



Shari Pescatore, LPC
Certified Cognitive Behavior Therapist
847 Easton Road
Suite 2300 B
Warrington, PA 18976
(215)- 343-3091

INTAKE FORM

Name: _____ Date of Birth: _____

Street Address: _____

City _____ State: _____

ZIP _____ Home phone: _____

Cell _____ Work: _____

E-mail: _____ Other: _____

How did you first here of me? _____

Person to contact in an emergency: _____

Phone: _____

Address: _____

Relationship to you _____

Persons with whom you live and their relationship to you:

_____	_____
_____	_____
_____	_____
_____	_____

Pets (type/names): _____

Children: NO _____ YES _____ (Please answer below)

Name	Age	Date of birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Occupation or work emphasis _____ Years of Education _____

Education major or training:

Employer _____ Years worked there _____

Marital status (i.e. single, married, separated, divorced, and living with partner)

_____ Spouse/partner name: _____

Do you experience any of the following? Abdominal Pain ___ Changes in Appetite ___ Dizziness ___
Headaches ___ Fatigue ___ Frequent Urination ___ Fainting Spells ___ Chest Pain ___ Rapid Heart Rate ___
Breathing Problems ___ Nausea ___ Colds ___ Nose bleeds ___ Constipation ___ Sore throat ___ Coughs ___ Menstrual
Problems ___ Memory Problems ___ Weight loss/gain ___

List any of the operations, Medical Procedures or Hospitalizations for medical, psychiatric/emotional, drug or alcohol problems. Please include Dates:

List any medications presently taking and whom prescribed:

May we contact your physician, If yes please sign for your permission:

Signature

Date

Legal Status i.e. Are you currently involved with the criminal justice system?

Please help me understand what problems brought you to this office.

Check all that apply: ___ Marital ___ Job ___ Career ___ School ___ Alcohol ___ Substance Abuse ___ Depression
___ Moodiness ___ Self Confidence ___ Illness ___ Fatigue ___ Children ___ Family ___ Sexual Problems
___ Traumatic Experience ___ Loneliness

Other or elaborate on above:

Are you currently having any suicidal ideation?

Please explain why you are seeking therapy:

List some goals you may like to achieve through your counseling experience:

Previous Counseling or Psychotherapy? (Please designate when, where, with whom and whether it was as a child, adult, couple or court ordered)

Previous contact with psychiatrist for medication, or psychologist for psychological evaluation:

YES ____ NO ____

If so explain:

Insurance Company: _____ Policy #: _____

PRACTICE AGREEMENT

Welcome to my practice and thank you for entrusting me with your care. This document contains important information about my professional services and business policies. So that misunderstandings may be avoided, it is very important that you read these policies carefully and ask for clarification when needed. After reading this, please sign and date this form. If you have any questions or concerns about your care please contact me with your concerns.

WHAT TO EXPECT FROM OUR PRACTICE

(For those seeking a Certified Cognitive Behavior Therapist/Counseling): Our first few sessions will involve an evaluation of your needs. During this time, you and I will both decide if I am the best person to provide the services you need in order to meet your treatment goals. Once psychotherapy has begun, I will usually schedule one 45- 50 minute session. Once an appointment time is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (with the exception of illness or inclement weather).

FEE SCHEDULE

This practice accepts checks, payable to “Shari Pescatore, LPC.” as well as Master Card, American Express, Discover and Visa. The fees are as follows:

Initial Diagnostic Interview or Consultation: \$150.00

Counseling Session (including individual or family therapy): Standard 45-50 minute session \$130.00

Pre-scheduled 30 minute session: \$100.00

Telephone Consultations per quarter hour: \$45.00

Form Preparation, per quarter hour increments: \$35.00

Preparation or Attendance in Legal Proceedings, per hour: \$400.00

Missed appointment/Late cancellation: \$75.00

Returned Checks: \$45.00

For other services not listed above, please discuss with your therapist. You will be expected to pay for each session in full at the time it is held, unless we agree otherwise or unless you have insurance coverage, which requires another arrangement. In addition, during the course of therapy it may become necessary to increase fees to compensate for increased overhead costs and inflation.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. Please note that Shari Pescatore is an “*Out-of-Network*” provider for all other insurance carriers, other than Aetna and United Health Care. If you choose to file insurance, our office will gladly fill out a bill that will enable you to submit to current insurance carrier. Once you receive the claim forms from your insurance carrier you mail the bill I provided along with the claim form to your insurance company, who in turn, should mail you a check. We strongly recommend researching details about your mental health coverage. If you have a secondary health insurance company, you’ll need to find out that coverage and the interactions with the first coverage. It’s helpful to find out specifics of your mental health coverage with your insurance company by asking questions such as: *Is there a deductible? How many visits per year are covered? What are the dates of the benefit year? Which services are covered (e.g., couples therapy, group therapy)?*

You should also be aware that your contract with your health insurance company requires that this office provide it with information relevant to the services that your therapist provides to you, including a clinical diagnosis. Sometimes your therapist is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, your therapist will make every effort to release only the information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, your therapist has no control over what they do with it. In some cases, they may share the information with a national medical information databank. Your therapist, Shari Pescatore, will provide you with a copy of any report submitted, if you request it. By signing this Agreement, you agree that your therapist can provide requested information to your insurance.

Your therapist, Shari Pescatore, will gladly provide whatever assistance she can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of this practice’s fees. Also, please note that you always have the right to pay for your services without seeking insurance reimbursement in order to avoid the problems described above (unless prohibited by contract).

CANCELLATION POLICY: Your appointment time is reserved exclusively for you. Unless cancelled **at least 24 hours in advance**, you will be charged for the missed appointment/late cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. In case of inclement weather, the practice will be closed. If the weather conditions are questionable, please call my voice mail the morning of your appointment and listen for the outgoing message regarding the office opening. Late fees will not be applied in case of illness, hazardous driving conditions or emergencies.

CONTACTING YOUR THERAPIST: Prior to your initial visit, you will be provided with the office phone number and email address. Please note that email is not a secure form of communication, and its use is best for scheduling purposes. If someone is not available for your immediate attention, please leave a message on the voicemail and someone will make every effort to reach you within 24 hours of your call (with the exception of week-ends and holidays). For psychological emergencies, call 911 and go to your nearest hospital and ask for the psychiatrist on call. If someone will be unavailable for an extended period of time, you will be notified and referred to another colleague, as needed.

CONFIDENTIALITY: In general, the law protects the privacy of all communications between a client and a psychotherapist. In most situations, information can only be released about your treatment to others with your written permission, but there are a few exceptions. You should be aware that this practice contracts with independent business associates for administrative purposes, such as, billing and quality assurance.

Disclosures required by healthcare insurers or for overdue fee collection are discussed elsewhere in this Agreement. If the therapist believes that her client presents an imminent danger to his/her health or safety, she may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

If your therapist has cause to suspect that a child under 18 is abused or neglected, or if there is reasonable cause to believe that a disabled adult is in need of protective services, the law requires that a report is filed within the appropriate state agency. If the therapist believes that a client presents an imminent danger to the health of another, the therapist may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the Therapist/client privilege law. The therapist cannot provide information without your written authorization, or a court order. If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend our practice.

Sometimes it is helpful for the therapist to consult each other and other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our clients. The consultant is also legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless we feel that it is important to our work together.

CONFIDENTIALITY and COUPLES THERAPY:

When providing couples therapy, my objective is to work to help both partners improve their interactions so in this case, my primary client is the relationship. My goal as a couple's therapist is to enhance the couple's relationship; however that isn't always the effect. Sometimes, despite everyone's best efforts, individuals discover that their own self-interests and the interest of the relationship are not compatible. In those cases, my goal is to help couples end their relationship as amicably as possible and identify community resources to aid the healing process.

At times, this may mean meeting with each partner individually as part of the treatment. What is said in individual sessions will be considered a part of couple's therapy and may be discussed in our joint sessions. Do not tell me anything you wish to keep secret from your partner. I will use my discretion in revealing information, but if

information is told to me that's harmful to the couple and would interfere with treatment, I reserve the right to disclose information and/or terminate the couple's treatment, with the understanding that I cannot be the guardian of any one partner's secret from the other. If either partner would like to release a copy of the record, I cannot give it to you unless both of you agree as you both have the right to privacy. If the relationship breaks up and either or both of you wish to pursue individual counseling, I will use my discretion in deciding if I can continue working with you. Often in these cases, I refer to other therapists in order to minimize a conflict of interest.

ACCESSING RECORDS:

The laws and standards of our profession require that psychologists keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and your therapist believes that access is reasonably likely to cause substantial harm to such other person, 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 your therapist's presence, or have them forwarded to another mental health professional so you can discuss the contents.

A SEPARATE CONSENT TO RELEASE MEDICAL RECORDS form must be executed by the client before we can release these records. If your therapist refuses your request for access to your records, you have a right of review, which your therapist will discuss with you upon request.

Your signature below indicates that you have read this agreement and agree to its terms during our professional relationship.

Client's Name:

Signature:

Client's Name (partner/spouse in couple's therapy):

Signature:

Signature of Parent (if Child under age 14 years old)
