Katie Dine Young, Psy.D.
Licensed Clinical Psychologist

New Client Intake Form

Contact Information:

Name: _____

Address:_____

Phone: _____ Cell:_____ Email:_____

Date of Birth: _____ SSN#_____

Emergency Contact: Name_____ Ph #:_____

May I communicate with you by e-mail? ☑ Yes ☐ No

Please note that my communication via email/text is limited to things such as scheduling of appointments due to the limits of confidentiality of the internet.

How did you learn of my services and/or who referred you to us (source of referral)?
_____

Do you give Katie Dine Young,Psy.D. permission to acknowledge this referral? ☐ yes ☐ no

Insurance Information

Company Name:_____ Insured Name & DOB_____

Identification/Member ID#_____ Group Number:_____

Family/Relationship Information:

List the members of your immediate family like partners, children, parents, etc.

Relationship	Name	Age	Occupation	Check here if deceased
				☐
				☐
				☐
				☐
				☐

Years of Education completed (or current grade in school): _____

Occupation /Work status: _____

Marital Status of client: ☐ Single ☐ Married ☐ Cohabitating
☐ Separated ☐ Divorced ☐ Widowed

Are you planning or currently in an open law suit relevant to this treatment: Yes / No

Briefly described why have you have chosen to seek my services:

_____
_____
_____

Treatment and Medical Information:
Are you currently receiving or have you previously received services from a counselor/mental health professional? ☑ Yes ☐ No

If yes, please list provider name and date(s) of treatment:

_____
_____
_____

Please list any medical conditions that you have or believe you might have:

_____
_____
_____

Please list any medications which you are currently taking:

_____

_____

<u>Consent for Treatment</u>

I hereby give consent for receipt of services for myself and/or my children from Kathleen Dine Young, Psy.D. Katie Dine Young, Psy.D provides psychotherapy (individual, group, and couples), assessment, consultation and referral services, which are confidential.

I understand that treatment outcomes vary, and that I will be involved in the ongoing formation of evaluation and treatment goals. Depending upon the nature of your concern, current service demands or other circumstances, your counselor may refer you to another health care provider(s) who can better meet your needs.

My office voicemail is available to you around the clock. Phone calls are not answered or returned during sessions. However, messages are retrieved several times daily Monday through Friday 9am-6pm and calls will be returned as quickly as possible. In

cases of emergency or crisis you are advised to contact the local crisis line **[(502) 589-4313]** or 911 and/or the nearest emergency room.

I understand that treatment and information related to evaluation and treatment is confidential and that my therapist cannot release treatment information without written consent.

I understand, however, that there are exceptions to this right to confidentiality and that Dr. Dine Young is legally obligated to contact relevant authorities in cases of 1) past or present, suspected or confirmed child neglect, physical abuse, sexual abuse; 2) violence between spouses or domestic partners; and 3) when a client shows intent to harm self or to kill another person. I understand that Dr. Dine Young will make every reasonable effort to obtain prior consent and keep me informed of any necessary breach of confidentiality.

I understand that to promote a high quality of care, confidential case consultation (i.e., sharing case information without identifying information such as names) may occur between Dr. Dine Young and qualified colleagues. Due to the nature of this office, I understand that a mobile phone is used at times to make phone calls to clients.

I understand that to follow ethical guidelines and to protect my confidentiality, Dr. Dine Young will not connect with me on Facebook, LinkedIN, Pinterest, etc.

By signing below, I acknowledge the above information and provide consent for myself and/or my child. I also acknowledge that I have received a copy of this consent.

Client/Guardian Date

Witness Date