Welcome to Gearing Up! Psychologists and Counselors ("Gearing Up!"). We are delighted that you have chosen our practice. Please fill out the following MASTER INTAKE FORM. **Please note that if you are participating in either marital therapy, each partner must fill out an individual master intake form. If you are seeking services for your child, please complete the forms in his/her name.**

Please read this MASTER INTAKE FORM carefully and completely. There are _____ sections to this MASTER INTAKE FORM. Some sections must be filled out with your therapist in your initial session. In each section, you will be required to place your initials and sign where appropriate to indicate your understanding of the important matters contained in each section. If you are unable or unwilling to place your initials and signatures where required, Gearing Up! will be unable to assist you. Furthermore, completion and submission of this MASTER INTAKE FORM to Gearing Up! does not constitute the creation of any type of patient-client relationship and should not be viewed as implied consent by Gearing Up! to provide services to you. The agreement to provide services can be made only after the initial session with your therapist, the completion and submission of this MASTER INTAKE FORM, and the payment of any and all amounts due to Gearing Up! as detailed herein.

When filling out this MASTER INTAKE FORM, please be as thorough and candid as possible. The more we know about you, the more effective we can be in our efforts to help you. If the space provided for you in this MASTER INTAKE FORM is inadequate to respond to the question presented, please feel free to explain further on additional pages.

Section One: Basic Information

Patient Name:_____ Nickname:_____
If a Minor, Parents' Names: _____
Social Security #: _____ Street Address: _____
City: _____ State: _____ Zip Code: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____ Date of Birth: _____
Gender: _____ Marital Status: _____ Employer:_____
Occupation: _____ Employer's Address: _____
City: _____ State: _____ Zip Code: _____
Person Financially Responsible for Patient: _____ Relationship to Patient: _____
REFERRED BY: (Please fill out)_____ Relationship: _____
Insurance Company: _____ Phone: _____
Primary Insured's Name: _____ Their Social Security #: _____ I.D. #: _____
Relationship to Patient: _____ Date of Birth: _____ Group #: _____

Spouse's or Parent's Name: _____ Social Security #: _____
Street Address: (if different from Patient's) _____ City: _____
State: _____ Zip Code: _____ Home Phone: _____ Work Phone: _____
Cell Phone: _____ Date of Birth: _____ Gender: _____ Marital Status: _____
Employer: _____ Occupation: _____
Employer's Address: _____ City: _____
State: _____ Zip Code: _____ Emergency Contact Information: _____
Relationship: _____ Home Phone: _____ Work Phone: _____

I hereby assign all medical benefits, which include major medical benefits, to which I am entitled including private carrier and other health plans to Gearing Up!. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be as valid as the original. I understand that pre-certification for services by my insurance company does not guarantee payment for services rendered. **I understand that I am financially responsible for all charges whether or not paid by any insurance carrier**. I hereby authorize Gearing Up! to release all information necessary to

secure the payment for services rendered. I understand that the information contained in this document will be released to the appropriate collection agencies if I do not pay all fees for services rendered. I give my full permission to Gearing Up! to release all necessary information to collection agencies to collect all fees I incur.

I UNDERSTAND THAT I WILL BE CHARGED $80.00 EACH TIME I MISS OR CANCEL A SCHEDULED APPOINTMENT IF I FAIL TO CALL TO CANCEL WITHIN 24 HOURS BEFORE MY SCHEDULED APPOINTMENT. IF I AM IN ANY THERAPY PROGRAM THAT REQUIRES TWO THERAPISTS, I UNDERSTAND THAT I WILL BE CHARGED $160.00 EACH TIME I MISS OR CANCEL A SCHEDULED APPOINTMENT AND I FAILED TO CALL TO CANCEL WITHIN 48 HOURS. I AGREE TO PAY THESE LATE FEES BEFORE MY NEXT SESSION WILL BE SCHEDULED. Exceptions to this late-cancel fee include life-and-death emergencies and extreme illness. Work-related demands are NOT included.

I hereby authorize Gearing Up! to release all information necessary to secure all payments including any late cancel or "no show" fees that I incur. _____(initial)

I understand that I am required to pay my co-pay at the time of my appointment and that failure to pay my co-pay will release any obligation of Gearing Up to schedule any future appointments until all amounts due by me are paid in full. _____(initial)

If your child is being treated and you are married, the authorization to treat a minor must be signed by both parents before treatment of a minor can proceed. _____(initial)

Patient: _____ Date: _____
Spouse Signature: (must be signed by both spouses for relationship counseling) _____
Date_____
Parent/Guardian Signature_____ Date_____

Section Two: Personal Information

Age: _____ Present Marital Status: (Please circle and specify for how long) Single / Separated (How long?) _____
Divorced: (How many times?) _____ Married: (How many times?) _____ Widowed: (Date of Spouse's Death) _____
Highest grade completed academically? _____
Degrees earned: (If you attended college or graduate school, please specify where. Please include the date of degree(s):) _____
_____
_____
Profession: _____ Birthplace: (City, State, Country) _____
Father's Name: _____ Profession: _____ Living / Deceased: (please circle one)
If Deceased, when? _____ Mother's Name: _____
Profession: _____ Living / Deceased: (please circle one) If Deceased, when? _____
Spouse / Significant Other's Name: _____ Age: _____ How Long Married / Dating?_____
Siblings: (Ages and whether living or deceased) _____
_____
Children: (Ages and whether living or deceased) _____
_____

"Therapy That Works"

Symptom Checklist: (please check all that apply)

- ☐ Aggression/ Anger
- ☐ Alcohol Abuse
- ☐ Anxiety
- ☐ Avoidance of People
- ☐ Chest Pains
- ☐ Computer Addiction
- ☐ Depression
- ☐ Difficulty Thinking
- ☐ Distractibility
- ☐ Disinterest in Life
- ☐ Drug Abuse (Prescription or Street drugs)
- ☐ Dizziness
- ☐ Irritability
- ☐ Loneliness
- ☐ Memory Problems
- ☐ Mood Swings
- ☐ Muscle Tension
- ☐ Panic Attacks
- ☐ Obsessive Compulsive Disorder
- ☐ Restlessness/On Edge
- ☐ School Avoidance/Anxiety
- ☐ Sexual Addictions
- ☐ Sexual Difficulties
- ☐ Sleeping Problems
- ☐ Eating Disorder
- ☐ Elevated Mood
- ☐ Fatigue
- ☐ Fears
- ☐ Gambling
- ☐ Grief/Loss
- ☐ Hallucinations
- ☐ Headaches
- ☐ Feelings of Helplessness, Hopelessness
- ☐ Impulsivity
- ☐ Indecisiveness
- ☐ Stress
- ☐ Suicidal Thoughts, Gestures/Attempts
- ☐ Trauma
- ☐ Weight Gain/Loss
- ☐ Withdrawal
- ☐ Worrying
- ☐ Feelings of Worthlessness
- ☐ Other Symptoms

Please specify whether any of these problems affected anyone in your biological family. Were they treated successfully with medication and/or psychotherapy? (Please include their diagnosis, treatment and relationship to you.) _____

_____

_____

Family History

Does your family have a history of depression, anxiety or any other mental disorder? If yes, please explain in detail:

_____

_____

Previous Psychiatric Hospitalizations? _____ If you answered yes, when, where, how long and for what? _____

_____

_____ What was your diagnosis? _____

Previous Counseling? _____ If you answered yes, when, where, how long and for what? _____

_____

_____ What was your diagnosis? _____

Substance Abuse History (Please circle both Current and Past used substances)

Past Use Substances:

Tobacco Caffeine Marijuana Cocaine Crack Heroin Amphetamines LSD Ecstasy

Inhalants IV Drug Use Prescription Drugs (Include Names of Prescription Drugs) _____

Other: _____

Current Use Substances:

Tobacco Caffeine Marijuana Cocaine Crack Heroin Amphetamines LSD Ecstasy

Inhalants IV Drug Use Prescription Drugs (Include Names of Prescription Drugs) _____

Other: _____

Amount Used: _____ Frequency: _____ Date Last Used: _____

Additional Comments: _____

Please list any use of herbal supplements: _____

Do you misuse any over-the-counter medications? If yes, please explain: _____

Alcohol Frequency: (Please circle one) Never Less than 1 time/mth 1-4 times per mth 2-3 times per week Daily

Usual Alcohol Consumption: (Please circle one) None 1-2 drinks per sitting 3-4 drinks per sitting 5+ drinks per sitting

Intoxication Frequency: (Please circle one) Never Less than 1 time/mth 1-4 times per mth 2-3 times per week Daily

If you have participated in AA/NA, please describe: _____

_____

Current Problems
Please describe your presenting problem: _____
Why are you seeking psychological services at this point? _____

History of Legal Problems
Please describe any current charges, pending court dates, history of arrests, probation, convictions, or lawsuits in which you have been involved: _____
Are you currently involved in child custody litigation or impending divorce proceedings? If yes, please describe:
_____
If you are involved in litigation, please list the name of your attorney: _____
Please note that it is your sole responsibility to inform Gearing Up if you enter into any kind of child custody litigation or divorce proceedings: _____(initial)
If you are divorced or are the legal guardian of your child who is receiving therapy at Gearing Up, you are required to provide a copy of the divorce decree or court orders proving your authority to seek treatment for your child. _____(initial)

Forensic Work Agreement
The fees paid by client to the counselor under this Agreement contemplate in-office visits only. The counselor reserves the right, in the counselor's sole discretion, to decline to provide any services to client in any fashion or venue apart from a regularly scheduled in-office visit. Due to insurance reimbursement restrictions, to the extent client wishes to secure the counselor's services for any reason outside of the parameters of an in-office visit, including any and all matters compelled by lawful subpoena or court order pertaining to client matters, client must pay, in full and in advance, for such requested services according to the terms of this Agreement. To the extent any such additional services are reimbursed or covered by client's insurance, it is the client's sole responsibility to file any required or necessary paperwork to recover any fees charged by the counselor in this manner.

For any forensic or litigation-related services (whether in anticipation of a lawsuit or after the commencement of one), client agrees to pay counselor at the rate of $150 per hour (applied in quarter-hour increments, with a minimum three hour commitment required), including any time reasonably required for travel from and back to the counselor's office. Client agrees to advance funds to the counselor for any and all reasonably necessary costs of travel. To the extent possible, Client also agrees to give the counselor 21 days' advanced notice of any event requiring the counselor's attendance. Furthermore, should the counselor be required to reschedule existing appointments to comply with a subpoena or court order pertaining to client matters or to accommodate Client's request for services away from the office and the event is subsequently canceled through no fault of the counselor, Client agrees to pay the counselor's minimum three hour requirement.

Client understands, agrees, and consents that the counselor may disclose client's confidential information in the possession of counselor as reasonably necessary to comply with the requirements of any lawful subpoena or court order."

Brief Medical History
Name of Primary Care Physician: _____ Date of Last Visit: _____
Date of Last Physical: _____ Have you experienced any of these problems? (Please circle all that apply)
Allergies Closed Head Injury Heart Disease Hepatitis High Cholesterol Hypoglycemia Asthma High Fevers Seizures Lung Disease TB Diabetes Arthritis Meningitis Thyroid Problems Liver Disease HIV Cancer Chronic Pain Loss of Consciousness Hypertension High Blood Pressure Kidney Disease STD Memory Problems Sleep Problems Appetite Problems Headaches Other Medical Issues (please explain) _____
Please describe any of these conditions and the age of onset: _____
Please list any surgeries: _____ Please list any hospitalizations: _____

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Current Medications

Medication: _____ Dosage: _____
Date Started: _____ Prescribed By: _____

Brief Social History

Where did you grow up? _____ Did your family move around? If yes, please describe:
_____
Which family members are you close to? Please describe: _____
Please briefly describe your childhood: _____
_____
When growing up, did you ever experience physical, sexual or emotional abuse? If yes, please describe: _____
_____
Upon whom do you rely for emotional support (spouse, siblings, children, parents, co- workers, mentors at work, etc.)?
_____
Are there any current job stressors in your life? _____
What kinds of changes have your family (or you) experienced in the last five years? Please describe: _____
_____
Describe any kinds of losses you have experienced in the last five years? _____
What do you do for enjoyment or fun (hobbies, church activities, exercise, etc.)? _____
Are you getting the happiness you deserve in life? (If not, please say why you are not.) _____
What would you need to change about yourself or your life that would bring you the satisfaction that you deserve?
_____

Relationship History

Describe your close current relationship(s), including any problems: _____
_____
Describe any prior marriages or long-term relationships and the reason for the divorce or break up? _____
_____
Please describe any problems you are experiencing with your children: _____
_____
List all people currently residing in your home: _____
_____

Military History

If you have served in the military, what branch and dates of service: _____
Were you ever stationed in a combat or other high-risk zone? If yes, please describe: _____
_____
Type of discharge: _____

Occupational History

Are you currently employed? (please circle one) Yes No
Where do you work? _____ What is your current position? _____
How long have you worked in that position? _____
Do you like your job? _____

"Therapy That Works"

Section Three: The Practice at Gearing Up Psychologists and Counselors (Please review the following)
Gearing Up! provides assessment, counseling, and therapy services to hundreds of children, adolescents, and adults who are seeking assistance in solving life problems, a better understanding of relationship difficulties, or better functioning as an individual. We also provide consultations for anxiety, depression, stress and personality disorders, child and adolescent issues, eating disorders, trauma recovery, grief and loss, divorce and separation, obsessive compulsive disorder, learning differences, anger management, attention deficit disorder, psychological testing and much more.

Services are provided by Drs. Milt and Sylvia Gearing who are licensed clinical psychologists and their staff of licensed professional counselors. Our professional staff has the highest level of training and professional expertise. In addition, our administrative staff is dedicated to making your experiences at Gearing Up! extremely rewarding, effective and satisfactory. Typically, during the first few sessions, an interview is conducted to review your concerns, your personal and family history, and your present relationships. Your therapist will discuss the next steps after a comprehensive assessment has been conducted. Further psychological testing may be recommended to assist in diagnosis and treatment planning. Your therapist will then develop goals of treatment and discuss the therapeutic strategies and techniques required to meet those needs.

While there is no guarantee that all psychological service goals will be met, your therapist is committed to applying his or her expertise to your challenges and is dedicated to working with you in good faith to achieve the stated goals. Your therapist will discuss the relevant aspects of the services to be provided so that you can make an informed decision about whether to proceed with the services. Relevant aspects include such information as procedures, treatment goals, fees, confidentiality, and use of the information obtained. Ultimately, the most successful therapeutic outcomes are achieved by a collaborative relationship between you and your therapist.

Appointments
Expected length of the services to be provided is often difficult to predict with certainty because we cannot predict your response and dedication to achieving your therapy goals. To maximize the effectiveness of your therapy, we see our patients a minimum of once a week and our sessions are 45 minutes in length. While your therapist makes every effort to be on time, please be patient because our therapists are busy taking care of many patients and their families. If insurance or other restrictions influence the number of sessions to be scheduled, you are responsible for discussing this matter with your therapist. Such restrictions may limit the timely accomplishment of treatment goals because your particular situation may demand more time and extended effort to overcome. Treatment occurring on less than a once-a-week basis must be approved by the therapist in writing before frequency is reduced.

Standing appointments are scheduled for patients on a once-a-week basis at Gearing Up. Because your therapist holds this time open for you, please be mindful of the cancellation policy detailed above, including any fees associated that may be assessed for failing to follow the cancellation policy.

If a patient misses two consecutive scheduled sessions without good cause, as deemed in the sole discretion of Gearing Up, the patient will be considered to have given a notice of termination of therapy. A patient who does not reschedule within 14 days following their last therapy session will be considered to have terminated therapy._____(initial)

Emergency calls should be made to the above telephone number. Directions are given at this number for handling emergency situations.

Ending Therapy
Sessions usually end when the psychologist or patient agree that therapy goals have been achieved and that further

progress is no longer being made. Patients are free to terminate at any time. However, patients considering premature termination or with complaints about the services are urged to discuss their concerns with their psychologist or counselor. The psychologist or counselor may also terminate services. We are dedicated to serving your goals. Referrals to alternate sources of treatment can be provided.

Fees for Service

Fees are set with you prior to initiating psychological services. If you are using your managed care benefits (insurance), you will be responsible for all fees not paid by your insurance plan. Your co-pay is due at the time of your appointment. THERE ARE NO EXCEPTIONS TO THIS POLICY. Failure to pay your co-pay will result in canceling of your future appointments until you pay your bill in full. We request that a credit card be kept on file with our staff to assist in co-pays and in recovering any other unpaid fees. Cash, credit cards, or checks are accepted._____(initial)

Please note that Gearing Up will work with only one financially responsible party and is not responsible for managing payments between family members or divorced spouses. The party signing the forms is the identified responsible party and is fully responsible for all fees incurred for our services. _____(initial)

Confidentiality

The therapist keeps a record of each of your counseling sessions, a report of any tests results, and other materials relevant to the continuity of care. Normally, "raw" test data and answer sheets are not considered a part of the record available to disclosure since this material is usually technical and copyrighted. Your session records and assessment tests are protected by law from disclosure to anyone else, except under certain circumstances (see below). Please be aware that there are some important exceptions to this privileged communication, and you should discuss these with your therapist if there are concerns. If you consent to services provided by a therapist who is under supervision, or services provided by a treatment team, relevant treatment information is shared with the supervisor and/or treatment team. Of course, at any time you may give you consent to release information to another professional.

Parents or legal guardians have a right to the records of their minor children or those under their legal guardianship. When the therapist is working with a minor, information is also considered confidential to the extent allowed by law. Parents are informed if the child appears dangerous to himself/herself or others. However, the child's confidentiality will be observed with parents while allowing for periodic updates concerning progress, completed goals, etc._____(initial)

In some cases, psychological services involve a group, a couple, or a family. The same confidentiality applies in this context to the extent allowed by law, except that the therapist cannot guarantee that others in the family or group will keep the information confidential.

Exceptions to Confidentiality

- If your psychologist believes, in his or her sole discretion, you (or your minor) may be dangerous to yourself or others, we will release this information to the appropriate people (for example, parents, spouses, law enforcement, etc.) without your consent.
- Mental health information is also required to be released pursuant to the terms of a court order or a valid subpoena.
- Patients who have their psychological services paid in part by a third party, such as an insurance company, should discuss with the billing office any concerns about the exact information the third party payer requires. Your insurance company may require the release of clinical information in order to access your benefits.
- Any and all occurrences of sexual abuse of a minor must be reported to law enforcement officials. This law is man dated by the State of Texas and there are no exceptions to this policy.

I acknowledge and understand the foregoing exceptions to patient confidentiality and how those exceptions apply to me (or my minor).

Furthermore, because of my understanding, I consent to treatment for myself (or my minor) by Gearing Up with these exceptions in mind. Finally, even if I fail to place my initials below immediately following this paragraph, by agreeing to meet with a counselor at Gearing Up for myself (or my minor), I waive all claims, demands, causes of action, suits, rights, counter-claims of any kind, whether known or unknown, against Gearing Up, for any disclosure of my confidential information pursuant to the exceptions outlined hereinabove or other exceptions as permissible or required by applicable federal and state law and regulations. This provision is not intended as a waiver of your (or your minor's) rights under any federal or state law, including information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164, subject to the exceptions (both required and permissible) outlined therein. _____ (initial)

Professional Relationship

In order for your professional relationship with the therapist to be helpful and supportive, it must be free of any complications that might influence objectivity or taking unfair advantage of either party. For these reasons, business, personal, or other outside relationships between the therapist and client are not permitted. This policy is in accordance with American Psychological Association's Code of Ethics for Psychologists.

It is vital to remember that psychological services can sometimes generate emotions such as anxiety or depression. Counseling may alter your view of an important relationship, and you may alter your attitudes toward important people in your life. Such outcomes are possible when people are in psychotherapy, and these changes are to be processed during the sessions. The professional boundaries with your therapist must be maintained to insure his or her professional perspective on your issues.

Questions

Please ask any questions at any time concerning any of the above material, the services provided, or your expectations. Your welfare is our top priority, and we are dedicated to serving your mental health needs. As mentioned, psychological services are most effective with a collaborative working relationship, and we work very hard to earn your satisfaction. This patient information brochure is prepared with that collaborative relationship in mind. If any concerns or questions remain, please do not hesitate to let us know.

I have read and agree to the above information.

Signature:_____ Date:_____

Section Four: Gearing Up Payment Policies

Patient Responsibility: You are ultimately responsible for 100% of charges incurred in our office. You understand that pre-certification of services by your insurance company does not mean the insurance company will pay the fee. IF YOUR INSURANCE COMPANY, PARENT, EMPLOYER OR ANY OTHER SOURCE REFUSES TO PAY, YOU ARE RESPONSIBLE TO PAY IN FULL._____(initial)

Two Types of Payment Options: (Please Circle One)

1. Direct Payment Plan: You agree to pay Gearing Up for services rendered (Cash, Check, Credit Card or Debit Card). The fee is due in full at the time of service delivery.
2. Third-Party Reimbursement Plan: Gearing Up agrees to accept direct third-party payment (e.g. insurance company, parent or employer). You will be responsible for paying that portion of the fee that is not covered by the third-party source (i.e. unmet deductibles, your co-pay, or any late cancel or no-show fees). Please note that we are contractually bound by your insurance company to collect all co-pays at the time of service delivery. ALL CO-PAYS, UNMET DEDUCTIBLES AND LATE CANCEL OR NO-SHOW FEES ARE DUE IN FULL AT THE TIME OF EACH APPOINTMENT.

"Therapy That Works"

Please designate the number you wish for us to use for your reminder call: (Please circle one) Cell Home Work
Courtesy Call Only: Please note that these courtesy calls do not replace your responsibility for your appointment. They are only a courtesy. If our office cannot reach you or does not call, you are still financially responsible for your appointment time.
Medicare-Eligible Patients: Gearing Up is not an enrolled provider in Medicare and has no current plans to become an enrolled provider in Medicare. If you (or your minor) are eligible or become eligible during the course of your sessions for enrollment in Medicare, you must inform Gearing Up of your eligibility no later than your first or next, as applicable, scheduled appointment. It will be necessary for you to sign a separate agreement acknowledging that Gearing Up is not an enrolled provider in Medicare and that you assume full financial responsibility for the services rendered to you (or your minor) by Gearing Up and agreeing to refrain from submitting any invoices for services rendered to Medicare for reimbursement. Failing to inform Gearing Up of your (or your minor's) eligibility for Medicare does not in any way reduce your personal liability for payment of services rendered. _____ (initial)

After-Hours Phone Consultations or Between-Session Phone Consultations: All life-threatening emergencies will be handled at no charge. Please call us if you fear you or someone else's life or safety is in danger.

ALL OTHER EMERGENCY PHONE CALLS LASTING OVER FIVE MINUTES WILL BE BILLED AT THE RATE OF $130 PER HOUR (prorated per quarter hour). This charge is not covered by your insurance company and must be paid at the time of service. This policy insures your doctor's availability in your time of crisis. Please call if you need us.

Payment Options: Cash, personal checks, and major credit card/debit cards are welcomed, but there will be a $30 charge for all returned checks. After two returned checks payments, only cash or credit cards will be accepted as payment.
I understand all of the above policies and I agree to abide by them.
Patient Signature: _____ Date: _____

Section Five: Intake Assessments

All new Gearing Up clients 12 years of age and over take the Minnesota Multiphasic Personality Inventory – 2 (i.e., MMPI) as part of our routine intake procedures. This test evaluates your symptoms of depression, anxiety, and stress levels in addition to certain aspects of your personality. All new clients under the age of 12 years will have a parent fill out the Behavioral Assessment System for Children (BASC-R) to assess the same symptoms.
This test will be billed to your insurance as a session to cover the doctor's hour of time in scoring and writing your report. Your co- pay is due at the time of the test to cover your share of the testing appointment.
The MMPI-2 is a "true-false" test that takes about 45 minutes to one hour to complete. If there is a need for medication or other ancillary therapies, the MMPI-2 will help point you in the right direction.
Here are the Options for Completing the MMPI-2:

- You must fill out the test in our waiting room, because professional/ethical restrictions prevent us from letting the test books leave the office. However, you may come to complete the test any time that the office is open (8 A.M. to 8 P.M. Monday-Thursday, 8 A.M. to 6:30 P.M. Fridays and 8 A. M. to 4:00 P.M. Saturdays).
- If you can complete the MMPI-2 during regular weekly business hours (i.e., 9:00 AM to 5:00 PM) it is unnecessary to call ahead to notify the staff. Just come to the office window and tell them you are here to complete the MMPI-2, and they will give you a test book and instructions. If you wish to complete the test at a time when the secretarial staff is not here, then you must schedule with our staff so that a test booklet is waiting for you.
- Dr. Milt Gearing will provide a summary of the test results that your therapist will review with you. This report will be sent to your physician with a written release (see next page).

Here are the Options for Completing the BASC-R:

- The BASC can be completed in the privacy of your own home. Once we receive the parent's completed copy (required within the first week of your first appointment), Dr. Milt Gearing will provide a summary of the test results that can be reviewed with your therapist. This report will be sent to your physician with a written release.

MMPI-2 AGREEMENT AND BASC-R AGREEMENT
I understand the intake assessment procedures and I agree to schedule a time to complete the MMPI-2 test or the BASC-R BEFORE my next therapy appointment.

Patient Signature: _____ Date: _____

Section Six: Receipt of Notice of Privacy Practices

When you are seen for your appointment, you will be given a printed copy of HIPAA regulations. Please sign below to verify the receipt of these forms.
Patient: _____ Given to patient on: _____ Version/Effective Date: _____
Signature of Patient or Personal Representative: _____ Date: _____
Relationship of Personal Representative to the Patient: _____

Section Seven: Physician Communication Form

Your insurance company requests that we communicate with your primary care physician (family physician, pediatrician, psychiatrist, ob-gyn, internist, etc.) to coordinate your care. If you are being prescribed an anti-depressant or any other mood-altering drug, informing your physician of your treatment in our offices is an important aspect of your care.

Please fill in the form below and we will send a letter regarding your diagnosis, treatment and your assessment to your physician to coordinate your care.
Patient Name: _____
Name, Address, & Phone Number of Physician: _____
_____
Person/Organization Disclosing Information: (Gearing Up) _____
Person/Organization Receiving Information: (Physician Name) _____
Specific Description of the Information to be disclosed: _____

Clinical information to coordinate treatments: The purpose of this request is to coordinate care with your physician._____(Please Initial). This authorization will continue until revoked by patient (or parent or legal guardian) in writing. I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions, as well as other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices. I understand that the treatment may not be denied if I refuse to sign this authorization.

PLEASE CHECK ONE:
☐ I give permission for Gearing Up to contact my physician
☐ I do not give permission for Gearing Up to contact my physician

Signature of Patient or Representative: _____
Relationship of Representative to Patient: _____ Date:_____

"Therapy That Works"

GearingUp
PSYCHOLOGISTS & COUNSELORS

Section Eight: Credit Card Information and Permission to Charge Card

To maximize efficiency in the processing of your account, we are maintaining credit cards on all Gearing Up patients. You may pay by cash or check, but we do request that a credit card is kept on file in case you forget to pay at the time of your appointment or if our administrative staff is unavailable. We do not provide monthly billing statements, since all co-pays and deductibles are due at the time of service delivery.

Please note that you are ultimately responsible for all fees incurred through our office. Occasionally, insurance companies misinform our office about patient benefits and we do our best to acquire the correct information as soon as possible. Our professional billing department is here to assist you with your insurance needs.

Your signature below acknowledges your total responsibility in paying for any fees not covered by your insurance company and gives Gearing Up permission to charge your credit card for all co-pays, deductibles, test fees, late cancels or no-show fees associated for any therapy or diagnosis provided to you (or your minor). Your signature acknowledges that these fees will be automatically charged or debited, as applicable, from your card without further notice within 24 of your scheduled appointment. If there are any questions, please contact our billing department.

Please circle one of the following and complete the form: MASTERCARD AMERICAN EXPRESS VISA DISCOVER
Number of the Card: _____ Card's Expiration Date: _____
Name as It Appears on the Card: _____
Signature: _____ Date: _____ Security Code: _____

Thank you for completing this form, and we appreciate the opportunity to assist you. We look forward to getting to know you and to providing the most professional and effective services in the industry.

We earnestly want you to have a great experience while you are a part of the Gearing Up Community, so please let us know if there are any concerns during your time with us. We look forward to helping you to achieve a new empowerment and to celebrate every day as you begin Gearing Up!

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PSYCHOLOGISTS & COUNSELORS

Section Nine: Informed Consent Agreement

Please Note: Your psychologist/counselor must have your signature on this form to treat you.
PLEASE DO NOT FILL OUT THIS FORM PRIOR TO YOUR FIRST SESSION. PRINT IT AND BRING IT TO YOUR FIRST SESSION.
Please bring to your first therapy session and your therapist will fill in the blanks. You must sign this form during your first session with your therapist. Keep in mind that all information contained herein, including any additional information you share with the therapist is kept strictly confidential, subject, however, to the exceptions as detailed in the Master Intake Form.
_____ (client) will receive services from _____ (provider), beginning _____, for the fee of $130 per hour. Unless services are being funded by another party, full payment is due at the time services are provided. Insurance consignment is/is not (circle one) accepted. The client agrees to accept personal payment responsibility for standing appointments that the client does not keep unless there is an emergency or 24 or 48 hours advance notice, or unless such billing is prohibited by a third party coverage. A collection agency will be used for outstanding accounts. The client understands that the client remains personally responsible for the cost of any treatment that is not reimbursed by the clients' insurance or other third party coverage.

The client is/is not eligible for Medicare coverage: (circle one) is is not
Services will be directed to the following treatment challenges: (Check all that apply)

☐ Depression ☐ Anxiety/Panic ☐ Obsessive Compulsive Disorder
☐ Trauma/Abuse ☐ Stress ☐ Anger
☐ Eating Disorder ☐ Family Relationships ☐ Marriage
☐ Grief/Loss ☐ Divorce Recovery ☐ Trauma Recovery
☐ Other (Please Specify) _____

The following therapy modalities will be used to meet these therapy goals:

_____Psychological Evaluation _____Female Executive Stress Counseling (Dr. Sylvia Gearing only)
_____Coping Skills (Stress Management Skills) _____Anger Management _____Individual Therapy
_____Relationship/Marital Therapy _____Adolescent/Child Services _____Family Therap
_____Group Therapy _____Other (Please Specify) _____

During your initial sessions, your therapist will review your diagnosis. The diagnosis is: _____

- Please verify that you have been informed of your diagnosis by initialing here. _____(Initial)
- I have reviewed this diagnosis with my psychologist or counselor and understand my treatment plan. _____(initial)

I understand that the information obtained during the services provided will remain confidential except as provided by law and more fully described in the Master Intake Form. Additionally, information may be provided to third party payers as part of your managed care plan and to facilitate insurance reimbursement for therapy services. Please discuss any concerns about this release with your therapist.

The client may terminate therapy at any time, but, full payment for services rendered is required. Concerns regarding services are to be discussed with the psychologist/counselor. Any dispute regarding services that cannot be resolved through such discussion will then be submitted to mediation (a binding arbitration if unresolved by mediation in 10 days) under the procedures of the American Health Lawyers Association Alternative Dispute Resolution System.

I understand the material presented above. If I have any concerns, I will discuss this concern with have the psychologist/counselor. I voluntarily **give** my informed consent to the arrangements presented.

Signature(s) of Client(s) and Date: _____
Name of Parent/Legal Guardian: (If Applicable): _____
Signature of Parent/Legal Guardian and Date: _____

"Therapy That Works"