Linda Cook Cason, MA LPC NCC 903 Northeast Drive Suite 101 Davidson, NC 28036-7437 704.437.2762

Intake Information Form

Patient Name:							Today's Date:		
Address:									
City:						State:		Zip Code:	
Cell Phone:		Home Phone:			Work Phone:				
If I need to contact you between sessions, where may I leave a message? **(please circle)**						Cell	Home	Work	**NONE**
Social Security#:		Birth Date:				Birth Place:			
Gender:	Ethnicity:		Age:	Occupation:					
Employer:						How long?			
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:		Employer:							
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:							
Referred by:	Name:	Title:	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:							
(Please complete both sides of this form)									

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Intake Information Form

Patient Name:	**Date of birth:**
General Health Information: Name of primary care physician, other physician(s), or specialist(s):	
Date of last physical exam:	Known allergies:
Dates of surgical/invasive procedures:	
Current Medications:	
Insurance Information: If your insurance company requires me to do the filing, 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 this benefit year, how much you are required to pay per visit, (d) how many visits are you allowed, (e) date your coverage year begins/ends.	
I authorize insurance payment of medical benefits to Linda Cook Cason, MA 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 Linda Cook Cason, MA 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 Linda Cook Cason does not provide medical or legal assistance or psychological testing.

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: _____