Ada Liberant, Psy.D.
ADULT INTAKE PACKET

Today's date: _____/_____/_____

Name: _____Date of Birth: _____/_____/_____Age: _____

Address: _____

City: _____State: _____Zip:_____

E-mail_____

Cell: (____)_____Home: (_____)_____Work: (_____)_____

Occupation: _____Employer: _____

Education: _____

If applicable, religious denomination:
_____

Emergency contact: _____Relationship to you: _____

Cell: (____)_____Home: (_____)_____Work: (_____)_____

Relationship status: (Circle One) Single / Cohabiting/ Married / Separated / Divorced / Widowed

Spouse/Partner (Provide Name & Age): _____Occupation: _____

Children (Provide Names & Ages): _____

Referred by: _____

Are you currently in treatment with another therapist? (Circle one) Yes / No

If yes, please list your therapist's name: _____

Have you ever been in therapy in the past? (Please provide names & dates of previous therapists):

Name: _____Dates: _____/_____/_____to _____/_____/_____

Name: _____Dates: _____/_____/_____to _____/_____/_____

Are you currently taking medication for a psychiatric problem? (Circle one) Yes / No

If yes, please list the name, address, and telephone number of your prescribing psychiatrist:

Name:_____

Address:_____

City: _____State: _____Zip:_____

Office: (____)_____E-mail:_____

If yes, please list the names, dosage, & dates of each of your medications:

Rx Name: _____Dosage:_____mg Start Date: _____/_____/_____

Rx Name: _____Dosage:_____mg Start Date: _____/_____/_____

Rx Name: _____Dosage:_____mg Start Date: _____/_____/_____

Have you ever taken medication for a psychiatric problem? (Circle one) Yes / No
If yes, please list names, dosage and approximate dates you took the medication.

Rx Name: _____Dosage:_____mg Start Date: _____/_____/_____

Rx Name: _____Dosage:_____mg Start Date: _____/_____/_____

Rx Name: _____Dosage:_____mg Start Date: _____/_____/_____

Have you ever been hospitalized for a psychiatric problem? (Circle one) Yes / No
If yes, please list the hospital, dates, and reason:

When was the last time you had a physical examination by a doctor, and what was the outcome?

Physician Name: _____Office: (_____)_____

Are there any medical issues, surgeries, or illnesses that have had a significant impact on you? (Circle one) Yes / No *If yes, please describe:*

Are you currently taking any medication for a medical problem? (Circle one) Yes / No
If yes, please list medications below:

CURRENT AND PAST CONCERNS
Please circle the issues you are currently seeking help for: (Circle each one)

ANXIETY MAKING DEPRESSION

SUICIDAL THOUGHTS

SUICIDALITY

DECISION FEARS

LONELINESS

ASSERTIVENESS

AGGRESSION/VIOLENCE

PHYSICAL COMPLAINTS

PROBLEM SOLVING

LOW ENERGY

HOPELESSNESS

SOCIAL SKILLS

RELATIONSHIP/MARITAL ISSUES

JOB/CAREER ISSUES

SHYNESS

BODY IMAGE

INSOMNIA

IRRITABILITY

MOOD SWINGS

IMPULSIVITY

SELF-CRITICISM

OBSESSIVE THOUGHTS

REGRETS

SEXUAL ISSUES

PROCRASTINATION

ALCOHOL/SUBSTANCE ABUSE

SELF-ESTEEM

CONFLICT RESOLUTION

PANIC MEETING PEOPLE

OTHER (Please Explain)_____

Are there any sources of stress you have experienced in the past year? (Circle one) Yes / No

If yes, describe:

Have you ever experienced a trauma? (Circle one) Yes / No

If yes, describe:

Where were you on September 11, 2001?

Are there any situations or people you avoid because they make you feel anxious? (Circle one) Yes / No

If yes, describe:

Do you exercise? (Circle one) Yes / No

If yes, is your exercise excessive?

What are some things you like to do for fun (e.g. sports, hobbies, leisure)?

Describe your eating habits:

Have you ever had an eating disorder (e.g., Anorexia, Bulimia, or Binge Eating)? (Circle one) Yes / No

If yes, which disorder and when?

How much coffee, tea, or caffeine do you consume daily?

Have you ever had or do you have a problem with substance abuse? (Circle one) Yes / No

If yes, please list if alcohol, medication, illicit drugs and when:

Have you ever experienced any of the following? (Circle each one)

CONSUMING MORE THAN FIVE DRINKS IN ONE DAY	FEELING AN OVERWHELMING NEED TO DRINK
DRIVING WHILE INTOXICATED	NOT ABLE TO RECALL EVENTS THE NIGHT AFTER YOU DRINK
PEOPLE CLOSE TO YOU THINKING YOU HAVE A DRINKING PROBLEM	DRINKING TO REDUCE YOUR ANXIETY

Have you ever had a period of two days or more when you experienced any of the following? (Circle each one)

DECREASED NEED FOR SLEEP	VERY TALKATIVE	RACING THOUGHTS
EASILY DISTRACTED	VERY IRRITABLE OR ANGRY	DRIVING VERY FAST
UNUSUALLY HIGH SELF ESTEEM	UNUSUAL DESIRE TO SPEND MONEY	

Is there anything else you would like me to know about you? (Please attach separate piece of paper if needed)

FAMILY AND RELATIONSHIP HISTORY

Family Origin:

Are your biological parents (Circle one): Co-habitating / Married / Separated / Divorced/Never Married? If your parents are separated or divorced, please indicate:

How old you were at the time of the separation/divorce?

If you were a minor at the time of separation/divorce, which parent you did you primarily reside with?

Did you maintain contact with your non-custodial parent? Please describe:

What does your family of origin look like at its best?

What does your family of origin look like at its worst?

How did people express anger or settle conflicts in your family?

What was your role in your family of origin (i.e., caretaker, mediator, black sheep, rebel)?

Relationship History

Are you satisfied with the quality, frequency and/or quantity of your dating and romantic relationships? (Circle one) Yes / No

If no, please describe:

If you are currently in a relationship, how satisfied are you with the relationship? (Please circle one)

.	.	.	.	.	.	.
EXTREMELY UNHAPPY	FAIRLY UNHAPPY	A LITTLE UNHAPPY	HAPPY	VERY HAPPY	EXTREMELY HAPPY	PERFECT

What do you enjoy most about your boyfriend/girlfriend/partner/spouse?

What do you and your boyfriend/girlfriend/partner/spouse disagree on most frequently/intensely?

Have you ever been the victim of domestic violence? (Circle one) Yes / No

If yes, please describe and indicate if the abuse is ongoing:

If you identify yourself as gay/lesbian/bisexual, have you come out to your family? (Circle one) Yes / No

If yes, how old were you when you came out?

How did your family respond to your coming out?

Family Psychiatric History

Relationship to You ***(Please list name):***	**Living / Deceased** ***(If deceased, please note year and cause of death):***	**Age**	**Occupation** ***(Please list past and present)***	**Mental Health Issues/Psychiatric Diagnoses/Alcohol or Substance Abuse** ***(Please Describe)***
Mother				
Father				
Sibling				
Sibling				
Sibling				
Step-Mother				
Step-Father				
Half-/ Step-Sibling				
Half-/ Step-Sibling				

Any psychiatric history among your grandparents, aunts, or uncles?

Please describe and note if maternal or paternal:

CANCELLATION AND FEE POLICIES

This policy statement has been prepared to prevent misunderstandings regarding your attendance and payment for sessions and consultations conducted by Dr. Liberant and to insure the continuity of your treatment.

APPOINTMENTS

I understand that once I begin treatment with Dr. Liberant, I will have a specific time reserved to meet with her, typically once a week for 45 minutes. I am responsible for attending my session on time and understand that if I appear late for a session it unfortunately means that I will lose time from that session.

FEE

I understand that Dr. Liberant and I will agree on a starting fee for treatment. I also understand that Dr. Liberant has the right to increase my session fee at any time by giving me verbal and/or written notice at least 4 weeks in advance of the fee increase.

PAYMENT

I understand that payment is due in full at the end of each session. If I fail to pay for two or more consecutive sessions, Dr. Liberant has the right to stop treatment with me and refer me to another appropriate treatment provider. I will pay by cash, check or credit card (Discover, MasterCard, or Visa). If I choose to pay by check, I agree to leave a debit or credit card on file in the event that I delay payment for my services by 10 or more days. In the event that my check is returned for insufficient funds, I understand that a $20 fee will be incurred.

CANCELLATION POLICY

I understand that a **$50 fee** is charged for cancellation for any reason, which includes, but is not exclusive to: illnesses, medical emergencies, child care conflicts, travel delays, and job demands. If I have to miss a session, I will notify Dr. Liberant at least 24 hours in advance via e-mail at help@adaliberant.com in order to avoid incurring the charge of my session fee. If I do not give 24 hours advanced notice, I understand that I will be charged **$50 fee**.

PHONE SESSIONS AND CONSULTATIONS

I understand that phone therapy sessions will be conducted only in emergency situations or under special circumstances that have been negotiated and agreed upon between Dr. Liberant and myself. In the event of a phone session, I will incur all long distance charges. I understand that phone sessions conducted with me or phone consultations conducted at my expressed request with other professionals (e.g., my psychiatrist) or family members, which I have provided Dr. Liberant a written release of information to contact, are prorated and billed on the basis of my full session rate. I understand billing for these consultation sessions begins only after the first 15 minutes of the phone conversations and will paid in full at my next treatment session.

I have read and reviewed Dr. Ada Liberant's cancellation and fee policies and agree to abide by them.

Printed Name: _____

Signature_____ **Date**_____

☐ **Patient has received a copy for their records on:**_____

(To be filled out by Dr. Liberant)

CREDIT CARD AUTHORIZATION FORM

Please indicate how you would like to use your debit/credit card:

_____I would like to put my card on file to pay regularly (e.g. weekly, bimonthly) for my sessions.

_____I am planning to pay by cash or check and would like to put my card on file to be used only in the event that I delay payment by 10 or more days from the date of service or for use on an emergency basis with my expressed verbal consent.

Client Name:
_____

Card Holder's Name (If different from above):_____

Billing Address:_____

City: _____State: _____Zip:_____

Billing Phone: (_____)_____

Debit/Credit Card Type (Please check one): _____Discover ____MasterCard ____Visa

Debit/Credit Card Number: _____Exp. Date:_____/_____

Security Code: _____(This is a 3 to 4 digit number on the back of your debit/credit card).

I authorize Ada Liberant, Inc. to charge the debit or credit card listed above in accordance with the terms of the cancellation and fee policies agreement.

Card Holder's Signature: _____

Ada Liberant, Psy.D.

HIPPA NEW YORK NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• "PHI" refers to protected health information, which is demographic and health information that could identify you.

• "Treatment, Payment and Health Care Operations"

Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

• "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization, or release of information, from you before releasing this information. You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

• Child Abuse: If, in my professional capacity, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or I have reasonable cause to suspect a child is abused or maltreated where the parent, guardian, custodian or other person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment, or the local child protective services agency.

• Health Oversight: If there is an inquiry or complaint about my professional conduct to the New York State Board for Psychology, I must furnish to the New York Commissioner of Education, your confidential mental health records relevant to this inquiry.

• Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

• Serious Threat to Health or Safety: I may disclose your confidential information to protect you or others from a serious threat of harm by you.

Worker's Compensation: If you file a worker's compensation claim, and I am treating you for the issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records which contain information regarding your psychological condition and treatment.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

• Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

• Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

• Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

• Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

• Right to a Paper Copy: You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my policies and procedures, I will provide you with an updated copy if you are still in therapy with me. If we have ended therapy, you may request an updated copy to be sent to you by mail.

V. Questions and Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please contact Ada Liberant, Psy.D. at 201-540-9170 or help@AdaLiberant.com about your concerns. If you do not feel comfortable doing this, you may call The New York State Psychology Licensing Board at 1-800-442-8106 or send an email to conduct@mail.nysed.gov with your questions or a complaint. You may also address your complaints to the Secretary of the U.S. Department of Health and Human Services by obtaining
their contact information on their website at www.hhs.gov/ocr/hipaa.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on September 9, 2009.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by providing you with a paper copy at our next session from the date of revision. If you are no longer in therapy, I will provide a revised notice only at your written request.

VII. Consent for Treatment

I have read and understood this policy statement. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in this intake evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Printed Name: _____

Signature: _____ **Date:** _____

Ada Liberant, Psy.D.'s Signature: _____ **Date:** _____

Patient has received a copy for their records on: _____

(To be filled in by Dr. Liberant)