



PSYCHIATRIC INTAKE FORM

Patient Information – Please print clearly

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Patient's Social Security # _____ - _____ - _____

Work Phone: (____) _____ - _____ Birth Date: ____ / ____ / _____

Cell Phone: (____) _____ - _____ Sex: Male Female

May we leave messages? **Yes** at home at work on cell phone

OR **No**, please don't leave messages Employer: _____

Marital Status: Single Married Other Referred by: _____

E-mail Address (optional) _____

Welcome to Family Counseling Associates, Inc. We are please to be able to offer psychiatric services provided by Judith Cecil, MD.

Dr. Cecil is a graduate of The University of Glasgow, Scotland and completed her psychiatric residency at Indiana University School of Medicine. She is Board Certified in Psychiatry. Dr. Cecil has been a member of the medical staff of Community Hospital, Indianapolis since 1989, providing psychiatric services to the patients at Gallahue Mental Health Center. Recently Dr. Cecil has elected to expand her practice to meet our need for physician coverage at this facility. Her role with FCA will be to provide psychiatric evaluation of patients and medication management when appropriate.

We are committed to improving your emotional health. With that in mind, we are aware that rarely is it appropriate to provide medication alone. Your needs will be much better met with a combination of ongoing regular talk therapy with your therapist, in addition to medication management by Dr. Cecil.

You are responsible for scheduling and keeping all of your appointments. Payment is expected at the time of service. When appointments are not kept, it prevents others from having the opportunity to be seen and benefiting from treatment. Therefore appointments must be cancelled at least 24 hours in advance or a rate of \$45 will be charged and payment will be expected prior to your next session.

In the event that you have an urgent clinical concern that you feel cannot wait until your next scheduled appointment with Dr. Cecil, you should make every effort to call the office during normal business hours at (317) 585-1060. Our phones are answered 8:30am–4:00pm. You will be asked to leave a detailed message regarding your concern. Dr. Cecil will return calls Monday through Friday after 3:00pm. For urgent clinical concerns after hours or on weekends, please call Community Hospital's Crisis Line at 621-5700. Please note that there will be a charge of \$25 per 15 minutes for any phone consultation made by Dr. Cecil.

In the event of a life-threatening emergency, please call 911 or present yourself to the nearest emergency room.

As Dr. Cecil specializes in outpatient treatment only, if your condition would require admission to an inpatient facility, your care would be assigned to the Inpatient Psychiatrist on-call at Community Hospital, North – Indianapolis.

Please know that we are committed to providing secure confidentiality. Your medical record is confidential to the extent of established professional and legal standards. A signed authorization from you is required to release information from your medical record to sources outside this office.

Thank you for selecting Family Counseling Associates. We look forward to working with you.

Please read, date and sign back of page.



CONSENT FOR PSYCHIATRIC TREATMENT

HIPAA COMPLIANCE

The staff of Family Counseling Associates (FCA) is committed to providing quality professional care to all of our clients. Your treatment information is handled with the utmost of care to ensure your privacy. Take a few moments to read the Privacy Information Policy (Health Insurance Portability & Accountability Act – HIPAA) you were given and sign this form for our records. FCA works as a group of providers and your confidentiality is extended to all therapists in the organization. If you are working with a Resident Therapist or Intern, that Counselor will review your case with a Licensed Supervisor on a regular basis for recommendations as part of the training provided Residents and Interns.

THERAPY SESSIONS

Fees for Licensed Therapists

25 minute session	\$55.00
50 minute session	\$ 100.00
80 minute session	\$ 135.00
110 minute session	\$ 165.00

Fees for HSPP Psychologist

25 minute session	\$60.00
50 minute session	\$ 110.00
80 minute session	\$ 145.00
110 minute session	\$ 180.00

PHYSICIAN APPOINTMENTS

Fees for Psychiatrist

Initial Evaluation	\$ 225.00
40 minute appointment	
Medication Management	
20 minute appointment	\$ 85.00
30 minute appointment	\$ 110.00

PAYMENT

Payment in full is due and expected at the time of service. Payment can be made by: **check, cash, VISA, MasterCard, American Express or Discover.** Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

PLEASE NOTE: There is a \$20.00 fee for ALL RETURNED CHECKS.

INSURANCE CLAIMS TO BE FILED BY CLIENT

If you have insurance, you are encouraged to file each claim with your insurance company by sending the "Insurance Copy" of the receipt you will receive to the *claims mailing address* on your insurance card, therefore receiving your benefit reimbursement. If you have any questions, contact the *Member Services number*, also located on your insurance card. Upon receiving an Explanation of Benefits (EOB) from your insurance company, if it appears that Dr. Cecil is in network with your insurance company, bring the EOB with you to your next appointment with Dr. Cecil and FCA will make the necessary adjustment to your rate.

AUTHORIZATION FOR TREATMENT AND/OR SERVICES

This signed consent authorizes FCA to provide counseling treatment, psychiatric treatment and/or other services. I understand the disclosures made on this Psychiatric Intake Form.

I acknowledge that I have been given opportunity to review Family Counseling Associates, Inc.'s Notice of Privacy Practices and will be given a copy of the same if I request it.

Signature of Client (required)

Date (required)