

**Billing Information Form**  
**Madison Psychotherapy Center, LLC**

Th. Name \_\_\_\_\_

**1. Client Information**

Diagnosis \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone ( ) \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Employer Telephone # \_\_\_\_\_  
Referred By \_\_\_\_\_  
E-mail address \_\_\_\_\_ Okay to contact you via email? Y N

**2. Billing Information**

Person Responsible for Payment of Bill (if different from above) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone ( ) \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_  
Relationship to client \_\_\_\_\_ Employer \_\_\_\_\_

**3. Insurance Information**

Insurance Company \_\_\_\_\_  
Address for sending claims \_\_\_\_\_  
ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Deductible? \_\_\_\_\_ How much? \_\_\_\_\_ Co-pay \_\_\_\_\_ Effective date \_\_\_\_\_

**Secondary insurance information**

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Deductible? \_\_\_\_\_ How much? \_\_\_\_\_ Co-pay? \_\_\_\_\_ Effective date \_\_\_\_\_

The client is ultimately responsible for the payment of all services received at Madison Psychotherapy Center, LLC (a.k.a.MPC). If MPC bills a medical insurance company for services, this is done as a courtesy to the client and is not a substitute for the client's responsibility for payment of services.

**Payment Options:** \_\_\_\_\_ Insurance coverage. Client is responsible for co-payments at time of each session.  
\_\_\_\_\_ Pay cash or check at each appointment. (Please circle your preference.)  
\_\_\_\_\_ Make individual arrangements for monthly payments with your therapist.

**Appointment Cancellation:** Appointments which are cancelled with less than 24 hours notice will be billed to the client. Insurance companies do not pay missed appointment charges.

\$300.00 initial visit

**Fee:** Your fee will be \$250.00 per \_\_\_\_\_ 50 Min \_\_\_\_\_ session.

**Other conditions:**

**Assignment of benefits**

I hereby assign mental/health/psychotherapy benefits to which I am entitled (including Medicare, private insurance, and other health plan benefits) to Madison Psychotherapy Center, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original copy. I understand that I am financially responsible for all charges. I hereby authorize said assignee Madison Psychotherapy Center, LLC, to release all information to secure payment on my behalf.

**Signature of client** \_\_\_\_\_ **Date** \_\_\_\_\_  
(or person responsible for payment)

## **INTAKE QUESTIONNAIRE – CHILD**

*Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.*

Name of person completing form: \_\_\_\_\_ Date: \_\_\_\_\_

Child is (circle one): my biological child my adopted child my foster child Other: \_\_\_\_\_

### **IDENTIFYING INFORMATION (for individual receiving services)**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Sex: \_\_\_\_\_

\_\_\_\_\_ Work Phone (indicate whose #): \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Household Income: \$ \_\_\_\_\_

Who referred you to [name]? \_\_\_\_\_

#### Child's Race:

- |  |   |
|--|---|
| <input type="checkbox"/> White/Caucasian                     | <input type="checkbox"/> Asian                  |
| <input type="checkbox"/> American Indian or Alaska Native    | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Two or more races      |
| <input type="checkbox"/> Unknown                             |   |

#### Child's Ethnicity:

- Hispanic or Latino  
 Non-Hispanic or Non-Latino

#### Child's Language of Choice:

- |                                  |                                       |
|----------------------------------|---------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish      |
| <input type="checkbox"/> Hmong   | <input type="checkbox"/> German       |
| <input type="checkbox"/> Russian | <input type="checkbox"/> French       |
| <input type="checkbox"/> Laotian | <input type="checkbox"/> Other: _____ |

#### Family's Religious Affiliation:

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Catholic  | <input type="checkbox"/> Protestant (including Lutheran, Methodist, etc.) |
| <input type="checkbox"/> Muslim    | <input type="checkbox"/> Non-Denominational                               |
| <input type="checkbox"/> Jewish    | <input type="checkbox"/> No Affiliation                                   |
| <input type="checkbox"/> Amish     | <input type="checkbox"/> Other: _____                                     |
| <input type="checkbox"/> Mennonite |   |

#### Disability:

Do you have a disability?  Yes  No If yes, please specify: \_\_\_\_\_

If you have a disability, does the office accommodate your needs?  Yes  No

If no, please explain: \_\_\_\_\_

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

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### **PRESENTING PROBLEM (current situation and history)**

1. What is the primary problem for which you are seeking help? (please circle)

- |                       |                       |                     |
|-----------------------|-----------------------|---------------------|
| a. Behavior at home   | g. Overactivity       | m. Grieving         |
| b. Family problems    | h. Peer problems      | n. Abuse or trauma  |
| c. Depression         | i. Eating disorder    | o. Relationship     |
| d. Mood swings        | j. Alcohol/drug use   | p. Anger            |
| e. Behavior at school | k. Physical problems  | q. Anxiety or worry |
| f. Self-confidence    | l. School performance | r. Other (explain): |

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2. How long has the child had this/these problem(s)? \_\_\_\_\_

3. Has the child received treatment for this problem or any other problem in the past?  Yes  No

If yes when, where and with whom? \_\_\_\_\_

### **FAMILY HISTORY**

1. With whom does the child currently live (names and relationship)? \_\_\_\_\_

Has the child lived with anyone else in the past?  Yes  No With whom? \_\_\_\_\_

2. Please provide the following information about the child (as applicable):

Father's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Mother's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Stepfather's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Stepmother's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____

Foster Father's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Foster Mother's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Guardian/Other's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____

3. Please provide the following information about the child's brothers and sisters and other children living in the home:

Name (First and Last)	D.O.B.	Relationship (full, half, step, foster)	Lives with Child?		If no, lives where?
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	

4. Does the child or any other family member have a history of alcohol or drug problems?  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

5. Has the child or any other family member experienced any type of abuse (physical, sexual, domestic or emotional)?  Yes  No If yes, please describe the circumstances: \_\_\_\_\_  
 \_\_\_\_\_

**LEGAL HISTORY**

Please describe any involvement the child has had with the legal system (arrests, convictions, probation, parole):  
 \_\_\_\_\_  
 \_\_\_\_\_

## DEVELOPMENTAL HISTORY

1. Pregnancy and delivery were normal?  Yes  No  I don't know

If no, please explain: \_\_\_\_\_

2. Did mother use alcohol or other drugs during pregnancy?  Yes  No  I don't know

If yes, please explain: \_\_\_\_\_

3. Please list any medications taken during pregnancy: \_\_\_\_\_

4. Did the child reach developmental milestones at a normal age:

Developmental Milestones	Yes	No	Don't Know	If no, please explain
Slept through the night				
Sat alone				
Stood alone				
Walked without help				
Said first words				
Spoke in simple phrases				
Toilet trained – day				
Toilet trained - night				

## MEDICAL HISTORY

1. Primary Care physician/pediatrician: \_\_\_\_\_

2. Please check the appropriate box if the child has experienced any of these problems:

- |  |   |
|--|---|
| <input type="checkbox"/> Eye disease, injury, poor vision    | <input type="checkbox"/> Cancer                         |
| <input type="checkbox"/> Ear disease, injury, poor hearing   | <input type="checkbox"/> Bowel problems                 |
| <input type="checkbox"/> Nose, sinus, mouth, throat problems | <input type="checkbox"/> Hemorrhoids, rectal bleeding   |
| <input type="checkbox"/> Head injury                         | <input type="checkbox"/> Loss of consciousness          |
| <input type="checkbox"/> Convulsions or seizures             | <input type="checkbox"/> Frequent or severe headaches   |
| <input type="checkbox"/> Memory problems                     | <input type="checkbox"/> Sleep disturbances             |
| <input type="checkbox"/> Extreme tiredness or weakness       | <input type="checkbox"/> Neck stiffness, pain, swelling |
| <input type="checkbox"/> Thyroid disease or goiter           | <input type="checkbox"/> Marked weight changes          |
| <input type="checkbox"/> Skin disease                        | <input type="checkbox"/> Circulatory problems           |
| <input type="checkbox"/> Heart disease                       | <input type="checkbox"/> Allergies or asthma            |
| <input type="checkbox"/> Back, arm, leg or joint problems    | <input type="checkbox"/> Diabetes                       |
| <input type="checkbox"/> Blood disease                       | <input type="checkbox"/> Encephalitis                   |
| <input type="checkbox"/> Stomach problems                    | <input type="checkbox"/> Meningitis                     |
| <input type="checkbox"/> Premenstrual Syndrome (PMS)         | <input type="checkbox"/> Pregnancy                      |
| <input type="checkbox"/> Eating disorder                     | <input type="checkbox"/> High blood pressure            |
| <input type="checkbox"/> Liver, gallbladder disease          | <input type="checkbox"/> Other                          |

Please explain anything checked above: \_\_\_\_\_

\_\_\_\_\_

3. Please provide information about medication(s), prescription or over-the-counter, which the child takes regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): \_\_\_\_\_  
 \_\_\_\_\_

**SCHOOL INFORMATION**

1. What school does the child currently attend? \_\_\_\_\_

2. What is the child’s teacher’s name? \_\_\_\_\_

3. What grade is the child in? \_\_\_\_\_

4. How many schools has the child attended? \_\_\_\_\_  
 In which cities/towns were they located? \_\_\_\_\_

5. Does the child have a written IEP?  Yes  No  
 Is the child in special education classes?  Yes  No Type: \_\_\_\_\_

6. Is the child experiencing any problems in school?  
 Academics (grades):  Yes  No  
 Behavior:  Yes  No  
 Social (peers or adults):  Yes  No

Please explain any “yes” responses: \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL RELATIONSHIPS / FRIENDS**

1. How does the child get along with peers? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. How does the child get along with adults? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does the child spend more time with (check the closest answer):

- Same age children                       Adults  
 Older children                             Mostly alone  
 Younger children

4. What are the child's hobbies and interests? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### HOME LIFE

1. Is there a behavior problem at home?    Yes    No   If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What are the child's strengths? \_\_\_\_\_  
\_\_\_\_\_

3. What are the family's strengths? \_\_\_\_\_  
\_\_\_\_\_

4. What are the child's weaknesses? \_\_\_\_\_  
\_\_\_\_\_

5. What are the family's weaknesses? \_\_\_\_\_  
\_\_\_\_\_

6. What kind of discipline is used with the child? \_\_\_\_\_  
Who is the primary disciplinarian? \_\_\_\_\_

7. Are there any family circumstances you would like us to be aware of? \_\_\_\_\_  
\_\_\_\_\_

8. What goals would you like to see reached as a result of your child's involvement [Your Organization's Name]?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. How will you know when these goals have been reached (describe changes in behavior or functioning)?

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**THERAPIST REVIEW**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_