

**Dr. Suzanne Veilleux, LLC
Clinical Psychologist**

CLIENT INTAKE FORM

Last Name _____ Middle Initial _____ First Name _____

DOB _____ SSN _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Billing Address _____

City _____ State _____ Zip _____

Mailing Address _____

If different than billing address – If same as billing check here ()

City _____ State _____ Zip _____

Email Address _____

Referred by _____ Primary Physician _____

Emergency Contact Info

Name _____ Relationship to Patient: _____

Cell Phone#: _____ Home Phone#: _____

PRIMARY INSURANCE: BILLING / INSURANCE INFORMATION: Responsible party information:

Subscriber/Policy Holder Name _____ Relationship to Patient _____

Subscriber SSN _____ DOB _____ Cell Phone #: _____

Insurance Company: _____ Insurance Phone#: _____

Policy/Member ID #: _____ Group Name: _____ Group Number: _____

SECONDARY INSURANCE: BILLING / INSURANCE INFORMATION: Responsible party information:

Subscriber/Policy Holder Name _____ Relationship to Patient _____

Subscriber SSN _____ DOB _____ Cell Phone #: _____

Insurance Company: _____ Insurance Phone#: _____

Policy/Member ID #: _____ Group Name: _____ Group Number: _____

Signature _____ **Date** _____

Current Symptoms/Problem Checklist: Please check any symptoms....

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Family Issues |
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increase risky behavior | <input type="checkbox"/> Avoidance | <input type="checkbox"/> Legal Issues |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Increased/decreased libido | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Loss/Bereavement |
| <input type="checkbox"/> Concentration/Memory | <input type="checkbox"/> Decrease need for sleep | <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> Pain Issues |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Excessive guilt | |
| <input type="checkbox"/> Increased irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Crying spells | |

OTHER: _____

Suicide Risk

Have you ever tried to harm yourself in the past? Yes No.

Have you had any recent thoughts, or do you currently have any thoughts of suicide? Yes No.

Medical History: Allergies _____ Current Weight _____ Height _____

List ALL current medications and how often you take them/dosage:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current over-the-counter medications or supplements: _____

Current/Past major medical problems (chronic illness, surgeries, hospitalizations...)

For women:

Date of last menstrual period: _____ Are you currently, or do you think you are pregnant? Yes No.

Are you planning to get pregnant in the near future? Yes No

Family History (Medical/Psychiatric Diagnoses, Substance Abuse or Self-Injury/Suicide):

Past Psychiatric History

Outpatient treatment Yes No. If yes, Please describe when, by whom, and nature of treatment.

Psychiatric Hospitalization Yes No If yes, describe for what reason, when and where.

Past Psychiatric Medications: If you have ever taken any of the following medications (please circle).

Mood/Thoughts: Prozac, Zoloft, Luvox, Paxil, Celexa, Lexapro, Viibryd, Effexor, Cymbalta, Wellbutrin, Remeron, Serzone, Anafranil, Pamelor, Tofranil, Elavil, Tegretol, Lithium, Lamictal, Tegretol, Topamax, Seroquel, Zyprexa, Geodon, Abilify, Clozaril, Haldol, Prolixin, Pristiq, Brintellix, Fetzima, Savella

Sleep: Ambien, Lunesta, Sonata, Rozerem, Restoril, Desyrel/trazodone

ADHD: Adderall, Concerta, Ritalin, Vyvanse, Focalin, Dexedrine, Strattera

Anxiety: Xanax, Ativan, Klonopin, Valium, Restoril, Librium, Tranxene, Buspar, Vistaril, Benadryl, Propranolol

Other: _____

Any negative/positive experiences with these medications? _____

Substance Use:

Do you (or others) think you may have a problem with alcohol or drug use? () Yes () No

Have you ever been treated for alcohol or drug use or abuse? () Yes () No

If yes, for which substances and when/where were you treated? _____

Days/week drinking alcohol: _____ Avg. Number drinks/day: _____ Most drinks/day: _____

Do you have current/past problems with the use/abuse of illegal substances? If so, which substances?

Have you abused prescription medication? If so, which medications? _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History: active _____ past _____

Family Background and Childhood History:

Where were you born? _____ where did you grow up? _____

Were you adopted? () Yes () No

Did your parents' divorce? () Yes () No Your age at their divorce: _____ you lived with _____

List your siblings and their ages: Sisters (ages) _____

Brothers (ages) _____

Educational History: What is your highest educational level or degree attained? _____

Spiritual life: Do you belong to a particular religion or spiritual group? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? () Yes () No.

Occupational History:

Are you currently: () Working () Not working by choice () Unemployed () Disabled () Retired

What is/was your occupation? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Relationship History and Current Family:

Are you currently: () Married () Divorced () Single () Widowed

How long? _____ Total number of marriages? _____

If not married, are you currently in a relationship? () Yes () No If yes, how long? _____

Do you have children? () Yes () No. If yes, list ages and gender _____

Legal: Have you ever been arrested? _____ Do you have any pending legal problems? _____

DR. SUZANNE VEILLEUX, LLC

OFFICE POLICIES AND FINANCIAL AGREEMENT

I. POLICY RELATING TO PAYMENT FOR SERVICES

Psychotherapy services may be totally or partially covered by insurance or some form of managed care. If you plan to use your insurance to pay for my services, you must provide me with the specifics of your insurance before we begin therapy. With such information, I will be able to determine the amount of your deductible and of your co-pay, if you have any. In addition, some insurance contracts require authorization before services are rendered. Under such contracts, if pre-authorization has not been obtained, payments are denied. Please understand that decisions about coverage are made by your insurance company; it is ultimately your responsibility to inquire about your coverage for mental health services.

Please note that requested services may not be covered by your insurance. If you have any questions about what is likely to be covered, please make sure to address these issues with me and with your insurance company in advance.

1. FEE FOR SERVICE

If you are paying out-of-pocket, **I DO NOT OFFER PAYMENT PLANS**. Also, **charges are subject to change**. All payments for services are due at the time the service is rendered and fees will be collected prior to each session.

Time in excess of standard sessions is prorated. Fees for special services (e.g., letter preparation and writing, obtaining prior authorization when needed, and/or any other forms of paperwork) need to be agreed upon separately and a prorated fee will be charged. When requesting any service, it is best to inquire in advance what the charge will be. In the event that I am personally subpoenaed to testify in any proceeding, or any deposition, or requested to produce any files, documents and/or records by any party, any attorney, or any Court in any matter relating to you, you agree to pay for my professional time and expenses as well as any related attorney fees and costs.

2. INSURANCE (NON-PROVIDER)

If you have insurance but I am not a participating provider in your insurance plan, you will be responsible for the full amount of the charges unless a flat fee agreement for sessions has been previously agreed upon.

3. INSURANCE (PROVIDERS)

If I am a participating provider in your insurance plan, fees are reimbursed at the Usual and Customary rate allowed by my contract with your insurance company. Provided that services have been properly pre-authorized, you are responsible for any co-payment required by your insurance company and you are expected to pay for these at the time of service. Often, the amount is a percentage of the contracted fee. This percentage may change as determined by your insurance. If you have a deductible that has not yet been met, you will be required to pay the full fee for each session until it is. I will bill your insurance company for each session so that your deductible is reduced accordingly. Some services may not be covered under the mental health benefit of your insurance contract. If you request any not covered services, these will be billed directly to you. Please note that psychological testing and report writing is usually not covered by insurance.

II. POLICY ON MISSED/LATE APPOINTMENTS

You will be charged for all time reserved for you. With sufficient notice, an appointment can generally be cancelled or rescheduled. Failure to give **at least 24-hours' notice** of cancellation will result in a charge **at my fee-for-service rate which is \$170.00 for a 55 minute session**. Since insurance and managed care companies do not pay for missed sessions, you will be required to cover the full fee, even if you ordinarily only pay the co-pay/deductible. You can send a text or leave a message on my voice mail (843-368-6937) at any time to cancel an

appointment at least 24 hours prior to your appointment. **If you want to cancel a Monday appointment, you must text or call me before 3:00 pm on Saturday.**

III. CONFIDENTIALITY

The patient/provider relationship is privileged and is protected by the law and ethical standards. Ordinarily, no information can be released without your specific written approval. Certain legal circumstances can arise whereby written documents can be subpoenaed. In addition, I am mandated to report to Protective Services whenever there is reason to suspect abuse of a child in the care of an adult and abuse of a disabled person. Note that when you sign the Consent and Authorization Release Form, you are authorizing me to release information as noted.

Insurance companies generally require diagnostic/treatment information before they will agree to pay benefits. I will release that information to them with your permission, as indicated on the Consent and Authorization Release Form. I will discuss with you the diagnosis and any other information your insurance company requests. While this information is very sensitive and is generally treated as such by insurance carriers, I cannot guarantee that your confidentiality will be respected by any particular insurance carrier or employer of such insurance carrier. If you prefer that I do not release information to your insurance carrier for reimbursement purposes, you will remain responsible for the fee for services.

IV. PHONE CALLS/PHONE CONSULTATIONS

I typically return routine/non-urgent phone calls within the same business day if the message is left within normal business hours. My policy is to provide quality patient care through scheduled office visits and you may be directed to schedule an appointment

V. PHONE/SKYPE/FACETIME APPOINTMENTS

If your insurance company allows such appointments, these may be substituted for office appointments in the event you cannot be seen in person and will be charged at the same rate as an in-office appointment.

Disclosure: Information transmitted over a website, Skype, email, or phone may not be secure.

VI. EMERGENCIES

In the event of an emergency, please go to the nearest emergency room or call 911 immediately.

Your signature below indicates that you have read and understand the office policies and financial agreement.

Signature

Date

Social Security Number

Date of Birth

Cell Phone Number

Home Phone Number

Dr. Suzanne Veilleux, LLC

Cell: (843) 368-6937 Fax: (843) 757 7390

UNDERSTANDING REGARDING PAYMENTS FOR CANCELLED OR MISSED APPOINTMENTS

- Appointments are made according to your therapist's availability and at times that are convenient to you. If for any reason you need to cancel your appointment, you must call at least 24 hours in advance. If you cannot attend your session and need to cancel in less than 24 hours, you will be required to pay out-of-pocket for your missed appointment. Please note that neither insurance companies, nor Medicare pay for missed appointments. **The charge will be your therapist's regular out-of-pocket fee which is \$170.00 for a 55 minute session.**
- Your therapist and you both agree that a wait of 20 minutes, unless you call to indicate that you will be further late, will qualify for a missed appointment.
- If you wish to cancel a Monday appointment, please call or text your therapist directly on her cell phone at 843-368-6937 before 3:00 pm on the Saturday prior to your Monday appointment. If you leave a telephone message, the time of your cancellation will be determined by the date and time indicated on the voice-mail. Similarly, if you send a text, the time of your cancellation will be determined by the date and time indicated on your therapist's phone.
- Your therapist understands that there are situations beyond your control and you may believe that you should not be charged for appointments not cancelled on time due to such situations. However, please understand that her own financial obligations are not lessened when she misses an hour of work because she was not given sufficient time to fill that hour with another client; it should not be expected of her to assume the loss of such unforeseeable circumstances. You may have one such situation during the course of many months whereas, given the number of clients that she sees in a week, she may be faced with many such hours in a single month with the resulting loss of income. Consequently, you will be responsible for **any** appointment that was not cancelled within the 24 hours minimum requirement, **whatever the reason** for missing the appointment.
- Before agreeing to this Understanding and signing it, do not hesitate to ask any question you may have and clarify any misunderstanding.

By my signature below, I hereby acknowledge having been made aware of and fully understand the conditions and functioning of payments for missed appointments.

Client's Name:

DOB: _____ SS#: _____

Client's signature: _____ Date: _____

DR. SUZANNE VEILLEUX, LLC

CLINICAL PSYCHOLOGIST

ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND

ACCOUNTABILITY ACT (HIPPA)

I hereby acknowledge that a copy of Dr. Veilleux' *Notice of Privacy Practices*, which describes how my health information is used and shared, has been made available to me. I understand that Dr. Veilleux has the right to change this Notice at any time. I may obtain a current copy by visiting Dr. Veilleux' website at: <https://drsuzanneveilleux.com/>

_____/_____/_____
Signature of Patient or Personal Representative Date

Print Name

Personal Representative's Relationship to Patient

For Office Use Only

I have made a good faith effort to obtain a written acknowledgement of receipt of my Notice of Privacy Practices but was unable to for the following reason:

- Client refused to sign
- Client is unable to sign
- Other _____

Date

DR. SUZANNE VEILLEUX, LLC

CREDIT CARD AUTHORIZATION FORM

Please indicate which credit card you wish to use for any services rendered through this practice. The following cards are accepted: VISA, MASTERCARD, and DISCOVER. Service fees will be deducted from the designated account at the time services are rendered for office visits, (fees, co-pays, deductibles), and/or for no-show and missed appointments, and for cancelled appointments when less than 24 hours' notice was given.

PATIENT INFORMATION:

CLIENT'S NAME _____ DATE OF BIRTH _____

CARDHOLDER INFORMATION: *same as above*

NAME _____ PHONE #: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL: _____

I authorize Dr. Suzanne Veilleux to keep my credit card on file and charge/deduct for any service fees (listed above) from the credit or debit card ending in _____
(last four digits of card)

CREDIT/DEBIT CARD INFORMATION:

PLEASE PROVIDE YOUR PAYMENT INFORMATION BELOW.

CARD TYPE (circle one): **VISA** **MASTERCARD** **DISCOVER**

CARD #: _____ EXP. DATE: ____/____/____ CVV: _____

CARDHOLDER SIGNATURE

DATE