PATIENT ID _____

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:

☐ Fear ☐ Anger ☐ Anxious

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Nightmares

☐ Frequent feelings of guilt ☐ Feeling numb ☐ Flashbacks

☐ Avoiding people/places ☐ Racing thoughts ☐ Hypervigilance

☐ Change In appetite ☐ Large gaps in memory ☐ Frequent worry

☐ Repetitive Behaviors (counting, checking doors, washing hands)

☐ Intrusive thoughts/ images/ memories

☐ Thoughts/plans/intent of harming self or ending your life ☐ Suicide attempt

☐ Thoughts/plans/intent of harming someone else

Therapy information

☐ I have been in therapy before _____ How long ago?

☐ I am currently in therapy ☐ Name of therapist _____

☐ Previous or current diagnosis: _____

☐ I was in treatment for my traumatic experiences

☐ I am prescribed medications: _____

☐ Prescriber: _____

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 #: _____

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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

_____ _____