PATIENT ID ______________

Alissa Dillon, LMHC, LCMHC, CPC

Kingston, NH 03848
(978) 857-6549

NAME [ ] Date of Birth: [ ] Age __[ ] _______

ADDRESS:

[ ] _

Street City State Zip

Cell Phone: [ ] Email: [ ]

##

Insurance Subscriber Information (**If Different** from patient information above):

Person's Name [ ] Relationship to patient: [ ] DOB: [ ]

Address [ ] Phone [ ]

Authorization number (if required): [ ]

##

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, LMHC, LCMHC, CPC
Kingston, NH 03848

Client Name: ____________ Client #: ________

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Private pay prices:

- Individual Therapy: 45 minutes $125
- Missed appointment fee: **$75** which must be paid prior to scheduling another appointment.
- Cancellation with less than 24 hour notice: **$ 50**

Notice

- 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 any fees may result in termination of services.
- A card on file will be automatically charged in the event of a missed appointment or will be due upon receipt of invoice.

____________________ ____________
Client Signature Date

****

You may keep a 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 (if different from patient): ____________

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

____________________ ____________
Client Signature Date

Client Questionnaire

Name ______ Age ______ Client # _________

Why are you seeking treatment today? (If patient is a minor, what are parent's concerns)

Please type into each box; text doesn't always continue onto the next line.

Please check the box for any behavior or feeling you are/have recently been experiencing:

- ☐ Angry ☐ Restless ☐ Sad ☐ Anxious ☐ Generally Unhappy
- ☐ Other ______ ☐ Aggressive behaviors ☐ Decrease in motivation
- ☐ Engaging in risky behaviors ☐ Poor concentration ☐ Suicidal thoughts ☐ Thoughts to harm others

Sleeping: ☐ increased ☐ decreased ☐ Nightmares

Employment ______ Number of children ______

Support network: Friends/family/significant others

Current living situation

Significant life events or 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: ______

Have you been diagnosed with a mental health disorder? If so, list here:

Prescribed medications:

Prescriber:

Alcohol or drug use: please explain:

Family history:

Parents ◯ Married ◯ Divorced ◯ Never married

Is mother or father married to someone other than your parent?

Mother: ◯ Living ◯ Deceased Have a relationship with her?

Father: ◯ Living ◯ Deceased Have a relationship with him?

Sibling ◯ Living ◯ Deceased Have a relationship w/ him/her?

Sibling ◯ Living ◯ Deceased Have a relationship w/ him/her?

Deaths or Losses you have experienced:

Trauma history:

Childhood Teenage Years Current

Physical Verbal/Emotional Sexual

Have you received any treatment for these losses or traumas?

Do you know about EMDR? Eye Movement Desensitization and Reprocessing

Have you had EMDR treatment before? If so, when:

Have you lost any friends or family members to suicide?

Have you ever attempted suicide?

Thank you for taking the time to complete this form. I look forward to working with you.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name ______________________ DOB __________

I authorize Alissa Dillon, LMHC, LCMHC, CPC to

☐ Obtain ☐ Disclose ☐ Exchange ☐ Emergency Contact

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

Name: ______________________

Address: ______________________

Phone: ______________________

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 (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