

**John Paul Jones, Ph.D.**

**Licensed Psychologist**

651 North Otsego Avenue  
Gaylord, Michigan 49735

Telephone: (989)732-6488  
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**CLIENT INTAKE INFORMATION SHEET**

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_ Emergency: \_\_\_\_\_ Yes \_\_\_\_\_ No

Client Name: \_\_\_\_\_ If Child, Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Telephone: (Home) ( \_\_\_\_\_ ) (Work) ( \_\_\_\_\_ )

Services Requested: \_\_\_\_\_

Assigned To: \_\_\_\_\_ First Appointment Time \_\_\_\_\_

Client D.O.B.: \_\_\_\_\_ S.S.N. \_\_\_\_\_ Driver's License: \_\_\_\_\_

Name of Employer or School: \_\_\_\_\_

Which is Best to Call: Home Work  
When Best to Call: Morning Afternoon Evening

In Emergency, Contact: \_\_\_\_\_ Phone# ( \_\_\_\_\_ )

**INSURANCE INFORMATION**

**DIAGNOSIS CODE: \_\_\_\_\_**

Primary Carrier

Secondary Carrier

Insurance Company: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Telephone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Telephone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Policy/Contract #: \_\_\_\_\_

Policy/Contract #: \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

Deductible: \$ \_\_\_\_\_

Deductible: \$ \_\_\_\_\_

Coverage: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Coverage: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Maximum/Year: \_\_\_\_\_

Maximum/Year: \_\_\_\_\_

Credentials Accepted: \_\_\_\_\_

Credentials Accepted: \_\_\_\_\_

Verified By: \_\_\_\_\_ Date: \_\_\_\_\_

Verified By: \_\_\_\_\_ Date: \_\_\_\_\_

**JOHN PAUL JONES, Ph.D.**  
**LICENSED PSYCHOLOGIST**

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**Fee Agreement**

	<b>Intake</b>	<b>Individual</b>
<b>Initial Intake or Individual</b>	\$ _____	\$ _____
<b>Deductible Not Met</b>	\$ _____	\$ _____
<b>Estimate Insurance Amount</b>	\$ _____	\$ _____
<b>Client Co-Payment Amount</b>	\$ _____	\$ _____
<b>Professional Courtesy</b>	\$ _____	\$ _____
<b>Deductible:</b> _____	<b>EAP:</b> Yes	No
<b>Total Charge Per Hour</b>	<u>Intake</u> \$210.00	<u>Individual</u> \$130.00

These are estimated amounts and are not a guarantee of benefits. Responsibility for payments remains with the client. The above fee schedule takes effect after the deductible is met. I understand that adjustment is in conjunction with the Professional Disclosure Statement.

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Client Signature

Date

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Therapist Signature

Date

*JOHN PAUL JONES, Ph.D.*  
*LICENSED PSYCHOLOGIST*

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**IMPORTANT POLICY INFORMATION**

Please be aware **late cancellation** of a scheduled appointment and **no show** for scheduled appointments **may be charged to you**. Your insurance policy will not pay for these late cancellation and no show of appointments.

You must cancel **24 hours prior to your appointment time** to avoid a late cancellation charge.

We do not charge for an emergency situation beyond your control.

My signature below indicates I have been made aware of this policy.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**JOHN PAUL JONES, Ph.D.**  
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**HIPAA Summary**

Welcome to our practice. The following is a summary of the HIPPA rules and regulations that we must provide you with by law. If you wish not to read the attached this summary will provide you with the key points. Please sign below after reading. Thank you.

This clinic is private and is not funded with any government money. Expenses have to be met by our resources; therefore most clients pay for services through insurance benefits. Most insurance companies pay for part of the fee. Any portion of the fee not covered by insurance benefits is the responsibility of the client. We will be glad to assist you in verifying insurance coverage's and in our office will submit insurance claims on your behalf.

Unless other arrangements are made this clinic's fee is \$ 210.00 per hour for the initial consultation (first hour) and \$130.00 per hour for an individual consultation. Co-pays and deductibles are collected at each session. A typical session begins on the hour and terminates ten minutes to the hour (i.e. 5:00-5:50). Fees for other services (i.e. psychological testing, medication reviews) are discussed with clients prior to them being initiated. Our office has a 1.5% interest rate for all balances over 60 days past due. If appointments are not canceled 24 hours prior to the scheduled time the client will be charged for that appointment.

All client information is confidential, but this clinic adheres to professional ethics and legal standards. Legal limits on confidentiality are in effect in cases involving: potential suicide, potential homicide, court orders and in cases of child abuse or neglect.

You may examine and/or receive a copy of your clinical record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. HIPAA provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your clinical records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records.

Professional counselors, psychologists and social workers in Michigan are regulated by the Department of Licensing, Regulation and Health Investigation Division, P.O. Box 30018. Lansing, Michigan 48909, 989-373-1737

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form as described above.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\*If you would like a copy of the full HIPAA Compliance Laws, please feel free to ask the receptionist.

## GENERAL SYMPTOMS

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Check off any of these symptoms which have been most bothersome or have occurred frequently during the last 8 weeks.

- Repetitive senseless thoughts
- Repetitive senseless behaviors
- Fainting or feeling faint
- Tremors, trembling or shakiness
- Seizures
- Skin rash
- Violent behavior/Thoughts
- Constant worry
- Irritability
- Tension
- Headaches
- Feeling in a dreamlike state
- Fearful feelings
- Fear of losing control
- Jumpiness
- Restlessness
- Sweating
- Dizziness/Lightheadedness
- Keyed up/On edge
- Agitation
- Nervousness
- Trouble concentrating
- Insomnia/Trouble sleeping
- Decrease in sex drive
- Frequent thoughts about sex
- Trouble making decisions
- Sad/Depressed/Down in the dumps
- Lack of/Loss of interest in things
- Having suicidal thoughts
- Fatigue/Lack of energy
- Weakness
- Increase or decrease in appetite
- Increase or decrease in weight
- Frequent crying or weeping
- Frequent thoughts of death or suicide
- Excessive feelings of guilt
- Increased feelings of self-importance

- Feeling life is not worth living
- Racing thoughts
- Excessively high mood
- Frequent negative thinking
- Memory problems
- Fear of doing something uncontrollable
- Fear of dying
- Chills
- Seeing or hearing things that are not real
- Fear of going crazy
- Fear that someone is out to get me
- Feeling worthless
- Feeling hopeless
- Feeling useless
- Feeling helpless
- Feeling discouraged
- Feeling sad
- Feeling mad/angry
- Lack of self-esteem
- Having panic attacks
- Having flashbacks of a trauma situation
- Muscle tension
- Tingling sensation (hands, feet, etc.)
- Feeling paranoid
- Eating problems
- Feeling jealous
- Withdrawing from people
- Having mood swings
- Loss of motivation
- Had a closed head injury
- Suffered from a lot of physical pain
- Drinking too much
- Abusing drugs
- Abusing prescription drugs
- Hyper/ Can't relax
- Obesity/Overweight
- Shy/Avoid social situations

If you have any other symptoms that you would like to list, please list them in the area below:

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