MASTER INTAKE FORM

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

Please note that there are eight sections requiring your initialing, full signature and date of that signature. Some sections must be filled out with your therapist in your initial session.

Read all provided information. When filling out these forms, please be as thorough as possible. The more we know about you, the more effective we can be in our efforts to help you.

Please Note: Signatures, initialing (where indicated) and complete information are required to receive psychological services.

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 Account______________________________________
Relationship to Patient____
REFERRED BY (Please fill out)____
Relationship____

Insurance Company_____________________________Phone________________________
Primary Insured's Name___________________Their Social Security #________________
Relationship to Patient___________________I.D. Number_________________________
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 to include major medical benefits to which I am entitled including private carrier and other health plans to Assignee (Gearing Up or Drs. Milton and Sylvia Gearing). 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 said insurance carrier. I hereby authorize said Assignee (Gearing Up) to release all information necessary to secure the payment. 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 Assignee (Gearing Up) to release all necessary information to collections agencies to collect all fees I incur.

I acknowledge and agree to the office policy that I WILL PAY A $80.00 LATE FEE FOR ALL INDIVIDUAL APPOINTMENTS MISSED BECAUSE I DID NOT CANCEL WITHIN A MINIMUM OF 24 HOURS. IF I AM IN THE COUPLINKS MARITAL PROGRAM OR IN THE EMPOWERED CHILD PROGRAM, I WILL PAY $160.00 LATE FEE IF I DO NOT CANCEL WITHIN 48 HOURS. These late fees must be paid by the patient or responsible party prior to your next scheduled session. Exceptions to this late-cancel fee include life-and-death emergencies and

extreme illness. Work-related demands are NOT included. I hereby authorize said Assignee (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 forfeit my future appointments._____________(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 occur at Gearing Up.___________(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: High School, College, or Graduate Education. 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 or Deceased (please circle one) If Deceased, when? _________________
Mother's Name: ________________________________Profession______________
Living or Deceased (please circle one) If Deceased, when? _________________

Spouse or Significant Other's Name: _____________________________________

Age: __________________How Long Married?_____________________________

Siblings (Ages and whether living or deceased): ____________________________
____
____
____

Children (Ages and whether living or deceased): ____________________________
____
____

Symptom Checklist: (please circle all that apply):

Aggression/ Anger	**Irritability**
Alcohol Abuse	**Loneliness**
Anxiety	**Memory Problems**
Avoidance of People	**Mood Swings**
Chest Pains	**Muscle Tension**
Computer Addiction	**Panic Attacks**
Depression	**Obsessive Compulsive Disorder**
Difficulty Thinking	**Restlessness/On Edge**
Distractibility	**School Avoidance/Anxiety**
Disinterest in Life	**Sexual Addictions**
Drug Abuse (prescription or Street drugs)	**Sexual Difficulties**
Dizziness	**Sleeping Problems**

Eating Disorder

Elevated Mood

Fatigue

Fears

Gambling

Grief/Loss

Hallucinations

Headaches

Helplessness

Hopelessness

Impulsivity

Indecisiveness

Stress

Suicidal Thoughts/Gestures/Attempts

Trauma

Weight Gain/Loss

Withdrawal

Worrying

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? (Circle one) YES NO If you answered yes, when, where, how long and what for? What was your diagnosis?

Previous Counseling? (Circle one) YES NO If you answered yes, when, where, how long and what for?

What was your diagnosis?

Substance Abuse History:

Please Indicate Both Current and Past Use:

Substance	Current Use		Past Use		Amount Used	Frequency	Date
	Yes	No	Yes	No			
Tobacco							
Caffeine							
Marijuana							
Cocaine							
Crack							
Heroin							
Amphetamines							
LSD							
Ecstasy							
Inhalants							
IV Drug Use							
Prescription Drugs							

(Include Names of Prescription Drugs)

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/month 1-4 times per month 2-3 times per week Daily

Usual Alcohol Consumption: (Please Circle One)

None 1-2 drinks per sitting 3-4 drinks per sitting 5 or more drinks per sitting

Intoxication Frequency: (Please Circle One)

Never Less than 1 time/month 1-4 times per month 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, or lawsuits you have been involved in:

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)

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 any 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:

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? _______Yes_______No

Where do you work and how long have worked you worked in your present position?

What is your current position? Do you like your job?

SECTION TWO: THE PRACTICE AT GEARING UP PSYCHOLOGISTS AND COUNSELORS

Please take a few minutes to review the material.

Leaders in their field, Drs. Milt and Sylvia Gearing headed hospitals, clinics and assessment teams before opening their private practice doors in 1986. Today, 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 the Gearings 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, headed by our practice manager, Cindy Lee Cassell, is dedicated to making your experiences at Gearing Up! extremely rewarding, effective and satisfactory.

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. He/she 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 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 since 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 since many problems need 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, we must have a minimum of 24 hours advanced notice for cancellations. If we do not receive at least 24 hours notice, there will be an $80 late fee that is due immediately. For the CoupLinks Marital Program and for the Empowered Child

Programs, we must have a minimum of forty-eight hours notice for cancellations. There will be a $160 late fee is there is less than 48 notice. _____(initial)

If a patient misses two consecutive scheduled sessions without a legitimate reason, 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 the psychologist or counselor. 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. 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 only work with 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 sign a 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 here 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 you may be dangerous to yourself or others, we will release this information to the appropriate people (for example, parents, spouses, etc.) without your consent.

- Mental health information is also required to be released if a court order or a valid subpoena is issued.

- 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.

- By law, any and all occurrences of sexual abuse of a minor must be reported to the authorities. This law is mandated by the State of Texas and there are no exceptions to this policy.

- I acknowledge that I have been informed of these legal exceptions to my confidentiality and understand that all doctor-patient confidentiality is waived under these circumstances.________(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. You can discuss the above material and the specifics of your services with the therapist, and your “informed consent” will be obtained prior to initiating services. As mentioned previously, 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 speak to either Cindy Lee Cassell, our practice manager or to the owner of the practice, Dr. Milton Gearing.

I have read and agree to the above information.

Signature:________________________________

Date:____________________________________

SECTION THREE: GEARING UP! PAYMENT POLICIES

Patient Responsibility: You are ultimately responsible for 100% of charges incurred in our office. Part of your ultimate success in therapy includes your personal responsibility for the fees you incur in our office. You understand that pre-certification of services by your insurance company does not mean they 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.

Cancellation Policies:

- **Twenty Four Hour Minimum Notice: Please provide a minimum of 24 hours notice for all cancelled individual appointments.________(initial)**

- **Forty-Eight Hour Minimum Notice: Please provide a minimum of 48 hours notice for all cancelled appointments if you are participating in either the CoupLinks Marital Program or the Empowered Child Program. These programs require two hours (two therapists) and their time must be accounted for collectively.______(initial)**

- **YOU WILL BE CHARGED AN $80.00 LATE FEE FOR INDIVIDUAL APPOINTMENTS OR $160.00 LATE FEE FOR THE COUPLINKS OR EMPOWERED CHILD PROGRAM THAT MUST BE PAID BY THE PATIENT OR RESPONSIBLE PARTY PRIOR TO THE NEXT SESSION._____(initial)**

- **Exceptions to this policy include life-and-death emergencies or extreme illness. Work-related demands are not included. Phone consultations are available for your convenience if you must miss. A credit card must be on file or presented at the time to pay for your co-pay, unmet deductible, etc._____(initial)**

- **Please designate the number you wish for us to use for your reminder call: (Please circle: Cell, Home, or Work:___________________________________)**

- **Courtesy Call Only: Please note that these reminder do <u>not</u> replace your responsibility for your appointment. They are only a courtesy. If our office cannot reach you or fails to call, you are still financially responsible for your appointment time.**

<u>After-Hours Phone Consultations or Between-Session Phone Consultations:</u> 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 $125 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.

<u>Payment Options:</u> Cash payments, personal checks, and credit card/debit cards are welcomed, but there will be a $30 charge for all returned checks. After two returned checks payments, only cash will be accepted only. All major credit cards are accepted.

I understand all of the above policies and I agree to abide by them.

Patient Signature____

Date__________________

SECTION FOUR: 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.

This form gives your therapist permission to perform psychotherapy. 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.

____________________________ (patient) will receive services from _________________ (provider), beginning _______until _______, for the following fee: $______. 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.

Services will be directed to the following treatment challenges:
(Circle 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 Therapy

____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 and agree to my treatment._________(initial)**

I understand that the information obtained during the services provided will remain confidential except as provided by law. Particularly, any information that suggests that the client may be dangerous to him or herself or others, or that abuse is involved may be released without client consent. 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.

These arrangements may be renegotiated or terminated by the client at any time. 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 ___ days) under the procedures of the American Health Lawyers Association Alternative Dispute Resolution System, with each party to bear one-half of the costs.

I understand the material presented above. If I have any concerns, I will discuss this concern with have the psychologist/counselor and had questions answered. I voluntarily gave 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

____

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, since 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 below).

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 HIPPA 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: (Please Initial)

____

The purpose of this request is to coordinate care with your physician._______(Please Initial).

This authorization will expire on:__________________

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:__________________________________

SECTION EIGHT: CREDIT CARD INFORMATION AND PERMISSION TO CHARGE YOUR CREDIT 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, late cancels or no-show fees. Your

signature acknowledges that these fees will be automatically debited from your card without 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____

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!

Drs. Milt and Sylvia Gearing
Owners of Gearing Up!
Psychologists and Counselors