Karin M. Tonkin, Ph.D.
Licensed Psychologist
Patient Intake Form

The following information will help me to serve you better. Please contact me if this information changes.

Name: _____ Date:_____
Last First Middle initial

Name you would like us to call you (if different than above): _____

Date of Birth: _____ Age: _____

Local Address: _____
Street City State Zip

Please fill in below the number(s) at which we may call you (note that cell phones may not be secure):
Home: (____) _____-_____ May we leave a message? Yes ☐ No ☐
Cell: (____) _____-_____ May we leave a message? Yes ☐ No ☐
Work: (____) _____-_____ May we leave a message? Yes ☐ No ☐
Email: _____ May we email you? Yes ☐ No ☐

_____ _____ _____
Employer Occupation Work Phone #

Do you have health insurance coverage? Yes ☐ No ☐
Name of insurer: _____

In case of emergency contact:_____
last first
Relationship:_____ Phone ( ) _____

Sexual Orientation (optional): _____ Ethnic/Racial Background(optional): _____

Relationship Status: _____ Spiritual/Religious Identity: _____

CAROLINA HEALTH AND HEARING

MEDICAL INFORMATION

Physician's Name: Phone #: _____

Physician's Address: _____

Street City/State Zip Code

Significant Medical Conditions (past or current):

_____

_____

Are you currently taking medications? Yes ☐ No ☐

If yes, please list:

Medication	Dosage	Frequency	Start date	End date	Physician Phone

Are you presently receiving counseling or psychotherapy from some person or agency other than this service? Yes ☐ No ☐

Where? _____

Name of counselor? _____

I use alcohol/other drugs

☐ Once a week or less
☐ More than once a week
☐ Do not use

The following has resulted from my alcohol/drug use: (check all that apply)

☐ traffic violation
☐ ruined relationship
☐ black outs
☐ fight with friend
☐ academic problems
☐ difficulties with memory
☐ other (specify):_____
☐ does not apply

I have tried to coutrol my weight by: (check all that apply)

PAST	**PRESENT**
☐ vomiting	☐ vomiting
☐ not eating	☐ not eating
☐ laxatives	☐ laxatives
☐ dieting	☐ dieting
☐ exercise	☐ exercise
☐ calorie counting	☐ calorie counting
☐ diuretics	☐ diuretics
☐ diet pills	☐ diet pills
☐ food rituals	☐ food rituals

I am experiencing the following:
None = This symptom not present at this time but have experienced in the past
Mild = Impacts quality of life, but no significant impairment on day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning
N/A = Have never experienced this symptom (past or present)

	None	Mild	Moderate	Severe	NA		None	Mild	Moderate	Severe	NA
Depressed feelings						Anxiety					
Feeling hopeless						Panicky feelings					
Sleep problems						Fears or phobias					
Fatigue/low energy						Obsessive thoughts					
Poor concentration						Compulsive behaviors					
Indecisive						Health problems					
Feeling worthless						Appetite disturbance					
Feeling overwhelmed						Weight gain/loss					
Irritability/anger						Body image issues					
Agitated/restless						Alcohol use					
Somatic complaints						Drug use					
Guilt/shame						Physical assault/abuse					
Mood-highs/lows						Sexual assault/abuse					
Feeling high without drugs						Verbal assault/abuse					
Overly energetic						Financial problems					
Lying/stealing						Gambling problems					
Aggressive behavior						Academic concerns					
Violent thoughts						Career concerns					
Thoughts about harming others						Family problems					
Thoughts about ending my life						Relationship problems					
Suicidal gesture/attempt						Feelings of grief/loss					
Self-mutilation						Social isolation					
Death of someone close						Withdrawing from others					
Sexual concern/question						Have other					

Have you ever experienced suicidal thoughts in the past? Yes___ No___
Have you ever attempted suicide? Yes__ No___
Have you ever been hospitalized for any mental health concerns? Yes___ No___ . If yes, please note approximate dates below:

Family History

Family Members	Relationship to You	Age	Educ/Occupation

Yes No Has any family member had a psychiatric disorder? If yes, who/what:

Yes No Has any family member used psychotropic medications? If yes, who/what/why (list all):

Yes No Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes, who/why:

Additional information (e.g., types of relationships with family, significant events in family):

To what extent does your cultural identity (i.e., ethnicity, nationality, etc) play an important role in your life:

To what extent does your religious or spiritual preference play an important role in your life:

Your signature below indicates that you have responded to this questionnaire as completely and candidly as you are able.

Printed Name **Signature** **Date**

CAROLINA
HEALTH AND HEARING

Appointments & Scheduling

Please initial each policy

____ Due to the rising number of patients who do not cancel their appointments when circumstances prohibit them from appearing at our office, we have instituted a "no show/late cancellation fee." Carolina Health and Hearing., requires a 24-hour cancellation notice. **Appointments broken without 24-hour notice will be charged $35.00.** You may choose to reschedule your session at another time within 2 weeks to avoid these charges. This fee will not be charged if a telephone cancellation due to illness or extenuating circumstances is received in our office **prior** to your appointment time. This fee is **not** billable to your insurance company.

____ Three consecutive no shows result in automatic removal from the schedule.

____ Arriving 15 minutes past scheduled appointment time results in a reschedule appointment.

I authorize Carolina Health and Hearing to provide appropriate evaluation and treatment as needed. Additionally, I authorize the release of any necessary information acquired in the course of the evaluation or treatment process to my referring physician, health plan/ insurance representative, or attorney. I have read and understand the above information as well as the insurance benefits verified from my insurance carrier, if applicable. I understand that I am responsible for all charges whether reimbursed by my insurance company.

_____	_____	_____
Signature	Print Name	Date

CAROLINA
HEALTH AND HEARING

Patient Financial Responsibility Policy

Thank you for choosing Carolina Health and Hearing to serve your healthcare needs. It is our policy to provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to all patients.

INSURANCE POLICY

- If you are a patient with insurance, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- Deductibles, co-payments, and coinsurances are your responsibility.
- If you do not want Carolina Health and Hearing to file to your insurance, please inform us at check-in. Services not filed to your insurance will be considered self-pay and payment is due at time of service.

PAST DUE BALANCES

- All over-due patient balances will be sent to collections. Patients sent to an outside collection agency risk negative credit ratings and possible dismissal from the practice.
- Past due accounts may hinder your ability to have appointments scheduled.

To help in this policy, we ask that you assist us by:

- Providing us with current and updated information on yourself and your insurance company.
- Presenting an updated photo identification card and insurance card when changes are made.
- Making the appropriate payment at the time of service, whether it is deductible, co-pay, coinsurance, or for the full amount if you are a self-pay patient.

I have read the financial polices contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage, and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient **Date**