KINGSBURY COUNSELING | Josh Kingsbury, Ph.D.
LICENSED PSYCHOLOGIST

251 Woodford Street
Portland, ME 04103
(207) 773-2828 x107
josh@kingsburycounseling.com
www.kingsburycounseling.com

Intake Information

Name			Intake Date				
Date of Birth	Age		F	M	MtF	FtM	
Preferred Pronouns			Relationship Status				
Street Address			City/State/Zip				
Cell Phone			Okay to leave message?		Y	N	
Home Phone			Okay to leave message?		Y	N	
Work Phone			Okay to leave message?		Y	N	
Email			Okay to contact via email?		Y	N	
Preferred method(s) of contact							
Cell	Home	Work	Email	Text			
Ethnic/Racial Identity			Sexual Orientation				
Occupation			Employer/School				
Spiritual Orientation			Referred by				

Initials (of Individual, couple or family) _____

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Please describe the issues you would like to address in therapy

_____

_____

_____

_____

_____

If you have engaged in therapy in the past, please note with whom and during what periods of time

_____

_____

_____

_____

_____

If you are currently taking medication, please list the medications and dosages

_____

_____

_____

_____

_____

Prescribing provider's name and phone number (if applicable)

_____

_____

When was your last physical exam?

_____

Primary care provider's name

_____

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Billing Information for Responsible Party

Name	Relation to client	
Date of Birth	Phone	
	F	M
Street Address	City/State/Zip	
Insurance Company	Insurance Company Phone	
Policy Number	Group Number	
Insurance Plan Name	Managed Care Authorization Number	
Employer		

Emergency Contact Information

Name	Relation to client		
Phone #1	Okay to leave message?	Y	N
Phone #2	Okay to leave message?	Y	N
Email	Okay to contact via email?	Y	N
Street Address	City/State/Zip		

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Authorization for Release/Request of Confidential Information

(Release for EMERGENCY CONTACT)

Permission is hereby given to Josh Kingsbury, Ph.D. to release and/or exchange information for professional use from the records of:

Client Name _____

This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record.

The type of information is limited to (check at least one):

[ ] any and all information
[ ] psychological evaluation(s)
[ ] discharge summary/report
[ ] confirmation of services
[ ] treatment summary
[ ] drug and alcohol issues
[ ] intake summary/report
[✖] other (Emergency Contact)

[ ] with the following exceptions_____

The information should be released to, received from, and/or exchanged with:

_____

Name

_____

Address

Telephone and Fax _____

This authorization shall remain in effect until. _____

I understand that I may revoke this consent at any time by notifying my therapist, Josh Kingsbury, Ph.D., in writing. I also hereby release Josh Kingsbury, Ph.D., from any liability in connection with the release of the above information.

_____

Client Full Name Date of Birth

_____

Address

_____

Client Signature Date

_____

Josh Kingsbury, Ph.D.

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Authorization for Release/Request of Confidential Information

(Release for PRIMARY CARE PROVIDER)

Permission is hereby given to Josh Kingsbury, Ph.D. to release and/or exchange information for professional use from the records of:

Client Name _____

This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record.

The type of information is limited to (check at least one):

[✖] any and all information
[ ] psychological evaluation(s)
[ ] discharge summary/report
[ ] confirmation of services
[ ] treatment summary
[ ] drug and alcohol issues
[ ] intake summary/report
[ ] other
[ ] with the following exceptions _____

The information should be released to, received from, and/or exchanged with:

_____
Name

_____
Address

Telephone and Fax _____

This authorization shall remain in effect until. _____

I understand that I may revoke this consent at any time by notifying my therapist, Josh Kingsbury, Ph.D., in writing. I also hereby release Josh Kingsbury, Ph.D., from any liability in connection with the release of the above information.

_____
Client Full Name Date of Birth

_____
Address

_____
Client Signature Date

_____
Josh Kingsbury, Ph.D.

Initials (of Individual, couple or family) _____