John B. Rowe, Ph.D., PC 4108 Park Road, Suite 310 Charlotte, NC 28209-2261 704.408.9060

INTAKE INFORMATION FORM

Patient Name _____Today's Date _____
Address: _____ PO Box_____
City _____ State _____ Zip_____
Cell Phone _____ Home Phone _____ Work Phone _____

If I need to contact you between sessions, where may I leave a message? (circle one):
CELL HOME WORK NONE Social Security # xxx-xx- __ __ __ __

Birth Date: _____Birthplace_____ Gender _____
Ehnicity_____Age ____ Occupation _____

Highest Level of Education Achieved _____ Year _____
Degree _____ Institution _____
Religious Preference: As a child _____Current _____

Marital Status (circle): Single Married Separated Divorced Widowed Civil Partnership
Date of: Marriage _____Divorce _____Death of Spouse/Partner_____

Children: Name _____ Age _____ Name _____Age _____
Name _____ Age _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____

Spouse/Partner: Name _____Age _____ Birth Date _____
Occupation: _____ Empoyer _____
Work Phone _____ Education _____ Religious Preference _____

Family History:
Mother's Name _____ Age _____ Deceased (y/n)? ____
(circle one) Single Married Civil Partnership Separated Divorced Widowed
Father's Name _____ Age _____ Deceased (y/n)? ____
(circle one) Single Married Civil Partnership Separated Divorced Widowed
Siblings:
I was born the (first, second, third, etc.) _____ of (one, two, three, etc.) _____ children.

Emergency Contact: Name _____ Relationship _____
Address _____ Phone _____
City _____State_____ Zip _____

Please complete both sides

Referred By: Name _____ Agency _____
Address _____ Phone _____
Do I have your permission to contact this person to thank them for the referral? **(circle one)** Yes No
Signed Permission: _____ Date _____

Presenting Issue: What are you experiencing and/or what has happened to cause you to seek psychotherapy? _____
_____
_____

Have you been in therapy before? **(circle one)** Yes No
Name of previous therapist _____ Dates _____

General Health Information:
Name of Primary Care Physician _____
Date of Last Physical Exam _____ Known Allergies _____
Current Medications _____
_____

Insurance Information:
If your insurance company requires me to do the filling, please: 1) sign the following authorization statement, 2) provide me with a copy of your insurance card, and 3) call your insurance company and obtain this information: (a) will they pay for you to see me? (b) your copay amount, or (c) your deductible amount, how much of your deductible has been met to date, how much you are required to pay per visit, (d) how many visits are you allowed, (e) date your coverage begins/ends.

I authorize insurance payment of medical benefits to John B. Rowe, Ph.D., LPC, for psychotherapy services. I further authorize the release of medical or other information necessary to process an insurance claim.

Signature _____ Date _____

Please complete the following or we can make a copy of your insurance card.
Name and address of Insurance Company _____
Policy Holder (circle one): Self Spouse Parent Policy #_____ Group _____
Is there other insurance? **(circle one)** Yes No
Company _____ Policy # _____ Group _____
Who will be responsible for the bill? _____ Relationship to patient _____
Any special circumstances you wish to make me aware of?_____
_____

I agree to receive psychotherapy services from John B. Rowe, Ph.D., LPC who is licensed by the State of North Carolina to provide counseling and psychotherapy for persons with individual, marital, or family problems. I am aware that John B. Rowe does not provide medical or legal assistance.

Please proceed to the next page

I agree to payment of fees at each session by cash, debit, or credit card. **I agree to change or cancel appointments with at least a twenty four (24) hour notice, or else pay for the missed appointment.**

I understand that the information shared by either the therapist or the patient is confidential and cannot be released to anyone without written consent except under the following conditions provided by the law:

- Medical Emergency – emergency personnel or services may be given necessary information.
- Imminent danger – the law states that if I judge that you are a danger to yourself or others, I am required to take action to prevent harm from occurring to you or to others.
- Child or Vulnerable Adult Abuse – I am required by law, to report all cases of actual or suspected physical, emotional, or sexual abuse or neglect of children or vulnerable adults to the Department of Social Services.
- Minors/Guardianship – parents or legal guardians of non-emancipated minors have a right to access the minor's treatment records.
- By judicial order – if ordered by a judge or other judicial officers, information regarding your treatment must be disclosed. Please note that a subpoena is not a court order.
- Patient death or disability – in the event of a patient's death or disability, information may be released to the patient's personal representative or beneficiary.

Signature _____ Date _____

For office use only:

Diagnosis _____ Fee $ _____