APOGEE COUNSELING ASSOCIATES

Personal Data Intake Form

Welcome to Apogee Counseling Associates. We endeavor to offer professional counseling to all who seek counseling service.For thoses requesting and seeking, we offer a biblically based, Christ-centered approach. Please make your request known and discuss with your prospective counselor.

Our Staff

Dr.Darryl Moore is a licensed clinical psychologist in the state of California. The license number is PSY 22459. Status of license can be verified at the Board of Psychology website. He is also a Certified Sex Addiction Therapist (CSAT) and Certified Multiple Addictions Therapist (CMAT).

Ryan Berwold is a licensed marriage family therapist. License # . Status of license can be verified at the Department of Consumer Affairs Board of Behavioral Sciences. Mr. Berwold specializes in the treatment of adults and teens with emphasis on behavioral and addiciton issues. He also specializes in Sexual Addiction recovery and is a Certified Sex Addiction Associate in training at the International Institute for Trauma and Addiction Professionals.

Training Program:
Apogee Counseling Associates also provides supervision for Psychological Assistants and MFT interns accruing required hours for licensure. If you are receiving services from a Psychological assistant His/Her name will be included here. _____. If you have any questions or concerns about your counseling services you can contact Dr. Moore or your counselors identified supervisor independently our through your counselor. Dr. Moore's number is (858) 433-8751.

_____

Client's initials

Limitations of Confidentiality:
It is understood (and agreed) that all statements, whether written or verbal, with your counselor/lay counselor are of a confidential nature and ethically cannot be
disclosed without written consent. The following exceptions will result in confidentiality being waived.
1. We reserve the right to report child abuse or suspicion of child abuse of any type to the proper authorities and/or the right to cause a report of child abuse to occur.
2. We reserve the right to disclose to the appropriate person, agency or civil authorities any harm that a person may attempt or desire to do to one's self or to others.
3. To insure the highest quality process, as a rule your counselor, if under supervision, will consult with their supervisor, regarding your therapy.

Resolution of Disagreements:
If a dispute should arise between the person receiving counseling and the counselor regarding the counseling, one should bring this dispute to the attention of the Dr. Moore.

Fees:

Regular session fees are $175.00 per session and sessions run for 45 minutes. Fee adjustments or sliding scales feels are available and should be discussed as soon and is feasible. Approximately ten percent (10%) of practice is reserved for low income individuals in order to maximize the availability of services to all.

Late Policy:
If you expect to be late for your appointment please call your counselor. Clients more than 15 minutes late to their scheduled appointment may forfeit that scheduled time. Please contact your counselor if you expect to be late. It is the client's responsibility to be on time and get full use of their scheduled appointment. Appointments missed or not cancelled the day before will charged $75.00. This must be paid before the next session and is not covered by insurance. _____
Client's Initials

Cancellations or Reschedules:
In the event you need to reschedule or cancel an appointment please call the day before your scheduled appointment to avoid being charged for the session. This also allows us to reschedule others who are waiting. Online scheduling and cancellations are available for Dr. Moore's clients through our website at apogeecounseling.com

_____
Client's initials

Third Party Reimbursements:
Insurance verification and billing may be possible. Please provide all insurance information and copy of insurance card. Please note that every effort will be made to verify and bill insurances. However, you are responsible for all fees if, for any reason, reimbursement is denied by your insurance.

_____
Client's initials

The information contained herein and the following data sheets are true and complete to the best of my knowledge. I have carefully read, understand, and agree to all of the above terms and conditions.

_____ _____
Print Name **Signature**

Date _____

PERSONAL DATA FORM

Name_____HomePhone_____

Address_____WorkPhone_____

City_____ State_____ Zip_____

Cell phone:_____ _____E-mail: _____

DOB: ____ ____ ____ SS# _____ ____ _____ (Needed for insurance verification)

You may need to be contacted by our office or by your counselor. Please choose a contact method which provides you with the level of confidentiality you need.

Phone number _____ Text: Yes____ No_____l _____

Email: _____

Gender _____ M_____F Birth Date_____ Age_____

Occupation_____Employer_____

Marital Status _____Single _____Engaged _____Married _____Divorced ____Widowed

Name of Spouse_____ Age _____ Years married____

Spouse's Occupation_____ Employer_____

Previous marriage (s) Client: _____ Spouse: _____

Names and ages of children: _____
_____
_____
_____

Referred by:

Name_____ Relationship_____

INSURANCE

Name of insurance company _____

Name of insured if different then client _____

Address of Ins Co. _____

Phone number _____

Policy Number _____ Group Number _____

HEALTH / COUNSELING / LEGAL DATA

1. Are you presently under the care of any medical doctor / practitioner? _____yes _____no

If yes, for what condition?:_____

Doctor's name:_____Phone:_____

2. Are you currently taking any prescription or non-prescription medications? ____yes ____no

If yes, please list with dose and/or frequency
_____
_____
_____

Prescribed by Dr. _____

3. Are you aware of any physical problems that impair your functioning? _____Yes _____No

If yes, please explain_____

4. Are you currently receiving or have you in the last 3 years received counseling, individual or marital therapy, or been under the care of any mental health provider for addiction recovery?

Provider's Name_____Phone:_____
____
Address_____

For what issue?_____
_____

5. May we contact this provider for additional information? _____yes _____no

6. Have you ever been hospitalized or been in an outpatient program for emotional or substance abuse? __yes __no If yes, please list when, where and for what issue.
_____

_____

_____

7. Are you currently involved in, or anticipate being involved in any litigation or legal action? ___yes___no. If yes, please
explain_____

_____

_____

CHURCH BACKGROUND
No significant religious background. _____
What church do you currently attend?_____
Attendance: Regularly ____ Sometimes _____ Rarely _____
Have there been any recent changes in your spiritual life?
_____

_____

PRESENTING PROBLEM

1. Please state in your own words the problem you are experiencing:
_____

_____

_____

_____

2. What is your goal in seeking help?
_____

_____

3. Are you open to and/or requesting biblical and spiritual guidance for this issue?
___ Yes ____ No

4. Is the use/abuse of drugs and/or alcohol related to this problem in any way? If yes, pleaseexplain
_____

_____

5. Is there any other behavior that is related to this problem?
_____

_____

6. Have you experienced any significant loss / crisis / life change
recently?_____

7. Do you have any thoughts of hurting yourself or others? ___ Yes ___ No
If yes explain: _____

_____

8. Have u ever attempted to commit suicide? ___ Yes ___ No
If yes, explain:
_____

_____

Place a check mark beside any descriptions of what you are currently experiencing.

___ Anxiousness ___Depression ___ Anger___ Confusion ___ Fear ___ Loneliness

___ Despair ___Thoughts of suicide ___Hurt___ Guilt / Shame ___ Withdrawing from others

___ Distance from God___ Marital distress ___ Parenting struggles ___Relational stress

Thank you for providing the above information. If there is any other information you would like to share, please include it here.

_____

_____

_____

_____

Please email or bring this to your first appointment.