Ruth H. Tallakson, Ph.D., L.P., Ltd.

Licensed Psychologist

CLINICAL CLIENT DATA SHEET

Name (Last, First, Mi) _____ Home Phone_____

OK to leave message at home? Yes ○ No ○

Address _____

City _____ State _____Zip _____ Cell Phone_____

OK to leave message on cell? Yes ○ No ○

DOB_____ Referred By _____

Occupation_____Work Phone _____

OK to leave message at work? Yes ○ No ○

Insurance Name/Address _____

Insurance Phone #_____Policy # _____

Group # _____Group/Plan Name _____

Coverage for Outpatient Psychotherapy: Limits/Deductibles _____

Person to call in case of emergency _____Phone _____

Complete if other than self

Insured Name (First, Last, Mi) _____Home Phone_____

Insured Address_____DOB_____

City_____State_____Zip_____

Relationship to Insured (Spouse, Child, Other) _____

Occupation _____Work Phone _____

821 Raymond Avenue, Suite 315-C
St. Paul, Minnesota 55114

Phone: 651.647.1001
Fax: 651.647.6111

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INTAKE PROBLEM RATING SCALE

Related to the situation(s) that brought you to therapy, rate each of the following problems. Beside each problem place a check mark that best describes the present severity.

	No Problem		**Moderate Problem**		**Severe Problem**
	1	**2**	**3**	**4**	**5**
Marital	☐	☐	☐	☐	☐
Significant Other	☐	☐	☐	☐	☐
Loneliness	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐
Social	☐	☐	☐	☐	☐
Spiritual	☐	☐	☐	☐	☐
Legal	☐	☐	☐	☐	☐
Alcohol Use	☐	☐	☐	☐	☐
Drug Use	☐	☐	☐	☐	☐
Emotional, Physical, or Sexual Abuse	☐	☐	☐	☐	☐
Assertiveness	☐	☐	☐	☐	☐
Health	☐	☐	☐	☐	☐
Self-esteem	☐	☐	☐	☐	☐
Sexual Issues	☐	☐	☐	☐	☐
Grief	☐	☐	☐	☐	☐
Finances	☐	☐	☐	☐	☐
Work/Career	☐	☐	☐	☐	☐
School	☐	☐	☐	☐	☐
Weight	☐	☐	☐	☐	☐
Anger	☐	☐	☐	☐	☐
Fear	☐	☐	☐	☐	☐
Communication	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Other:					

In your own words, describe the three most important problems:

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MEDICATION

Name _____

DATE	MEDICATION	DOSAGE	PRESCRIBING M.D.

Medical Contact Information

M.D. Name _____ Phone _____

Address _____

_____

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If you plan to use a credit card, please complete this form.

PERMISSION TO CHARGE CLIENT'S CREDIT CARD

I give Ruth H. Tallakson, Ph.D., L.P., Ltd. permission to charge my credit card for our sessions until further notice.

Exact Name on the Card _____

Exact Address on the Card _____

_____

City _____

State _____ Zip _____

Type of credit card _____

Credit card number _____

Expiration Date _____ CV2 Code *(back of the card)* _____

Signature _____ Date _____

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RESPONSIBILITY FOR PAYMENT

I acknowledge and understand that I am responsible for all the charges for services rendered by Dr. Ruth Tallakson.

These standard fees apply unless other arrangements have been made.

I understand that the fee for the first meeting is $200.00. Starting with the second meeting, I understand that the fee is $100.00 for 30 minutes, $150.00 for 45 minutes and $175.00 for 53 minutes or more. I agree to pay the amount due on the date the services are provided. If I choose to use my health insurance benefits, I agree to pay aspects of the bill including co-pays and deductible amounts. I understand that it is my responsibility to pay my bill in its entirety if my insurance company or other authorized agency chooses not to honor the claim. In the event that my account must be turned over to an agency for collection, through my failure to pay, I will pay all costs of collection, including reasonable attorney fees.

If my insurance company sends Dr. Tallakson's payment to me, I agree to mail or hand deliver the full amount to her within three business days.

I also understand that I will be charged full fee for my appointments not canceled with 24 hours of advance notice.

Client's or Authorized Person's Signature:

Signed: _____ Date: _____

AUTHORIZATON FOR RELEASE OF MEDICAL INFORMATION

I authorize Ruth H. Tallakson, PhD, LP, to release any medical information necessary to process my insurance claim. This includes authorization to release information to the insurance company. **A copy of this authorization shall be as valid as the original.**

Client's or Authorized Person's Signature:

Signed: _____ Date: _____

AUTHORIZATION FOR INSURANCE CLAIM PAYMENT

I hereby authorize payments of insurance benefits for services rendered to me and/or my dependents to Ruth H. Tallakson, PhD, LP, at 821 Raymond Avenue, Suite 315-C, St. Paul, Minnesota 55114. **A copy of this authorization shall be as valid as the original.**

Client's or Authorized Person's Signature:

Signed: _____ Date: _____

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SPOUSE, PARTNER, CHILDREN

Name:_____

Spouse/Partner: _____

Names and ages of children:

_____

_____

_____

_____

_____

_____

Family Values/Atmosphere/Major Events:

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