**Rosemarie Scolaro Moser, PhD, ABN, ABPP-RP, Director**
*American Board of Professional Neuropsychology*
*American Board of Professional Psychology-Rehabilitation*
*NJ Psychology Lic. # SI02148*
*NJ Certified School Psychologist*

# CONFIDENTIAL
# GENERAL PATIENT INTAKE INFORMATION



Name_____ Date of Birth _____Today's Date_____

Please Check: Female _____ Male _____ Age _____ Social Security #: _____

Home Address _____ City/State/Zip_____

Home Phone _____Cell_____Work Phone_____

Employer or School_____

Occupation or Grade in School _____ Years of Education _____

Place of Birth _____ Religion, if applicable _____

Emergency Contact Name & Phone _____

**IF AN ADULT (Please complete this section below)**

Check One: Single _____; Married _____; Separated _____; Divorced _____; Widowed _____

Spouse's/Partner's Name & Age _____

Spouse's/Partner's Occupation _____

Childrens' Names & Ages _____

**IF A CHILD (Please complete this section below)**

Parents' Names & Occupations _____

Sisters'/Brothers' Names & Ages _____

**Nature of Assistance you are seeking: (Please check all that apply)**
Psychotherapy/Counseling _____ Psychological Testing _____ Neuropsychological Evaluation _____
Memory Testing _____Baseline Testing____ Post Concussion Testing _____Career Counseling _____
Academic Coaching _____ Cognitive Rehabilitation _____ Hypnosis _____ Biofeedback_____
Other (explain)_____

How did you hear about this service? Who referred you?_____

Describe the difficulties or symptoms for which you are seeking assistance.

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Describe any significant past or present medical or health related conditions/surgeries/hospitalizations/head injuries or accidents since birth.
Are you currently receiving treatment for any of these conditions? If so, please explain:

List all your current doctors or treating health care providers:

Are you currently or have you in the past ever received any type of mental health, substance/alcohol, personal, or career counseling? If yes, when and what type of assistance have you received?

Have you ever been hospitalized for a psychiatric condition? If yes, where and when?

Has anyone in your family ever received psychological/psychiatric/mental health or alcohol/substance abuse treatment or assistance? If yes, please describe:

Have you or anyone in your family been identified as having had a learning disorder, attention disorder, or memory disorder? If yes, please describe:

Are you taking any medication? If yes, list name and dosage:

Do you use other non-prescription drugs or substances? If yes, please describe:

Do you drink alcohol? If yes, how often?

Do you smoke? If yes, how many cigarettes per day?

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I agree to accept responsibility for all payments of any services rendered to me by RSM PSYCHOLOGY CENTER, LLC/SCCNJ and its providers. I understand that payment is expected at the time services are rendered and that I am responsible for payment of all services whether or not covered by my insurance plan. I also understand that I will be charged for any appointments that I do not cancel 24 hours prior to my scheduled appointment.

_____ _____
Signature Date

**This Section Below Only For: Medicare (regular/standard), Personal Injury Program, Workers Comp, Victims Comp., NJ TBI Fund, Aetna Student Choice:**

I permit RSM PSYCHOLOGY CENTER, LLC/SCCNJ to bill the Third Party Payor(s) listed below for services provided and to provide necessary Protected Health Information as defined in HIPAA to the third party payor(s) in order to submit an insurance claim to the Third Party Payor (s).

_____ _____
Signature Date

PRIMARY Third Party Payor or Insurance Carrier

Company _____

Address _____

ID/Claim # _____ Group # _____

Name of Insured/Covered Entity

_____

Adjuster or Contact or Case Worker (if applicable)

_____

SECONDARY Third Party Pay or Insurance Carrier

Company _____

Address _____

ID/Claim # _____ Group # _____

Name of Insured/Covered Entity

_____