John B. Rowe, Ph.D., PC 4108 Park Road, Suite 310 Charlotte, NC 28209-2261 704.408.9060

INTAKE INFORMATION FORM

Patient Name ___________________________________Today's Date __________________
Address: __________________________________ PO Box____________________________
City ____ State _____ Zip________________
Cell Phone _________________ Home Phone ___________ Work Phone _________________

If I need to contact you between sessions, where may I leave a message? (circle one):
CELL HOME WORK NONE Social Security # xxx-xx- __ __ __ __

Birth Date: ____________Birthplace_____________________________ Gender ___________
Ehnicity_________________Age ____ Occupation ___________________________________

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: ______________________________ Empoyer ____________________________
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 ___________________
City ____State______ Zip ___________

Please complete both sides

Referred By: Name ______________________________ 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 _______________

General Health Information:
Name of Primary Care Physician ____
Date of Last Physical Exam ______________ Known Allergies ____________________________
Current Medications ____
____

Insurance Information:
If your insurance company requires me to do the filling, 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 to date, how much you are required to pay per visit, (d) how many visits are you allowed, (e) date your coverage begins/ends.

I authorize insurance payment of medical benefits to John B. Rowe, Ph.D., LMFT, 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 John B. Rowe, Ph.D., LMFT 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 John B. Rowe does not provide medical or legal assistance.

Please proceed to the next page

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 ____________

For office use only:

Diagnosis ____ Fee $ ______________