PATIENT ID _____

Alissa Dillon, LMHC, LCMHC

Kingston, NH 03848
(978) 857-6549

NAME Date of Birth: Age __

ADDRESS:

Street City State Zip

Cell Phone: Email:

Insurance Plan Phone #:

Policy # Group #:

Subscriber Information if different than above: Relationship DOB:

Name

Address & Phone #

##########

PLEASE **CHECK** THE FOLLOWING STATEMENTS:

- ☐ Failure to attend scheduled appointments will result in **termination** of my services.
- ☐ Missing appointments will result in a fee of $75, which **must be paid** prior to scheduling another appointment.
- ☐ I agree to pay insurance copays, deductibles and other fees as applicable.
- ☐ I authorize the release of any medical information necessary to process this claim and payment for services to Alissa Dillon.
- ☐ Your medical record is confidential will not be released to a third party without your approval

  UNLESS:

  - You are at a risk of committing harm to yourself or another person
  - You are at risk of harm (abuse or neglect) by another person
  - You are experiencing a medical event and it is considered an emergency
  - You require emergency mental health screening and/or hospitalization
  - A release of information for an emergency contact may be requested

Patient or Parent/Guardian: Date:

Alissa Dillon, LCMHC
Kingston, NH 03848

Client Name: Client #: _____

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- Individual Therapy: 45 minutes $150
- Missed appointment fee: **$75** which must be paid prior to scheduling another appointment.
- Cancellation with less than 24 hour notice: **$ 50**

- **I understand I am responsible for any balance insurance did not cover**
- **Payments are due at the time of rendered service**
- **Outstanding fees MUST be paid prior to scheduling another appointment.**
- **Failure to pay may result in termination of services.**

Client Signature Date

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****REQUIRED**** Keep credit card information on file for payments of copays, insurance deductibles and other fees as applicable

Credit Card Information: **Co-pay amount: $**

Please enter your credit card number below as payment for your co-pays/appointment fees

Type: ☐ Visa ☐ Mastercard Expiration: 3 digit code:

Number: zip code:

Name on card:

I authorize Alissa Dillon to charge my credit card for services rendered and other fees if applicable.

Client Signature Date

Client Questionnaire

Client Name Client # _____

In your own words, why are you seeking treatment today? (If patient is a minor, what are parent's concerns)

Mark an 'X' for each behavior or feeling you are/have recently been experiencing:

☐ Angry ☐ Guilty ☐ Restless ☐ Fearful ☐ Sad ☐ Anxious ☐ Unhappy

☐ Other

☐ Drinking more than usual ☐ Decrease in motivation ☐ Suicidal thoughts

☐ Engaging in risky behaviors ☐ Poor concentration ☐ Aggressive behaviors

Sleeping: ☐ increased ☐ decreased ☐ Nightmares

Difficult with: ☐ falling asleep ☐ staying asleep

Appetite: ☐ increased ☐ decreased

Employment

Support network (family/friends/etc.)

Support network (friends/family/etc) Describe relationship with significant others/partners

Number of children Current living situation

Significant life events: (Marriages/divorces/deaths/losses)

Current life Stressors

Have you been in therapy before? **(If yes, How long ago?):**

Are you CURRENTLY in treatment with another therapist? If yes, Clinician's name:

Are you taking any medications:

What do you hope to gain from treatment?

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name DOB

I authorize Alissa Dillon, LMHC, LCMHC to

☐ Obtain ☐ Disclose ☐ Exchange ☐ Emergency Contact

my protected health information, including psychiatric/mental health information with:

Name:

Address:

Phone/Fax:

Information that may be obtained/disclosed/exchanged include: (check all that apply)

☐ Intake Assessment ☐ Treatment Plan ☐ Progress Notes

☐ Psychiatric Evaluation ☐ Primary Care Doctor for coordination of care

☐ Other (please specify)

Date of treatment: to **OR** ☐ **All** dates of treatment

- I understand I may revoke this release of information at any time by informing both parties of my decision. This release will expire upon termination or completion of services.
- In cases where joint custody of a child exists, records/information may be released to each parent, at the clinician's discretion.

** I authorize the release of information pertaining to drug/alcohol treatment. (I may refuse release of this information).

The purpose of this release is:

Client (Parent/Guardian) Date

Witness Date