FATIMA AYDIN, PH.D.

Licensed Psychologist

7 Kent Street, Suite 4, Brookline, MA 02445

617.869.2883

aydin@fatimaaydin.com

www.fatimaaydin.com

INITIAL INTAKE INFORMATION

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CELL PHONE: _____ OTHER PHONE: _____

EMAIL ADDRESS: _____

PREFERRED MEANS OF COMMUNICATION:

CELL_____ WORK PHONE _____ HOME PHONE_____ EMAIL_____ TEXT_____

INSURANCE

PRIMARY INSURANCE COMPANY: _____

NAME OF INSURED IF DIFFERENT FROM CLIENT: _____

DOB OF INSURED: _____ ADDRESS OF INSURED: _____

INSURANCE ID#: _____ GROUP#: _____

INSURANCE COVERAGE INFORMATION

ANNUAL DEDUCTIBLE: _____

CO-PAYMENT PER SESSION: $ _____

AUTHORIZATION & AGREEMENT

1. I authorize payment of behavioral health benefits to my provider for services performed.

   Signed: _____ Date: _____

2. I agree to contact my insurance provider and obtain relevant insurance coverage including the required co-payment and deductible.

   Signed: _____ Date: _____

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PERSONAL HISTORY

DATE: _____
NAME: _____
DATE OF BIRTH: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
CELL PHONE: _____ OTHER PHONE: _____
EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____
RELATIONSHIP: _____
PHONE: _____

PLEASE INDICATE WHICH OF THE FOLLOWING ISSUES YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST:

☐ Depression	☐ Sexual Identity
☐ Anxiety	☐ ADHD
☐ Grief	☐ PTSD
☐ Eating Disorder	☐ Abuse
☐ Trauma	☐ Relationship
☐ Self Harm	☐ Anger Management
☐ Addiction/Substance Use	☐ Bullying
☐ Academic Challenges	☐ Other:

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HAVE YOU SEEN A THERAPIST BEFORE? YES or NO (Please circle)

HAVE YOU BEEN PSYCHIATRICALLY HOSPITALIZED IN THE PAST? YES or NO (Please circle)
IF YES, THE DATES AND LOCATIONS: _____

_____

_____

ARE YOU CURRENTLY TAKING MEDICATION? YES or NO (Please circle)
IF YES, PLEASE LIST YOUR MEDICATIONS AND THEIR DOSAGE?

_____

_____

_____

NAME OF PRESCRIBER: _____

NAME OF PRIMARY CARE PHYSICIAN: _____
ADDRESS: _____
PHONE: _____

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE ME TO KNOW TO BETTER SERVE YOUR NEEDS?

_____

_____

_____

_____

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AUTHORIZATION TO USE CREDIT CARD FOR PSYCHOTHERAPY SERVICES

I authorize Fatima Aydin, PhD to charge my credit card for the sole purpose of psychotherapy, consulting or counseling services rendered.

I authorize Fatima Aydin, PhD to use my credit card for the following purposes:

Copayments for Insurance covered visit(s) in the amount of: **$_____**

Private Pay for psychotherapy/consulting session(s) in the amount of: **$_____**

Missed appointments with less than 48 hours notice in the amount of: **$150**

Client Name (please print): _____

Client Address with zip code: _____

Credit Card: (circle one) **VISA, MASTERCARD, AMERICAN EXPRESS**

Credit Card#: _____

Exp. Date: _____

3 digit code: _____

Cardholder's Name (Please Print) _____

Signed: _____ Date: _____

Therapist Name (please Print) _____

Signed: _____ Date: _____

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FEES AND POLICIES

SELF-PAY AND REDUCED FEES

My self-pay fee ranges from $225-$250 for a 50 minute Individual or Couples Therapy session. Reduced rates can be negotiated, depending upon my low-fee client load and other circumstances. If your financial circumstances change over the course of treatment, we may renegotiate the fee. Also my own fee may go up over the course of a treatment that lasts more than one year.

INSURANCE

I am a provider for Blue Cross Blue Shield and Cigna Health Insurance. If you have a different insurance carrier, you can check with them to see if they cover out of network providers. If so, they would be able to reimburse you for our sessions.

BILLING

I accept credit/debit cards and would appreciate payment at each session.

CANCELATIONS

Please give me a 48 hour notice of cancellation if you are unable to attend your session. There will otherwise be a charge of $150 for the missed session or late cancelation. We always have the option of holding a phone session if you are ever unable to make it to your appointment in person.

CONFIDENTIALITY

I maintain a confidential record of your contacts with me. I will not reveal to anyone details about your consultation or therapy, or even the fact that you have met with me. There are also certain limits to the rule of confidentiality as specified by Massachusetts law. In the following instances, your records may be released without your permission:

1. If you are in danger of harming yourself or others
2. If a child, elderly or disabled person in your care is being abused and/or neglected
3. When a judge orders me to produce records or testify in connection with certain legal actions such as child custody, care and protection cases, adoption proceedings or rape and sexual abuse cases.

If, in the course of our work, we decide to meet with members of your family or friends, we will discuss the limits and expectations about confidentiality in advance.

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AGREEMENT

Your signature below indicates that you have read and agree to abide by the terms of our professional relationship described above.

_____	_____
Signature: Client or parent/guardian of minor child	Date
_____	_____
Signature: Client or parent/guardian of minor child	Date
_____	_____
Printed Name	Date
_____	_____
Clinician's Signature	Date