RESTORATION
Counseling Associates

Phone	(865) 357-4673
Email	info@restorationcounselingassociates.com
Address	9724 Kingston Pike, Bldg 6, Knoxville, TN 37922

Date	month	day	year

INTAKE FORM • PATIENT INFORMATION

GENERAL DETAILS

First Name			Date of Birth	
Last Name			Age	
Gender	male	female	Marital Status	
Spouse's Name			Years Married	
If divorced, how long?			Length of previous marriage(s)	

CONTACT INFORMATION

Address			Email		
City & State		Zip Code	OK to Email?	yes	no
Home Phone	area code		May we leave a message	yes	no
Cell Phone	area code		OK to Text?	yes	no

OCCUPATION DETAILS

Occupation			Employer		
Hours per week			Full or part time?	Full	Part

EDUCATION DETAILS

School / University		Highest level completed	

FAITH DETAILS

Faith Affiliation			Active?	yes	no

INTAKE FORM • PATIENT INFORMATION

LIFESTYLE DETAILS

Current Substance Use		yes	no
If yes, how much and how often?			
Regular Exercise		yes	no
If yes, what and how often?			
Legal History		yes	no
If yes, please list dates and more information			
Do you feel you have adequate social support at this time		yes	no
if yes, please explain			

INTAKE FORM • PATIENT INFORMATION

PAYMENT INFORMATION

Who will be responsible for payment?		Relationship	
Address if different			

MEDICAL INFORMATION

Primary Care Physician/Provider	
Describe any problems you have that require medication/ physical care /treatment	
Current Medications (include non-prescription drug, vitamins or supplements):	
Date of last physical	

PAST TREATMENT

Have you ever sought prior psychological treatment?	yes	no		
If yes, list dates of treatment			Provider	
Reason for seeking treatment				

REASON FOR SEEKING TREATMENT

Briefly describe what brings you to therapy	
Describe how this issue is presenting itself and/or impacting your current level of functioning.	
Is there anything else that you believe might be important for your therapist to know?	

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INTAKE FORM • POLICIES

POLICIES & PROCEDURES REGARDING TREATMENT

The following information is provided to assist you in understanding polices and procedures regarding your counseling. **All treatment is limited to the professional relationship between you and your individual therapist. It has no association to Restoration Counseling Associates, or any other therapist.**

We strive to provide you with the highest quality of care however, like anything in life, psychological care offers no absolute guarantee of success and there are limitations to any form of care offered a patient. Please do not hesitate to ask questions of your therapist at any time about your treatment.

APPOINTMENTS: Since patients are seen by appointment only, the appointment time given is reserved for you. Please give at least twenty-four (24) hours notice if you must cancel your reserved time. You will be charged the usual fee for appointments not canceled twenty-four hours prior to your scheduled time. The office does have an answering machine so that you can leave cancellation notices at any time. We do recognize that illness and emergencies happen which may prevent you from keeping your reserved time, and do not charge for these infrequent occurrences.

EMERGENCIES: There may arise occasions where you need to talk with your therapist other than your regularly scheduled appointment times. If this need is NOT life threatening to yourself or another, you may leave a message on the office answering machine and your therapist will contact you on their next business day in the office. IF THE EMERGENCY IS LIFE THREATENING OR YOU DO NOT FEEL SAFE, CALL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM.

FEES AND PAYMENT: Payment is required at the time of services unless another arrangement is agreed upon with your therapist. Fees will be discussed with you when you set up your first appointment. Appointments are 45 minutes in length unless otherwise agreed upon with your therapist. If your fees are not paid in accordance with the payment agreement, your therapist will discuss this with you. If after discussion payment is not made in the agreed upon time frame, your therapist retains the right to terminate treatment.

I have read all of the above information regarding the policies and procedures. My signature indicates my informed consent for care.

Patient Signature		Date Signed	month	day	year

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INTAKE FORM • PRIVACY RIGHTS

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law”, HIPAA provides patients protections related to electronic transmission of data, (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“the security rules”).

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you do not have legal training. Our Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important for you to know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we will do all we can to protect the privacy of your health record. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask your therapist for further clarification.

By law, we are required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. My signature is acknowledgement that I have read and understand the Notice of Privacy Practices (HIPAA) Form.

I _____ , understand and have been offered a copy of the Patient Notification of Privacy Rights Document. Which provides a detailed description of the potential uses and disclosures of my protected health information as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

Patient Signature		**Date Signed**	month	day	year