

**Alissa Dillon, LMHC, LCMHC, CPC**  
**14 Front Street, Suite 3-4**  
**Exeter, NH 03833**  
**(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/EAP number (if required):

**PLEASE EMAIL ME A COPY OF YOUR INSURANCE CARD, BOTH FRONT AND BACK. THANK YOU.**

#####

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:

# Patient Questionnaire

Name

Age

Patient # \_\_\_\_\_

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

## Please check any symptoms you have been experiencing for the past 1-3 months:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fear   | <input type="checkbox"/> Anger                     | <input type="checkbox"/> Anxious        |
| <input type="checkbox"/> Difficulty falling asleep                                      | <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Nightmares     |
| <input type="checkbox"/> Frequent feelings of guilt                                     | <input type="checkbox"/> Feeling numb              | <input type="checkbox"/> Flashbacks     |
| <input type="checkbox"/> Avoiding people/places   | <input type="checkbox"/> Racing thoughts           | <input type="checkbox"/> Hypervigilance |
| <input type="checkbox"/> Change In appetite   | <input type="checkbox"/> Large gaps in memory      | <input type="checkbox"/> Frequent worry |
| <input type="checkbox"/> Repetitive Behaviors (counting, checking doors, washing hands) |  |   |
| <input type="checkbox"/> Intrusive thoughts/ images/ memories                           |  |   |
| <input type="checkbox"/> Thoughts/plans/intent of harming self or ending your life      | <input type="checkbox"/> Suicide attempt           |   |
| <input type="checkbox"/> Thoughts/plans/intent of harming someone else                  |  |   |

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## Therapy information

- |  |   |
|--|---|
| <input type="checkbox"/> I have been in therapy before                   | <input type="checkbox"/> How long ago?                          |
| <input type="checkbox"/> I am currently in therapy                       | <input type="checkbox"/> Name of therapist <input type="text"/> |
| <input type="checkbox"/> Previous or current diagnosis:                  | <input type="text"/>  |
| <input type="checkbox"/> I was in treatment for my traumatic experiences |   |
| <input type="checkbox"/> I am prescribed medications:                    | <input type="text"/>  |
| <input type="checkbox"/> Prescriber:                                     | <input type="text"/>  |

Deaths or Losses you have experienced:

**Trauma history:**

- Childhood       Teenage Years       Current  
 Physical       Verbal/Emotional       Sexual

History of Concussions       Date of most recent concussion

**Perpetrator:**

- Parent       Another relative       Neighbor  
 Friend/peer       Partner/ spouse       Unknown

Have you lost anyone to **suicide**?  Yes       No

Friend(s)       Co-worker       Classmate

Family member(s)

Have you lost anyone to **homicide**?  Yes       No

If so, who:

I have memories of my traumatic events

I do not have memories of my traumatic events

I am familiar with EMDR

I have been treated with EMDR

I have little to no knowledge about EMDR

## Current Information

Employment  Current Living Situation

Single  Married  Divorced  Widowed  Number of children

Support network: Friends/family/significant others

Current living situation

Significant life events or stressors

Substance use:  Alcohol  Marijuana  Other:

Do you have an issue with any substances?

Family history of substance abuse?  Mother  Father  Guardian  Sibling

Mother:  Alive  Have a relationship with her  Deceased

Father:  Alive  Have a relationship with him  Deceased

Sibling:  Alive  Have a relationship with her  Deceased

Sibling:  Alive  Have a relationship with her  Deceased

Where did you learn about my services?

Friend/Colleague  Employer  Google search  Psychology Today.com

Thank you for taking the time to complete these forms. I will be in touch with you to schedule an appointment. I look forward to working with you.

The release of information on the next page is **optional**, if there is someone (family member, provider) you want me to contact.

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME  DOB

**I authorize Alissa Dillon, LMHC, LCMHC, CPC to**

Obtain  Disclose  Exchange  Emergency contact

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

Name:  Phone:

Address:

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

Intake Assessment  Treatment Plan  Progress Notes

**To have communication with:**  Family member  Friend  
 Therapist  Psychiatrist/ Nurse Practitioner  Primary Care Provider

Other (specify):

***The purpose of this release is for continuity of care.***

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).

Patient (Parent/Guardian)

Date

Witness

Date

Alissa Dillon, LMHC, LCMHC, CPC  
Exeter, NH 03833

Patient Name:

Patient #: \_\_\_\_\_

\*\*\*\*\*

**Private pay prices:**

- 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**

**\*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.

Patient Signature

Date

\*\*\*\*\*

You may 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 (if different from patient):

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

Patient Signature

Date