



Western Wake Counseling & Psychological Services, PLLC

8000 Regency Parkway, Suite 530
Cary, North Carolina 27518
(919) 467-3831 / (919) 467-1611 (fax)

Welcome to our Practice... We are a small clinical health psychology practice dedicated to treating clients by integrating the biological, psychological, and socio-cultural factors that impact an individual's emotional well-being. Our dedication and focus on quality of care is what makes a big difference in the service we provide. We consider all aspects of your life and will coordinate with other health providers as needed.

**The following information pertains to important information about your counseling session.
Please read, sign, and date this form.**

Confidentiality: All written information pertaining to your visit(s) are confidential and CANNOT be released to anyone, including family, spouses, attorneys, etc. without your consent. Exceptions to this are made only if you are in imminent danger of harming yourself or someone else. Additionally, we are required by law to report child or elderly abuse and to release records as ordered by a court judge.

Services Available: The foundation of our work is grounded in a "Cognitive and Behavioral" approaches to creating change. We offer a variety of services; including individual, couples, family, and group counseling services. We provide treatment for mental health issues, including a wide variety of mood disorders (i.e., anxiety & depression), grief and bereavement, job/career transition, marital or parental discord, multicultural counseling, and psychological testing services. Counseling and psychological services can help you to clarify your feelings, develop positive goals, and create a plan of action to achieve those goals.

Initial Session: Your initial evaluation will be utilized for exploring your concerns, and discussing what services might be useful. A treatment contract will also be discussed.

Fees and Payments: The basic fee for an initial diagnostic intake is \$150.00 per hour. A 50-minute individual psychotherapy session is \$120.00. The fee for couples and families is \$150 per hour. Psychological evaluations may range between \$300.00 and \$1,250.00 depending on the type of assessment needed. Dr. Moore participates as an in-network provider with several insurance companies including: Aetna; Blue Cross Blue Shield; Cigna; MedCost; Medicaid; and NC Health Choice. Payment (co-payment) is requested at the time services are rendered and may be made by check, cash, or credit card.

Cancellations: Late cancellations, less than 24 hours, will be charged a \$25.00 cancellation fee. Please schedule carefully.

Informed Consent: "I have read the above information, understand it, and I agree to the above conditions."

Signature

Date

1. What are the main reasons for seeking psychological services at this time?

2. What efforts have you made to deal with these concerns?

3. Do you currently have any suicidal thoughts? ___ **Yes** ___ **No**

4. Have you ever attempted suicide? ___ **Yes** ___ **No**

5. How often do you drink alcohol? ___ 1/p month ___ 1-2/p week ___ daily ___ none
On days you drink, how many do you usually have? _____
Do you consider it a problem? _____

6. Do you use non-prescription substances? If so, please list what substances and how often? _____

7. Please describe your diet? _____

8. Do you engage in regular exercise? _____

Referral Source: Please indicate how you heard about Dr. Tammie Moore or Western Wake Counseling & Psychological Services:

___ Professional Referral (Dr./attorney/etc) ___ Friend/Colleague ___ Family Member
___ Insurance Provider ___ Brochure/Flyer ___ website ___ Yellow Pages ___ other

Information about the person that referred you:

| Name | Address | Phone |
|------|---------|-------|
|------|---------|-------|

May we thank this person? ___ Yes ___ No

Name: _____ Date: _____

PLEASE CHECK ALL THAT APPLY:

(I HAVE EXPERIENCED THE FOLLOWING DURING THE PAST WEEK, INCLUDING TODAY:

| | | |
|--------------------------------|---------------------------------------|---|
| Academic concerns | Low self esteem | Sometimes |
| Abuse | Blaming or criticizing self | Frequently |
| Abused by others | Anti-social behavior | |
| Abuse of others | Concerns about family members | If female, is there the possibility that you may be pregnant? |
| Aggression | Parental concerns | |
| Anger | Child or step-child concerns | |
| Irritability | Sibling concerns | |
| Anxiety | An important loss | |
| Feeling tense | Sexual concerns | |
| Phobias/fears | Relationship problems | |
| Recurring thoughts | Financial concerns | |
| Panic attacks | Others' alcohol or drug abuse | |
| ADD/ADHD | Thought processes | |
| Distractibility | Disorganized thoughts | |
| Impulsivity | Disorientation | |
| Physical concerns | Memory impairment | |
| Chest pains | Judgment errors | |
| Heart palpitations | Things around you seem surreal | |
| Chronic pain | Hallucinations | |
| Fatigue | Drug or alcohol use: | |
| Dizziness | Never | |
| Hypertension | Sometimes | |
| Trembling | Frequent | |
| Often sick | Tobacco use: | |
| Frequent upset stomach | Non-smoker | |
| IBS | Daily smoker | |
| Sleep problems | Occasional smoker | |
| Problems with food | Trying to quit | |
| Eating Disorder | Any recent upsetting event? Explain: | |
| Depression | _____ | |
| Ideas of harming self | | |
| Suicidal thoughts | | |
| Ideas of harming others | | |
| Mood swings | | |
| Hopelessness | | |
| Often feeling sad or depressed | Involved in a church community?(List) | |
| Poor self-concept | _____ | |
| Ill at ease/shy with others | | |
| Lack of real friends | Exercise? | |
| Isolating self | Rarely | |

New Patient Intake Form

In order for us to have a better understanding of your problems, please answer the following questions. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission.

Name: _____ Date of Intake: _____

Please note, each item refers to your entire life history, not just your current situation, this is why each question begins' "***Have you ever.....***"

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? **YES NO**
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? **YES NO**
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? **YES NO**
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? **YES NO**
5. Have you ever heard voices no one else could hear or see objects or things, which others could not see? **YES NO**
6. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? **YES NO**
7. Did you ever attempt to kill your self? **YES NO**
8. Have you ever had nightmare or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? **YES NO**
9. Have you ever experienced any strong fear? For example fear of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? **YES NO**
10. Have you ever given in to an aggressive urge or impulse on more than one occasion that resulted in serious harm to others or led to the destruction of property? **YES NO**
11. Have you ever felt that people had something against you without them necessarily saying so, or to influence your thoughts or behavior? **YES NO**

12. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities or your choice of sexual partner?
YES NO
13. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example by repeatedly dieting or fasting, engaging in too much exercise to compensate for binge eating, taking enemas or forcing yourself to throw up?
YES NO
14. Have you ever had a period of time when you were so full of energy and your ideas came vary rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?
YES NO
15. Have you ever had spells or attack when you suddenly felt anxious, frightened, uneasy to the extent you began sweating, your heart begin to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?
YES NO
16. Have you ever had a persistent lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things you had done, washing and rewashing your hands, praying, or marinating a very rigid schedule of daily activities from which you could not deviate.
YES NO
17. Have you ever lost considerable sums of money through gambling problems at work, school, with family and friends as a result of your gambling?
YES NO
18. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?
YES NO

Insurance Verification

You may want to contact your insurance provider to verify mental health benefits...

Client Name _____ Client DOB: _____

Subscriber Name _____ Subscriber ID # _____

Subscriber Name _____ DOB: _____

Insurance Company _____

Are your mental health benefits covered by a different company? _____ If yes; what is the name of the company that covers your mental health benefits? _____

Has your Deductible been met? Yes ___ No ___ I don't have a deductible _____

What is your Benefit Period (calendar yr; June-July, etc.) _____

Effective Date _____

Do you know the number of mental health out patient visits you are allowed per year? _____

Do you need prior authorization before treatment? Yes ___ No ___

If yes, what is the authorization # _____

Send Claims to:

Phone _____

Fax _____

Date of Contact _____ Person _____

Additional Notes _____

Signature on File

(Please initial each applicable line and sign at bottom of page)

_____ I authorize use of this form on all my insurance submissions.

_____ I authorize the release of information to my insurance company relevant to the processing of insurance claims for myself or my dependent.

_____ I understand that I am responsible for my bill.

_____ I authorized Dr. Tammie D. Moore, (Western Wake Counseling & Psychological Services, PLLC) to act as my agent in helping me obtain payment _____ from my insurance companies.

_____ I authorize direct payment to Dr. Tammie D. Moore (Western Wake Counseling & Psychological Services, PLLC).

_____ I permit a copy of this authorization to be used in place of the original.

Patient Name

Date

Patient Signature

Date

* Relationship if not patient _____

- The signature of a parent or legal guardian is required if the patient is under 18 years of age or legally incompetent.