PHI so long as we maintain that PHI in our records. Federal law does not require us to agree to each such request. We will answer your questions concerning the amendment process.

E. You have a right to receive an accounting of most disclosures of PHI for which you have not provided consent. We will answer your questions concerning the accounting process.

F. You have a right to obtain a paper copy of this notice from us upon request, even if you have received this notice electronically.

V. QUESTIONS

G. If you have questions about this notice, disagree with a decision we make about access to your PHI or have other concerns, contact Shari Pescatore, Licensed Professional Counselor, PC004016 (215) 343-3091. You may also file a complaint with the Secretary of the US Department of Health and Human Services. We can provide you with that address. You have the right to be free from retaliation from us for exercising your right to file a complaint.
This policy is effective this 1st day of September, 2008.

Acknowledgment of Receipt of Privacy Notice

I have received a copy of this firm's Notice of Privacy Practices.
Signature: _____

Date: _____

SHARI PESCATORE, LPC
847 EASTON ROAD
SUITE 2300 B

WARRINGTON, PA 18976
215-343-3091

I am now requesting that all clients have a current credit or debit card number (MasterCard, American Express or Visa) on file. This card will only be charged in the event that you have an outstanding balance on your account that is not met within 30 days of the statement date OR if you cancel less than 48 hours of your next appointment. If you would like your credit card to be charged for any given session it can be done upon your request.

Thank you.

Please let me know if you have any questions about this. Thank you.
Credit Card Information

Client Name _____

(Please print)

Name on Card _____

Card Number _____

Three digit/four digit code _____

on front/back of card

Expiration Date _____

I authorize Shari Pescatore, LPC to bill my credit or debit card in accordance with the terms stated above.

(Signed) _____

Date _____