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_____

Dr. Suzanne Veilleux, LLC Name: _____

NEW CLIENT HISTORY Date: _____

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

( ) Depression	( ) Racing thoughts	( ) Excessive worry	( ) Substance Abuse
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety/Panic	( ) Family Issues
( ) Sleep disturbance	( ) Increase risky behavior	( ) Avoidance	( ) Legal Issues
( ) Loss of interest	( ) Increased/decreased libido	( ) Hallucinations	( ) Loss/Bereavement
( ) Concentration/Memory	( ) Decrease need for sleep	( ) Suspiciousness	( ) Pain Issues
( ) Change in appetite	( ) Excessive energy	( ) Excessive guilt	
( ) Increased irritability	( ) Fatigue	( ) 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, Latuda, Depacote
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.

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

With sufficient notice, an appointment can generally be cancelled or rescheduled. Failure to give **at least 24-hours' notice** of cancellation will result in my notifying Medicaid of your failure to abide by this agreement. 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 CANCELLED 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.

- Your therapist and you both agree that a wait of 20 minutes, unless you call at 843-368-6937 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 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.

- Please understand that your therapist's financial obligations are not lessened when an hour of work is missed because there was not sufficient time given so as to fill that hour with another client. Given that Medicaid clients, due to their financial limitations, cannot be personally charged for a missed appointment or for an appointment not cancelled on time, as are other clients, your therapist's only recourse for non-compliance with cancellation requirements is to refuse to give you further appointments and to notify Medicaid.

- 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 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**