PEMBERTON COUNSELING SERVICES, PSC
ADULT COVER

PATIENT INFORMATION

Patient's Name: ____ SS# _____-_____-______ Sex: ☐ Male ☐ Female

Date of Birth: _______________ Age: ______ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: ____

Home Phone: (________)____________________________ Occupation: ___________________________________ ☐ Student

Cell Phone: ____

Employer (School, if student): ___________________________________ Work/School Phone: (________)_________________

Employer/School Address: ____

E-mail Address: ____

Does anyone else have access to your email address? ☐ Yes ☐ No

Do we have your permission to use email to correspond? ☐ Yes ☐ No Signature____________________________________

SPOUSE'S INFORMATION

Spouse's Name: _______________________________________ Date of Birth: _________________

Cell Phone: ____Work Phone: (___________)____________________________

INSURANCE BILLING: We do not bill insurance. We will provide patients with receipts that may be submitted to insurance carriers for reimbursement. Patients/Responsible Parties are responsible for all charges whether or not they are covered by insurance. **Therapists of Pemberton Counseling Services, PSC are not Medicare providers.**

PAYMENT POLICY: Pemberton Counseling Services, PSC require payment for services at the time they are rendered. Payment may be made by cash, personal check or credit card (American Express, MasterCard or Visa). As patients are expected to maintain a zero balance our office does not send patients statements on a regular basis. Accounts need to stay current in order to maintain ongoing treatment. Unpaid accounts over 60 days old are routinely reviewed for submission to our collection agency.

FEES CHARGED: The fees charged by doctors/therapists at Pemberton Counseling Services, PSC are based on the amount of time scheduled for dealing with patient issues. The minimum amount of time scheduled/charged by our therapists is for a half session (20-30 minutes in length). If additional time beyond the scheduled time is taken to assist patients, there will be a charge for the amount of time used. In addition, patients are charged for time spent with a patient on the telephone and time taken to write reports or correspondence on patient's behalf.

CONFIDENTIALITY: Interactions between client and counselor are confidential. Unless the therapists of Pemberton Counseling Services, PSC have permission, we will not discuss anything that transpires between us with anyone. There are four major exceptions to confidentiality that Kentucky Law requires all mental health professionals to report:

1. Incidences of child or elder abuse or neglect
2. Intent to commit suicide.
3. Threats to do harm to yourself or another person.
4. Court order.

Additionally, in the event of a billing dispute, names, dates and lengths will be disclosed.

APPOINTMENT CANCELATION POLICY: Pemberton Counseling Services, PSC require that cancellations for scheduled appointments be received 24 hours in advance during regular office hours (Monday through Friday 8:00am to 5:00pm). **Unkept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee at the discretion of your therapist or doctor**. This fee can equal but will not exceed the therapist/doctors fee for the time originally scheduled. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge.

***I have read and understand the above stated policies of* Pemberton Counseling Services, PSC.**

***Signature of Responsible Party* (required): ____**

PEMBERTON COUNSELING SERVICES, PSC
1700 UPS Dr., Suite 107 Phone: (502) 327-8045
Louisville, KY 40223 Fax: (502) 327-7227
www.pembertoncounseling.com

Adult Intake Questionnaires

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. Any questions that require additional space to answer, please note on question and finish answer on the back. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information. Thank you!

PATIENT IDENTIFICATION
Name ________________________________ First Appointment Date __________________________________
Birth Date ____________________________ Age _________ Sex ____________________________________
Religion _____________________________ Marital Status ____
Race ________________________________ Children ____
Address ______________________________ City _______________________ State ____ Zip _______________
Home Phone # ______________________ Work # ________________________Cell #______________________
Who are you currently living with? ____

REFERRAL SOURCE _______________________ Address ____
Phone #____________ Do we have your permission to release information to the referring professional when it is appropriate? Yes ____ No _____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)
____
____
____
____
____
____
____
____
____
____
____
____
____
____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?
____

____

____

PRIOR ATTEMPTS TO CORRECT PROBLEMS
Have you had previous counseling or psychiatric help? Please check all that apply.

☐ **Individual Counseling:**
If yes, when and where did you receive counseling and what were the issues? Did you feel that this helped?
____
____

☐ **Group Counseling:**
If yes, when and where you receive counseling and what were the issues? Did you feel that this helped?
____
____

☐ **Hospitalizations:**
If yes, when and where you receive counseling and what were the issues? Did you feel that this helped?
____
____

MEDICAL HISTORY

MEDICATION	DOSAGE	START DATE	END DATE

Any history of head trauma? (describe): ____
____
Any seizures or seizure like activity? ____
Any periods of spaciness or confusion?____
Prior hospitalizations (place, cause, date, outcome):___________________________________
____
Prior abnormal lab tests, X-rays, EEG, etc.:____
____
Allergies/drug intolerances (Please list): ____
____

Present Height _______ *Present Weight* _______ Change *in weight in past 3 months*_______ *Meals per day* _________

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)____
____
____
____

Prenatal and birth events: Your parents' attitudes toward their pregnancy with you ______________________
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc____
Any birth problems, trauma, forceps or complications?____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)
____
____

School History: Last grade completed _____________ Last school attended ____________________________
Average grades received _______________ Specific learning disabilities __________________________________
Learning strengths ____
Any behavior problems in school? ____

Employment History: (summarize significant jobs you've had, list most favorite and least favorite)
____
____
____
____
Any work-related problems? ____
What would your employers or supervisors say about you? ____
____

Military History? ____
____

Ever Any Legal Problems? ____
____

Alcohol and Drug History: Including: alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

Age when began using	**Type of drug used**	**Currently Using? Yes/No**	**How did this drug make you feel?**	**What were the benefits of this drug?**

Do you or have you ever experience withdrawal symptoms from alcohol or drugs? _________________________
Has anyone told you they thought you had a problem with drugs or alcohol? ______________________________
Have you ever felt guilty about your drug or alcohol use? ____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? ___________________
Have you ever used drugs or alcohol first thing in the morning?____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _______________________________________
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____________________
____
____

Sexual history: (answer only as much as you feel comfortable)
Age at the time of first sexual experience: ________ Number of sexual partners: __________
Any history of sexually transmitted disease? __________ History of abortion? _____________________________
History of sexual abuse, molestation or rape? ____
Current sexual problems?____
Any history of being physically abused: ____
____

FAMILY HISTORY

Family Structure **(who lives in your current household, please give relationship to each):**

NAME	AGE	RELATIONSHIP TO CHILD

Current Marital or Relationship Satisfaction____
____
____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)____
____
____
____

Explain any of Past Marriages ____

Natural Mother's History: age_____ outside work ____
School: highest grade completed ____
Learning problems (specify) ____
Behavior problems (specify) ____
Marriages ____
Medical Problems ____
Childhood atmosphere (family position, abuse, illnesses, etc)_____________________________________
____
Has mother ever sought psychiatric treatment? Yes ___ No ___
If yes, for what purpose?____
____
Mother's alcohol/drug use history ____

Have any of mother's blood relatives ever had any learning problems or psychiatric problems including things such as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?
(specify)____
____

Natural Father's History: age_____ outside work ____
School: highest grade completed ____
Learning problems (specify) ____
Behavior problems (specify) ____
Marriages ____
Medical Problems ____
Childhood atmosphere (family position, abuse, illnesses, etc.)____
____
Has father ever sought psychiatric treatment? Yes ___ No ___
If yes, for what purpose?____
____
Father's alcohol/drug use history ____
Have any of father's blood relatives ever had any learning problems or psychiatric problems including things such as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations?
(specify) ____
____

____
Siblings (names, ages, problems, strengths, relationship to patient) _______________________________________
____
____

Children (names, ages, problems, strengths) ____
____
____

Cultural/Ethnic Background ____
____

Describe your relationships with friends ____
____

Describe yourself ____
____

Describe your strengths ____
____

Name:______________________________

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General
- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other______________________

Neurological
- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ “Tics”
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other______________________

Respiratory
- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other______________________

Chest and Cardiovascular
- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Other______________________

Head, Eye, Ear, Nose, & Throat
- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other______________________

Gastrointestinal and Hepatic
- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other______________________

Musculoskeletal
- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other______________________

Skin, Hair
- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other______________________

Genitourinary
- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other______________________

Females
- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other______________________

Males
- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other______________________

Explanation

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

INFORMED CONSENT

Welcome to the practice. This document contains important information about the professional services and business policies. Please read it carefully and jot down any questions you have so we can discuss them. Once you sign this, it will constitute a binding agreement between us as well as your consent for us to begin therapy/treatment.

COUNSELING SERVICES

Dr. Charles Pemberton, Ed.D., is a Licensed Professional Clinical Counselor, (LPCC), licensed by the state of Kentucky. Currently all other employees are either licensed, an associate, or operating as a student. Dr. Pemberton currently supervises and oversees all active cases.

We offer a variety of services including counseling/therapy for individuals and couples, children and adolescents and consultation. The type of therapy that we generally prefer is called Cognitive Behavioral. This approach to change emphasizes both how we think and what we do. As we learn new and different ways to look at current situations we eliminate undesirable, unhealthy feelings and behaviors.

As counselors, we do not provide any medication or perform any medical treatments. If medication seems indicated, we maintain close working relationships with a number of physicians and psychiatrists, and will refer you to these practitioners.

When we work with people, one of the goals is to help them identify the underlying thoughts that are associated with undesirable feelings, actions, and behaviors. Unfortunately, there are no guarantees, and there are potential risks. Risks may include experiencing uncomfortable levels of feelings like sadness, anxiety, anger, frustration, etc., and people may recall unpleasant aspects of their personal history. People also sometimes report feeling worse before feeling better

At any time during our work together, you have the right to decide to end treatment, and there is no moral, legal, or financial obligation other than to pay for the services already rendered. If you are thinking about ending therapy, we encourage you to discuss this with us, and if you wish, we will be glad to provide you with the names of other mental health providers.

MEETINGS

First appointments generally last about an hour, and subsequent sessions are 50 minutes, although extended appointments are available. Unless 24 hours notice is given, you will be expected to pay for the appointment unless we both agree that you were unable to attend due to circumstances beyond your control and insurance companies/managed care organizations rarely if ever pay for missed appointments. In the event of extremely bad weather such as ice and snow, it is advisable to call just to make sure the office is open.

OFFICE HOURS

Office hours vary according to clients' needs and scheduled meetings. Meetings are scheduled Monday through Friday, 8:00 a.m. until 7:00 p.m. In the event that an appointment is scheduled outside of these times, we reserve the right to apply an after-hour charge.

TELEPHONE CALLS

We strive to return telephone calls between sessions (which is one reason sessions are 50 minutes). We are not interrupted during sessions for incoming calls. Generally, we do not believe that the telephone is the best manner to deal with therapy issues, and telephone calls that exceed five minutes may be charged at the normal therapy fees. In the event of a life threatening emergency, the office or answering service can always reach us or the person who is covering in the event that your therapist is out of town.

 Initials _______

PROFESSIONAL FEES

	Licensed Counselor	Licensed Associate Counselor
First appointment	$100.00	$80.00
25 minutes	$45.00	$25.00
50 minutes	$80.00	$40.00
80 minutes – for families/couples	$120.00	$70.00

If inpatient treatment is provided fees are billed at the hourly rate, as well as any extended sessions or consultations. Reports for insurance including treatment plans will be billed at the hourly rate.

All fees are subject to change, and in the event of fee changes, you will be notified at least 30 days prior to such changes. There is a $25.00 service charge on all returned checks.

INSURANCE

Pemberton Counseling does not file insurance claim forms at this time.

LEGAL MATTERS

Should we become involved in any legal matter such as giving testimony, depositions, etc., the fee is $200.00 per hour for preparation, review of materials, travel time, court time, and any other time involved. A retainer fee based on the estimated time involved will be paid in advance of any work. A minimum charge of $400.00 for the above work will be assessed.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless previously agreed. Payment schedules for other professional services will be agreed to at the time these services are requested.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I reserve the right to forward your account to GLA Collections If legal action is necessary, the costs of bringing that proceeding will be included in the claim, and the client or responsible party will be responsible for all costs of collection, litigation, and attorney's fees. In such cases, the only information that is released about a client's treatment would be the client's name, the nature of the services provided (e.g., individual therapy), dates of services, and the amount due.

CONFIDENTIALITY

Within the limitations discussed below, the information you reveal during our professional relationship will be kept confidential and will not be released to anyone without your written consent. However, certain conditions do require that confidentiality and privileged communication be breached including: (1) if you present a danger to yourself; (2) if you present an imminent danger to another person which can include a communicable disease that can be life-threatening to others; (3) if there is reason to believe that child abuse or neglect is present a report must be filed with a state child protection agency; (4) if a legitimate court order is issued; (5) if the treatment is ordered or under the supervision of the court; and (6) an insurance company or managed care company requires you to consent to release of records and/or information to them as a condition for reimbursement. When such is released, we cannot control how the information is treated, nor will Pemberton Counseling or its representatives be responsible for any injury or claim for damages arising from the release of records or information as required by the insurance company or managed care organization.

Information revealed in marital therapy is protected by privileged communication in Kentucky and requires permission of both to waive. When working with couples, we adopt a "no secrets" rule. That is, should we speak individually with either party (e.g., via telephone), we reserve the right to disclose any information to the other party if we believe such information is relevant to the therapy process.

SPECIAL NOTES

When a family is confronted by parental separation or divorce, it is very hard on everyone. It is important then when working as a couple, each person feels safe to speak openly and honestly, without fears that material revealed in therapy will be revealed in court and used in a negative fashion. In order to provide a safe environment for couples work, it is important that you agree not to call us as witness or to attempt to subpoena records in the event you choose to pursue divorce. While a judge may overrule this agreement and issue a court order for information, your signature(s) below reflect your agreement not to call us as a witness nor attempt to subpoena records.

If parents/guardians request or require that they are informed of the issues discussed in individual sessions, we require that the discussion occur in the presence of the child or adolescent.

In order to provide clinical coverage for me when your therapist is out of town, it may be necessary for that therapist to release general information to the licensed counselors, associates and psychiatrists who are covering.

AGREEMENT

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I understand that there are no guarantees stated or implied, and I accept the risks inherent in the course of therapy. I have familiarized myself with the fees and charges for services provided by Pemberton Counseling Services, PSC, and I understand and agree that the counseling services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of services, and I understand I am responsible for all costs of collection and litigation together with attorney's fees if the charges for services must be collected by an action of law. No one can predict the course of human relationships, and as we learn more about each other, it may be necessary to amend prior agreements.

Client Signature ____ Date __________________________

Complete the following for clients under 18 years of age:

I, __________________________________, give permission for a therapist from Pemberton Counseling Services, PCS
(name of parent/guardian)

to conduct counseling with my ____________________ , ________________________________.
(relationship) (name of minor)

Parent/Guardian's signature ____ Date __________________________

Minor's signature ____ Date __________________________