LaVelle and Associates

Mental Health Counselors

Mental Health Intake Form:

Name: _____Date: _____Sex: _____DOB: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____Email Address: _____SSN: _____

*IF you are a Tricare Recipient - Please list Sponsor's DOB and SSN: _____

Primary Physician: _____Current Therapist: _____

Complaint:

What is your major complaint? _____

Start Date: _____ Have your Suffered from this before? Yes / No

If yes, did you see a therapist? Yes / No If Yes, who? _____

Aggravating Factors: _____Relieving Factors: _____

Current Symptoms: (Circle All That Apply)

Anxiety Appetite Issues Avoidance Crying Spells Depression Excessive Energy

Fatigue Guilt Hallucinations Impulsivity Libido Changes

Loss of Interest Panic Attacks Racing Thoughts Risky Activity Sleep Changes Suspiciousness

Other: _____

Medical History

Exercise Frequency and Type of Exercise: _____

Previous Mental Health Diagnosis: _____

Was mental health diagnosis treated with medications? _____

Medical Conditions and Surgeries: _____

Current Medications: _____

Family History:

Were you adopted? Yes / No If yes, at what age? _____

How is your relationship with your mother? _____Father? _____

Do you have siblings? Yes / No Ages: _____

5024 S Bur Oak Place
Suite 212
Sioux Falls, SD 57108

LaVelle & Associates

lavelleassociates5024@gmail.com
(605) 275-2001
Fax: (605) 275-2019

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Mental Health Intake Form Continued (Page 2)

Are your parents Married / Divorced? If divorced, how old were you? _____

Did your parents remarry? Yes / No If so, how old were you? _____

Family member medical or health conditions: _____

Treated with medications? Yes / No Please list if known: _____

Early Development:

Have any family members died? Yes / No Who? _____

Any family members committed or attempted suicide? Yes / No Who? _____

Describe any neglect, abuse, or trauma you have suffered, and by whom: _____

Highest level of education: _____ Have you ever served in the military? Yes / No

Current Situation:

Work: (Circle) Full-Time / Part-Time / Student / Stay at home mom / Unemployed / Disabled / Retired

Employer: _____

Married or in a committed relationship? Yes / No If yes, how long? _____ Divorced? Yes / No

Prior Marriages? Yes / No If Yes, how many? _____

How is the relationship with your partners? _____ Sexual Orientation: _____

Are you sexually active? Yes / No

Do you have children? Yes / No Ages: _____ How is your relationship? _____

Have you ever been arrested? Yes / No If yes, When and Why: _____

Have you ever tried any of the following? (Please Circle)

Alcohol / Tobacco / Marijuana / Other Drugs not prescribed to you: _____

If yes to any, list frequency / dates of use: _____

Treated for Drug / Alcohol abuse? Yes / No If yes, when and what substance(s) _____

Do you smoke? Yes / No If yes, how many per day? _____ Do you drink caffeine? Yes / No

Have you ever abused prescription medications? Yes / No If yes, which one(s)? _____

Anything else you want Patricia LaVelle to know? _____

Signature: _____

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Financial Policy – Effective December 1, 2021

Not Billed to Insurance, Client Paid:

Missed 1 session or less than 24-hour cancellation - $50.00

Missed 2 sessions or less than 24-hour cancellation - $80.00

Missed 3 or more sessions - $200

Court - $300.00 per hour including time to and from office with a $300.00 retainer due prior to the court date.

CTRPT - $180.00 per hour for reporting related to court proceedings.

Unlisted psychological service or procedure 15 minutes - $75.00

Bill to insurance (you are responsible for any amounts not covered by insurance):

90791 Intake Psychiatric diagnostic evaluation 60 minutes or less - $250.00

90832 Psychotherapy, 30 minutes with patient and / or family - $150.00

90834 Psychotherapy, 45 minutes with patient and / or family - $175.00

90837 Psychotherapy, 60 minutes with patient and / or family - $200.00

96130 Psychological testing evaluation by QHP, first 60 minutes - $110.00

96131 Psychological testing evaluation by QHP, additional 60 minutes - $110.00

90839 Psychotherapy for crisis, first 60 minutes - $250.00

90840 Psychotherapy for crisis each additional 30 minutes - $125.00

90853 Group psychotherapy (Other than a multiple-family) 120 minutes - $100.00

Please remember your insurance is a contract between you, your employer, and the insurance company or between you and your insurance company directly. LaVelle and Associates, LLC is not part of that contract.

Please contact your insurance company to verify mental health benefits and determine your deductible, co-insurance, co-pay, and if you need authorization to receive treatment from the provider. Insurance companies require a diagnosis for mental health services. In order to receive reimbursement from insurance, a diagnosis and any requested information must be supplied.

My signature indicates that I understand and agree to the above.

Client Name (Printed): _____

Client signature: _____ Date: _____

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Financial Policy – Effective December 1, 2021 Continued

Insurance Carrier: _____

Subscriber Name: _____Subscriber Date of Birth: _____Subscriber Gender:_____

Member ID: _____ Group: _____

Relationship to client: _____

Subscriber's Address: _____

Payment Policy

Payment is due at time of service. Cash, Check, Credit Card, Debit Card, and HSA's are accepted. If sessions are submitted to your insurance by LaVelle & Associates on your behalf, any co-pays, deductibles, and amount owing will be charged to your respective credit/debit and/or HSA card upon LaVelle & Associate's receiving your insurance company's Explanation of Benefits (EOB). IF YOU USE YOUR HSA CARD, a credit/debit card will also be required to be on file. We will automatically bill the HSA card FIRST for any copays, deductibles, and co-insurance. BUT, If for any reason this card declines, we will then charge the credit/debit card. I understand that my signature authorizes LaVelle & Associates to submit for insurance payment as well as charge my respective card(s) for services rendered as outlined in this Financial Policy.

Credit/Debit Card

Name on Card: _____

_____Debit Card _____Credit Card _____Visa _____Mastercard _____Discover _____American Express

Card Number: _____ Expiration Date: _____ CVV: _____

Card Billing Address: _____

I, _____ authorize LaVelle & Associates, LLC to process payment on my card for my session(s).

Cardholder Signature: _____

HSA Card Information

Name on Card: _____

Card Number: _____ Expiration Date: _____ CVV: _____

Card Billing Address: _____

I, _____ authorize LaVelle & Associates, LLC to process payment on my card for my session(s).

Cardholder Signature: _____

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Informed Consent

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment). I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations and discuss with your provider any questions or concerns you may have.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment, or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Name (Printed): _____

Client signature: _____ Date: _____

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