Barbara N. Vosk, Ph.D.

Licensed Psychologist

3710 Benson Dr.

Raleigh, North Carolina 27609

919 878-7800

FAX: 919 878-9983

New Client Information

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City ST Zip

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Work Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Cell Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I leave messages at your: Home ( Y / N ) Work: ( Y / N )

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_ Single \_\_\_\_\_\_Married/Partnered \_\_\_\_\_Divorced \_\_\_\_Separated \_\_\_\_Widow(er)ed

Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years of Education/Highest Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Members: Please list the names and ages of your partner/spouse, children or step children

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for seeking therapy:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Previous Therapy:

Have you ever seen a therapist before? \_\_\_\_\_Yes \_\_\_\_\_\_\_No

If yes, whom did you see and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug and Alcohol Consumption:

How much alcohol do you consume? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much caffeine do you consume? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any illegal substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Health:

Do you take any prescribed medication? \_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No

How do you rate your general health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medical conditions you are being treated for at this time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: (Include supplements and over the counter drugs)

Medication Dose Date Started Prescribed By

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Referral Information:

Please let me know how you learned of my practice. (Please check all that apply.)

Health Care Provider:\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Friend or acquaintance:\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or former client: \_\_\_\_

Dr. Vosk’s web page \_\_\_\_\_

Office Policies

Fees and Billing Information: Fees are based on a 45-minute consultation hour. Payment in full is due at the time of service. It is helpful if you have your payment ready prior to your appointment so as not to interfere with valuable therapy time. Additional fees are charged for extended or frequent telephone consultation, written reports, as well as travel, preparation, and involvement in legal proceedings or other non-clinical services, unless prior arrangements have been made. These fees are not reimbursable by insurance. A monthly service charge of 1.5% may be added to accounts more than 60 days past due. Clients are responsible for all costs incurred in collecting delinquent accounts.

Missed Session Policy: Clients are responsible for the full fee for missed sessions which are not cancelled with 24 hours or one business day’s notice (whichever is longer). Sessions cancelled due to illness or family illness are not charged. Please note that health plans cannot be billed for missed sessions. Charges for missed sessions are due at the time of the next visit.

After Hours Emergencies: I can be paged through my voicemail system by following the prompts to flag your message as urgent. If there is an imminent threat to health or safety contact the nearest hospital emergency room or dial 911. You may also access the Holly Hill Hospital RESPOND program at 919

250-7000. E-mail contact should not be used for any matters of an urgent nature.

Confidentiality: My practice is compliant with HIPPA confidentiality guidelines which are described in detail in a separate document provided to you. In general, no information will be released without your specific written consent except in the following situations;

* suspicion of child abuse or neglect
* imminent threat of physical harm to self or others
* a lawful order from a judge to produce records in court
* billing information necessary to pursue collection of a delinquent account
* consultation with professional colleagues to assure coverage in my absence or to enhance treatment planning

I will be happy to respond to any questions or reactions that you have to the above policies or about charges or bills which you receive.

I HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICIES. I AGREE TO THE TERMS HEREIN. I ACCEPT PERSONAL RESPONSIBILITY FOR ALL CHARGES INCURRED. I AUTHORIZE DR. VOSK TO RELEASE NECESSARY WRITTEN, FAXED, AND/OR VERBAL (PHONE) INFORMATION REGARDING MY TREATMENT TO MY INSURANCE COMPANY.\* I CERTIFY THAT THIS AUTHORIZATION IS MADE VOLUNTARILY. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THIS CONSENT WILL EXPIRE 18 MONTHS AFTER COMPLETION OF TREATMENT.

I GRANT PERMISSION TO CONTACT THE INDIVIDUAL OR HEALTH CARE PROVIDER NAMED ABOVE TO ACKNOWLEDGE THEIR REFERRAL Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature (Client or Legal Guardian) Date

\* Subject to lawful provisions of applicable health care plans.