



Adult Intake Form (21 and over)

Today's Date: _____

Please provide the following information and answer the questions below. Information you provide here is *protected as confidential information*. If you rather discuss a question at the first visit, please note that.

Patient Name: _____
 Last First MI

Name of Parent/Guardian (if <18 yrs): _____
 Last First MI

Birth Date: ____/____/____ **Age:** ____ **Gender** Male Female _____

Marital Status: Single/Never Married Domestic Partnership Married Separated Divorced Widowed

Please list any children/age: No children

Address: _____
 Number/Street

 City State Zip

Home Phone: () _____ May we leave a message? Yes No

Cell/Other Phone: () _____ May we leave a message? Yes No

Email: _____ May we email you? Yes No

Where you referred by anyone? Yes No If yes, who? _____

Have you previously received any type of mental health services? (psychotherapy, psychiatric services, etc.)

Yes No Previous therapist/practitioner(s): _____

Are you currently taking any prescription medications? Yes No If yes, please list and reason for taking:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been prescribed psychiatric medications? Yes No If yes, please list and provide dates:

Medication	Approximate dates
_____	_____
_____	_____
_____	_____
_____	_____

General Health and Mental Health Information

How would you rate your current physical health?

- Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing: _____

How would you rate your current sleeping habits?

- Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing: _____

How many times per week do you generally exercise:

- None 1-2 3-5 Everyday

What types of exercise do you participate in: _____

Please list any difficulties you experience with your appetite or eating patterns: _____

Are you currently experiencing overwhelming sadness, grief or depression?

- Yes No If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

- Yes No If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain?

- Yes No If yes, please describe: _____
- _____

Do you drink alcohol more than once a week? Yes No

How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? Yes No If yes, for how long? _____

On a scale of 1-10 how would you rate your relationship? (1=poor) _____

What significant life changes or stressful events have you experienced recently? _____

Family Mental Health History

In the section below identify if there is a family history of any of the following issues. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

Issue	Yes	No	List Family Member/How related
Alcohol/Substance Abuse			
Anxiety			
Depression			
Domestic Violence			
Eating Disorders			
Obesity			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide Attempts			
ADHD			
Mood Disorders ("Bipolar")			
Behavior Problems			
Other psychological problems			

Additional Information:

Are you currently employed? Yes No If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

Do you consider yourself to be spiritual or religious? Yes No If yes, describe your faith or belief? _____

What do you consider to be some of your strengths? _____

What do you consider to be some of your weakness? _____

What would you like to accomplish out of your time in therapy? _____

Name of person filling in form: _____ Date: _____

Signature of person filling in form: _____

Therapist Signature: _____ Date: _____

Practice Policies and Procedures

We offer comprehensive services for children, adolescents, adults, and families. Our practice is composed of specialists trained in different modalities who can effectively manage the diverse aspects of psychiatric needs. We offer a wide range of services and in-depth evaluations. Please refer to our website for a complete listing of our services and modalities currently offered. Your practitioner will work closely with you to develop a treatment plan that meets your specific needs.

Appointments

All appointments must be scheduled directly with the Clinician. Some Clinicians use an online scheduling system and you will be setup with an user name and password if this is available to you at the first session. The session length will vary depending on the services required.

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. Thank you for your consideration regarding this important matter.

Confidentiality

The medical records of our clients are highly confidential. Information contained in the records will not be released without proper written consent. When treating a child or adolescent, parents are kept informed of the general progress of treatment but specific and personal information is kept confidential. In the case of a divorce situation where medical custody is shared, consent and authorization regarding disclosure of any information is required from both parents.

Contacting Our Office

Phone Calls

If you have an emergency, please reach out to your clinician, if you do not hear from them immediately, go to your nearest emergency room. Our office number is 203-329-3759 and each clinician has a voicemail box through that number. All phone messages are responded to as quickly as possible. Be sure to leave your name, phone number, and convenient times when you can be reached. Do not leave sensitive medical information on voicemail.

Email

You can also reach your individual clinician by email. You can find their email address on our website on their individual pages. Email addresses are all standardized to be the first letter of the clinician's first name plus their last name then @theriverwalkgroup.com. Due to privacy considerations, we do not discuss clinical matters via the internet or email. We will occasionally send follow-up emails that pertain to scheduling, billing, or other administrative matters that do not include any sensitive medical information. If you have a clinical matter that needs to be discussed between sessions, please contact your clinician to arrange a means to discuss further.

Fees/Payment Information

For further information on fees please speak directly to your clinician. Attached to this packet is a "Form of Payment" sheet to be completed to alert us how you will be settling your invoices. The Riverwalk Group accepts multiple forms of payment. We accept health savings accounts, cash, checks, bank to bank deposits and credit cards.

Insurance

The Riverwalk Group is an out of network provider, which means that you pay The Riverwalk Group directly after each session. This also means that we do not participate with any insurance companies. The Riverwalk Group will provide you with a paid invoice after each session that includes all necessary coding, dates and confirmation of payment so that you can submit to your insurance company. It is very important to us that our clients receive the maximum reimbursement from their insurance companies and we will help in any way possible to ensure this process is efficient and straightforward for our clients. We recommend that you begin exploring this process as early as before the first therapy session or consultation.

Questions to ask your insurance company when inquiring about Out-of- Network Benefits:

- Does my plan cover out-of-network behavioral/mental health?
- What are my out-of-network mental health benefits?
- Do I have a deductible? If so, what is it?
- What is the coverage amount per therapy session?
- Is the amount paid to me based on the actual fee or based on what is considered reasonable and customary?
- How many therapy sessions does my plan cover?
- Is there a limit to my coverage?
- Is a referral required from my primary care physician?
- What information does The Riverwalk Group need to provide to receive reimbursement?

Tips to help with getting insurance reimbursement:

We recommend that you create a paper file for all your claims. Each time an invoice comes to you from The Riverwalk Group, you should print it, make a copy and attach it to a claim form from your insurance company. Keep a copy of the claim form and invoice and mark the date you sent it. We recommend that you fill out the necessary items in the health form and make multiple copies so that it is easily accessible and is simple to attach our invoice to it. Mail, scan or fax to your insurance company. If you have not heard from them in two weeks, call to confirm that they have received the claim. Additionally, make a copy of your insurance card to have in the file. Make sure you copy both the front and back of card.

Visiting Our Offices & Parking

All the Riverwalk Group Clinicians see patients at our location in Stamford Connecticut at the Phillips Mansion at 666 Glenbrook Road. The mansion sits in a complex called "Riverwalk" and is surrounded by townhouses. When you enter the parking lot, **please park in a space that says APG, Mansion or ES.** APG spaces are in front of the mansion, if you are facing the mansion, the spaces are to the right. There are additional spaces located in the back of the mansion as well. If you park in the back, you can walk up the steps to the front door or ask your clinician about using our back entrance.

Please **do not** park in spaces with numbers. These are for the residents that live in the townhouses. Additionally, please **do not** park in spaces that say M. Sank or any other name, as these belong to our neighbors and are for their staff and clients.

When you enter the front door of the mansion, head straight back through the foyer to the door on the right next to "The Riverwalk Group" sign. Once in our offices, head down hallway to the waiting room. Your clinician will come to get you at the time of our scheduled appointment. Feel free to help yourself to complimentary coffee, tea or water while you wait. As there are several consultation rooms next to the waiting area, we respectfully request that you keep conversations to a minimum and allow the waiting area to be a quiet space.

Payment Policies for The Riverwalk Group

The Riverwalk Group provides psychotherapy, yoga therapy, group therapy, workshops and programming. Payment is expected at the end of each session, unless other arrangements have been previously made.

The following options are available for payment (please check one you chose):

- Cash or Check at time of visit
- Credit card payment. Note: A service fee of 3.5% will be added for credit card transactions

I, _____ (First and Last Name) have read the above policy and understand that payment is due at the end of each session by check, cash or credit card.

If payment is not received as mentioned above, then you have my permission to charge my credit card as written below and/or on file.

Signature: _____

Today's Date: _____

Name on Card: _____

Billing Address Credit Card: _____

Type of Credit Card: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

**Note: Information written here will be entered to a secure system that will store your credit card in a way that is encrypted and not accessible except under the appropriate circumstances to make a payment. This paper will be destroyed after this information is transferred. The credit card information is NOT stored anywhere in our offices.*

Notice of Patient Privacy Practices and Rights

Limits of Confidentiality

The confidentiality of your personal health information is very important to us. Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. If you have any questions or concerns, please feel free to discuss with your clinician. It is important to us that you understand this privacy notice and its clinical implications.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18)

Date



THE RIVERWALK GROUP LLC
The Phillips Mansion
666 Glenbrook Road, 1st Floor
Stamford, CT 06906
T: 203.329.3759
www.TheRiverwalkGroup.com

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received/reviewed and/or read the HIPAA Notice of Privacy Practices including the Limits of Confidentiality.

Signature of patient or
Representative

Printed Name

Date

If personal representative's signature appears above, please describe Personal Representative's relationship to the patient.

Witness

Printed Name

Date