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Intake Form for Dominique Samuels, PsyD (PSY23442)

www.doctorsamuels.com ***office: 415.358.4906*** ***email: samuelspsyd@gmail.com***

NAME (Please Print)_____ **Social Security #** _____

TODAY'S DATE **DATE OF BIRTH** **AGE**

ADDRESS

Street (Apartment #) City State Zip Code

PHONE NUMBER(S): Home ( ) Work ( )

May I call you ... at home? Yes No ... at work? Yes No

MARITAL STATUS: Single Married/Partnered Separated Divorced Widowed Other

LIVING WITH SPOUSE/PARTNER? Yes No **NUMBER OF YEARS TOGETHER**

EMPLOYER/SCHOOL **OCCUPATION**

PRIMARY CARE PHYSICIAN **PHONE NUMBER** ( )

EMERGENCY CONTACT **EMERGENCY CONTACT PHONE**

INSURANCE INFORMATION

Health Plan/Insurance Policy #

Subscriber Name Subscriber Social Security #

Employer Subscriber Birth Date:

Referred by:

Mental Health Insurance (May be different than Medical Insurance; e.g., MHN, UBH)

Address:

Phone: ( ) Group/Policy #: Insured's ID #:

Number of Sessions Approved (If Known): Certification # for Approved Sessions:

TYPE OF HELP DESIRED:

Individual Therapy/Counseling Family Counseling Couple's Counseling Psychological Testing

Other:

1. Major reason(s) for seeking help at this time:

2a. How long have you had these problems or symptoms?

2b. How often do they occur?

3. What are your goals for counseling?

4. What have you tried already?

5. Are you currently taking any medications (including over-the-counter and herbal)? Yes No
   If yes, please list:

6. Do you have any serious or chronic medical conditions (including past surgeries)? Yes No
   If yes, date(s) and details:

7. Do you have any serious medical accidents or injuries, head injury, or seizure history? Yes No
If yes, date(s) and details:

8. Symptoms

	Now	Past		Now	Past		Now	Past
Headaches			Restlessness			Hearing voices		
Dizziness			Decreased need for sleep			Seeing things other's don't		
Stomach/bowel trouble			Mood swings			Strange experiences		
Health problems			Excess energy			Feel people plot against you		
Pain			Confusion			Constant suspicion/ distrust		
Tremors or tics			Elated/euphoric mood			Unusual thoughts		
Drug/alcohol cravings			Excessive spending			Violent aggressive behavior		
Eating problems			Racing thoughts			Thoughts of physically harming someone		
Binge eating			Irritability					
Sleep problems			Impulsive behavior			Physical abuse		
Weight loss			Grandiose thoughts/plans			Sexual abuse		
Weight gain			Anger or explosiveness			Sexual problems		
Loss of appetite			Panic attacks			Relationship problems		
Feeling apart from others			Anxiety			Financial problems		
Low energy			Fears			Work problems		
Feeling worthless			Nightmares			Conflict in family		
Memory problems			Fears of losing self control					
Thoughts of suicide			Recurring unwanted					
Planning suicide			thoughts or behaviors					
Feeling depressed			Always worried					
Crying a lot			Concentration problems					
Unable to have a good time								

9. Past and Current Psychiatric Treatment

Psychotherapy:
*Year(s)*_____
*Type (Individual/Family/Couples)*_____
*Provided by*_____
*Helpful (Y/N)?*_____

Psychiatry:
*Year(s)*_____
*Past Psychiatric Medication(s)*_____
*Prescribed by*_____
*Helpful (Y/N)?*_____

Psychiatric Hospital Admissions
*Year(s)*_____
*Hospital(s) Name(s)*_____
*Length of Stay*_____
*Helpful (Y/N)?*_____

10. Alcohol and Other Drug Use:

A. Do you use drugs or drink alcohol? Yes No

If yes, how often do you use the following substances?
Cigarettes: ____ per day ____ per wk ____ per month ____per year (comment:)
Alcohol: ____ per day ____ per wk ____ per month ____per year (comment:)
Marijuana: ____ per day ____ per wk ____ per month ____per year (comment:)
Cocaine: ____ per day ____ per wk ____ per month ____per year (comment:)
Hallucinogens:__ per day ____ per wk ____ per month ____per year (comment:)
Other: ____ per day ____ per wk ____ per month ____per year (comment:)

B. Have you or anyone else ever thought that you "over used" any substances? Yes No
If yes, please describe:

C. Previous treatment programs (dates, locations, if possible):

D. How many cups of caffeinated beverages do you drink per day? (coffee, tea, colas, etc.):

11. Have relatives/significant others had psychiatric symptoms or drug or alcohol problems? Yes No
If yes, please describe:

POLICY STATEMENT
Please read the following important information.

Assessment and Treatment: Dominique Samuels will provide an assessment of your difficulties and available treatment options. If she recommends and you agree, she will provide psychotherapy for you. She will provide rationale for the psychotherapy approach or other treatment options recommended for you. She will try to provide an estimate of the number of treatment sessions that it will take to achieve your treatment goals, although this is only an estimate. For most patients, treatment may range from 10 to 50 sessions. No guarantees can be made regarding the success of treatment. There is a small risk that your condition may worsen during treatment. Treatment can be time consuming and stressful. It can bring up many strong feelings. It may result in changes that were not originally intended. Treatment decisions for you will be made collaboratively.

Alternative Options: There are often various treatment options, such as various individual psychotherapy approaches, group/couple/family/self-help therapies, medication treatment, etc. Testing and other diagnostic procedures may be helpful in some cases. She may recommend or you may wish to explore treatment options other than treatment with her. You are entitled to ask questions about all aspects of treatment. At times, she may recommend that you obtain a 2nd opinion or consultation with another professional. She will tell you rationale for any treatment recommendations made for you.

The Patient's Role: You are expected to play an active role in your treatment. This includes working with her to outline treatment goals, and includes completing symptom assessment questionnaires to monitor your symptoms. You will probably be asked to complete homework assignments between sessions. If at any point you are unhappy about the progress, process or outcome of your treatment, please discuss this with her so that you can attempt to resolve any difficulties and arrive at a treatment plan that better meets your needs.

Hours/Availability: Dr. Samuels is available for psychotherapy sessions on Monday through Friday in SF between 9 am – 8 pm. Therapy sessions are 45-50 minutes. Sessions typically occur 1-2x/week during the initial phase of treatment, and may taper to 1-2x/month during the final phase of treatment. Your therapist will discuss his/her recommendations for frequency of sessions with you after the assessment/evaluation of your treatment needs is completed. The first goal of the assessment/evaluation is to determine if our level of availability is suitable for your treatment needs.

Dr. Samuels is available by leaving a message on her voicemail or contacting her via email. She will get back to you within 24 business hours. Possible reasons for contacting Dr. Samuels will be discussed with you. She does not have hospital admitting privileges and does not prescribe medication and therefore is not available on an emergency basis. Again, an important part of the assessment/evaluation is to determine if Dr. Samuels' level of availability is suitable for your treatment needs.

Confidentiality: The confidentiality of communication between a client and a therapist is important. Your

confidentiality is protected by HIPAA (Health Insurance Portability and Accountability Act) Guidelines (1996). She will make every effort to keep information regarding your evaluation, diagnosis and treatment strictly confidential, as is required by law. A document entitled "Consent for Release of Information" must be reviewed and signed by you in order for oral, written or electronic information about you to be released by Dr. Samuels to any other person or agency (other than co-treating providers). She prefers to use the U.S. Postal Service or telephone to communicate with other providers about your clinical care. This avoids the possible risk of breaching confidentiality via internet communication.

You and your therapist may decide to e-mail each other as part of your treatment plan. E-mail updates between sessions often help clients to complete homework assignments, but pose some risks regarding confidentiality. If we decide to communicate via e-mail, we will review a document entitled "Consent for E-mail Communication". You must sign the document in order to communicate via e-mail, but you have the right to refuse or restrict e-mail communication. Dr. Samuels' e-mail address is samuelspsyd@gmail.com and is secured by a password known only to her. To the best of our knowledge, Dr. Samuels is the only person who can read mail at this e-mail address.

Exceptions to Confidentiality:
Information CAN be released WITHOUT your permission if:
*You are a danger to yourself or others, or are unable to care for yourself.
*There is suspected elder, dependent-adult or child abuse/neglect.
*Your therapist is ordered by a court to release information.

Record Keeping: Dr. Samuels maintains a clinical chart of handwritten notes for each patient. Information in this chart includes your name, contact information, diagnosis, description of your condition, treatment goals, treatment plan, dated progress notes from each session, symptom monitoring forms, and consent for release of information documents. These records are stored in a locked file cabinet.

Fees: Dr. Samuels' fee is $205.00 for a 50 minute individual session paid by credit card. A $5 discount is given for cash or check. Longer or shorter sessions will be prorated from this fee base. Phone calls over 10 minutes in length will also be charged at pro-rated fees according to the length of the call. Lower fees on a sliding scale based on income are available for qualified individuals upon request.

Session Location: All sessions are conducted at 1833 Fillmore Street or 110 Sutter Street. Between-session phone contact is also discouraged, and often indicates that the client needs more frequent in-person sessions as part of their treatment.

Cancellation: Dr. Samuels greatly appreciates 24 - 48 hours advanced notice of a cancellation of an appointment. She usually charges you for a cancelled appointment with less than 24 hours notice if she is unable to fill your cancelled appointment time. The earlier you notify her of the cancellation, the more likely it is that she will be able to offer your time to someone else and not charge you for the cancellation.

Payment and Insurance: Please pay Dr. Samuels at each session. Dr. Samuels does not take insurance, but can provide you with a billing statement if requested for reimbursement from your insurance or for documentation purposes. Most insurance companies require frequent updates on symptoms and progress in order to authorize additional symptoms. There may also be limits on how many sessions you are allowed in a year. Please review your insurance plan for this information.

Release of Information: I authorize the release of information for claims, certification/case management/ quality improvement, and other purposes related to the benefits of my Health Plan (release of information to providers, family, etc., requires a separate form). PLEASE NOTE: This authorization does not apply if you are not using insurance.

Acknowledgment: By signing your name below, you are acknowledging that you have read and understood this document and that you voluntarily agree to participate in this treatment. If you have any questions about the above information, please discuss them with Dr. Samuels. You will also receive a copy of this policy to

take home.

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Summary of Policy:

Please provide your initials for each line:

___ I have received and read the policies and agree to them.

___ I have received and read the HIPAA Notice of Privacy Practices.

___ I agree to pay the fee agreed upon at each session.

___ I understand that I will be charged for any appointments cancelled with less then 24 hours, barring emergency or illness.

___ I understand that I am expected to play an active role in therapy.

Client (or Parent/Guardian) Signature Date