Tracy J. Cohn, Ph.D.
Licensed Clinical Psychologist
Associate Professor of Psychology
2000 Kraft Drive, Suite 1210
Blacksburg, VA 24060

Psychological Works
www.tracycohn.com

P: 540.230.5958
F: 540.552.0918
EMERGENCY: 540.961.8400

Patient Account Ledger

Patient's Name: _____Age:____ DOB:_____

Physical Address: _____

Mailing Address: _____(zipcode)_____

Parent or Guardian:_____ Insured's name:_____

Patient's employer *or* school:_____ Emergency contact_____
Relation Ph#

Are you: ☐married ☐single ☐ other Are you employed: ☐part time ☐ fulltime ☐student

Phone: Home: _____Work/Cell: _____ Soc. Sec. #:___-_____-_____
(*May we call this number to reach you?* (☐Yes ☐No)
(*May we leave a message at this number?* (☐Yes ☐No)

Thank you. We'll complete everything below the line.

Acct. #: clnumber/monthstart/yearstart Page #: _____ Patient's insurance policy :_____

Diagnosis (ICD / DSM code): _____
Treatment Record: **CO-PAY _____**

	Date	Service	# of hrs	Charge/Bill	PAID co-pay today	Bal. Due
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						

All services were provided in the provider's office unless otherwise indicated.
Terms: Due upon receipt. A service charge of 1.5% per month will be added to all accounts over 30 days late. Any accounts that are turned over to an attorney for collection will include reasonable collection fees and court costs.

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Consent to Use and Discuss Your Health Information

This form is an agreement between you, your name:_____ and me/us_____Tracy J. Cohn_____. When we use the word you below, it can mean you, your child, a relative or other person if you have written his or her name here _____ ___.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form. If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 540-230-5958 or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

By signing below, I consent to the use and disclosure information necessary to receive treatment and care and for my psychologist to receive payment for services. I also acknowledge that I was offered and/or received a copy of the Notice of Privacy Practices.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

_____ (date)
Signature of authorized representative of this office or practice

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Financial Information Form

As part of providing high-quality services, we need to be clear about our financial arrangements.

A. Client's name: _____ Birth date : _____ Soc. Sec. #: _____
Gender _____ Marital status_____ Student_____ Employed yes ____no___
Address:_____ Home phone: _____

(If the patient is a dependent)
Insured's/policy holder's name: _____ Occupation: _____

Employer: _____ Work phone: _____
Address of employer: _____

B. (If client is a minor):
Parents
Father _____ Birth date _____Soc. Sec. #_____
Address:_____Home phone_____

Mother_____ Birth date _____Soc. Sec. #_____
Address_____Home phone:_____

C. (If applicable) Spouse's name: _____ Birth date: _____ Soc. Sec. #: _____
Occupation:_____ Employer: _____ Work phone: _____
Address of employer: _____

D. If you (or your spouse) have any private insurance, please fill in the numbers and names for each one.

1. ***Primary Carrier***:

Name of company: _____ Policy holder (if different from patient): _____
Policy #: _____ Certificate #: _____
Phone: _____ Provider's phone: _____
Address to send claims: _____

2. ***Secondary Carrier:***

Name of company: _____ Policy holder (if different from patient): _____
Policy #: _____ Certificate #: _____
Phone: _____ Provider's phone: _____
Address to send claims: _____

Over

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E. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

F. I understand that I am responsible for all charges, regardless of insurance coverage.

G. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicaid/Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or parent/guardian's) signature, indicating agreement to all of the statements above — Date

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CONCERNS AND PROBLEM LIST

Adult's Name: _____ Date: _____

Please identify your concerns about this adult by placing a number beside a problem, using the choices below. Do not place numbers next to problems about which you have no concerns.

8 = **Slight** concern but I have *not* thought about getting help for this problem
7 = **Some** concern *or* I have thought about getting help for this problem
6 = **Moderate** concern *or* someone has encouraged me to get help for this problem
5 = **Serious** concern *or* a few people have encouraged me to get help for this problem
4 = **Major** concern *or* many people have pressured me to get help for this problem
3 = **Unable to function** *or* I am totally unable to do what is age-appropriate in this area
2 = **A danger to self or others some of the time**
1 = **A persistent danger** to self or others

____ Acts without Thinking (Hyperactive or Impulsive)
____ Aggressive Behavior
____ Alcohol Consumption
____ Anger
____ Anxious, Tense, Worried
____ Appetite
____ Arguing
____ Bad Dreams or Nightmares
____ Being Ignored or Abandoned
____ Bothered by Recurring Thoughts
____ Bothered by a Traumatic Event
____ Bullying or Threatening Others
____ Career
____ Confused
____ Critical of Self
____ Destruction of Property
____ Eating
____ Energy Level
____ Family
____ Fears or Phobias
____ Feeling Detached from Myself
____ Fidgeting, Squirming, "Hyper"
____ Fighting
____ Finances
____ Grief, Bereavement
____ Guilt or Shame
____ Health Problems
____ Illegal Drugs or Substances
____ Illegal or Unlawful Behavior
____ Impact of Adult's Problems on Spouse
____ Legal Problems
____ Lonely
____ Lying
____ Making or Keeping Friends
____ Marriage
____ Memory
____ Mood Swings
____ Pain
____ Panic
____ Parent–Child Relationship
____ Paying Attention or Concentrating
____ Perfectionistic
____ Performing Unusual Habits or Rituals
____ Planning or Organizing Work
____ Procrastination
____ Restless
____ Sadness/Depression
____ Satisfaction with Life
____ Seeing or Hearing Strange Things
____ Self-Injurious Behavior or Suicide
____ Sexual Behavior or Responses
____ Shy
____ Sleeping
____ Social Skills
____ Social Support (Family and Friends)
____ Stealing
____ Strange, Weird, or Peculiar Behavior
____ Suspicious or Mistrustful
____ Thinking about Suicide
____ Trusting Other People

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____ Impact of Adult's Problems on the Children
____ Irritable
____ Job/Work Attendance
____ Job/Work Performance
____ Job/Work Satisfaction
____ Using Nonprescription Drugs or Substances
____ Weight
____ Well-Being
____ Lack of Interest/Enjoyment in Life

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ADULT INTAKE FORM

Thank you for taking the time to complete this information prior to our first meeting. Completing this in advance allows us to focus on your concerns more quickly.

A. Identification

Name_____ Date: _____

B. Family Members (chosen or biological):

Name	Age	Gender	Relationship

C. Relationships in your family of origin. Please describe the following:

- Your parents' relationship with each other:
- Your relationship with each parent and with other adults present:
- Your parents' physical health problems, chemical use, and mental or emotional difficulties:
- Your relationship with your brothers and sisters, in the past and present:

D. Chief concern

The main difficulty that has brought you to see me:

When did the difficulty first begin: _____

E. Treatment

Have you had Psychiatric or Counseling services before? ___No ___ Yes If yes, please indicate:

When	From whom	For what	With what results

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Have you been hospitalized for psychiatric or emotional problems in the past? ___No ___ Yes If yes, please provide dates and outcomes:

F. Medications for psychiatric or emotional problems? __ No __Yes If yes, please indicate:

Medication Name	Dose	Frequency	First Started Taking	To Treat…	Currently Taking Y/N

G. Current Providers

Primary Medical Practitioner: _____ Phone: _____

- *Would you like me to talk with your provider about the care you receive from me? ☐ No ☐ Yes*

Other Behavior Health Specialists/Consultants: _____ Phone:_____

- *Would you like me to talk with your provider about the care you receive from me? ☐ No ☐ Yes*

H. Substance Use History:

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/ Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

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I. Chemical Use:

1. Have you ever felt the need to cut down on your drinking? ☐ No ☐ Yes
2. Have you ever felt annoyed by criticism of your drinking? ☐ No ☐ Yes
3. Have you ever felt guilty about your drinking? ☐ No ☐ Yes
4. Have you ever taken a morning "eye-opener"? ☐ No ☐ Yes

J. Brief Abuse History (to the degree you are comfortable):

Your Age	**Kind of Abuse**	**By Whom?**	**Effects on you?**	**Whom did you tell?**	**Consequences of telling?**

K. Legal history

1. Is your reason for coming to see me related to an accident or injury? ☐No ☐Yes If yes, please explain:

2. Are you required by a court, the police, or a probation/parole officer to have this appointment? ☐No ☐Yes If yes, please explain:

3. Is your reason for coming to see me related to an accident or injury? ☐No ☐Yes If yes, please explain:

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BEFORE YOUR APPOINTMENT

- Please contact your insurance company and determine if you need an authorization number. If so, please bring that number with you. The number for your insurance company can be found on the back of your insurance card.

- Please contact your insurance company and inquire as to the amount of your deductible or copayment amount.

While I'm not able to accept credit cards, I do accept personal checks and cash for co-payment.

FOR YOUR APPOINMENT

- Please bring your completed paperwork
- Please bring your: (a) driver's license and (b) insurance card

Office address:

2000 Kraft Drive in the Corporate Research Center

Parking behind the building is easiest.

Please have a seat in the atrium of the building until your appointment time.

There is not a separate waiting room, so please wait until the office door at suite 1210 is opened so that the previous appointment can be completed. My office number is 1210.

If you cannot make the appointment, please call at least 24 hours in advance. If you get lost or need assistance, please call.