EMORY UNIVERSITY PSYCHOANALYTIC INSTITUTE (EUPI)
APPLICATION FOR ADULT TREATMENT

We would like to thank you for your time in completing this application. We realize it can be challenging to find a psychotherapist or psychoanalyst and we would like to collaborate and consult with you to match you with a clinician within two weeks of your application. Please note that treatment is by appointment only and we are unable to provide crisis intervention. If you need an immediate consultation, we recommend that you contact your local hospital emergency center.

Though we recognize your courage in taking this step to begin psychotherapy or psychoanalysis and hope to be able to ease the process, we do have some limitations to our services that are important for you to consider. The clinician will be an experienced, licensed professional who is a candidate in psychoanalytic psychotherapy or psychoanalysis at EUPI and supervised by a faculty member. While fees may be negotiated based on individual financial limitations, most of our candidates and graduate faculty do not accept Medicare, Medicaid or managed care plans. We do maintain a list of clinicians who will accept managed care plans.

There are two options for an individualized treatment through the Emory University Psychoanalytic Institute (EUPI)—Psychoanalytic Psychotherapy and Psychoanalysis. You may already know which treatment you prefer, but if you are unsure, you can discuss these options when you meet with one of us for the initial evaluation. The initial evaluation may consist of several 45 to 50-minute sessions. At its conclusion, we will make a treatment recommendation to you, involving either psychoanalytic treatment through the EUPI or referral to other treatment resources in the community. Sometimes psychoanalytic psychotherapy or psychoanalysis is not the best fit for life circumstances and contexts, we hope to facilitate your decision making as to what best suits you at this time in your life.

Sincerely,

Sharon Harp, LCSW
Director of the Consultation and
Treatment Service, EUPI

Please complete and print this form. Mail it with a $25.00 check made out to “Emory University Psychoanalytic Institute” to Yamy Belis c/o Ayanna Webb, 12 Executive Park Drive, Suite 142, Atlanta, GA. 30329. (For any questions about the forms, please contact the Consultation and Treatment Service at 404.727.2486 or email Eupicts@emory.edu.). The $25.00 fee is non-refundable and part of our thoughtful review and consideration of your application.

It is the policy of EUPI to provide equal opportunities without regard to race, color, religion, national origin, gender identity, sexual identity, age, or disability. The information you write on this form will only be shared with professionals directly involved in arranging your treatment. Thank you for completing this application form and for your interest in psychoanalytically based treatments.

A clinician will call you to schedule an evaluation.
When are you available to take a call?

| Day | Evening |
|---|---|
| | |

Are you available to schedule appointments between 9am and 5pm?

| Yes | No |
|---|---|

**CHECKLIST:**

____ I prefer one of the following treatments:

____ **Psychoanalytic Psychotherapy**: I understand that psychoanalytic psychotherapy is a two to three times weekly treatment.

____ **Psychoanalysis**: I understand that psychoanalysis is a four times weekly treatment.

____ I understand that while every analytic treatment is different, most analytic treatments require a commitment of several years of living in the same place and working with the same clinician to reap the desired benefits.

____ I understand that in order to be considered for an individualized fee treatment, I will meet with a psychoanalytically oriented clinician for possibly several 45 to 50-minute sessions. This clinician will then make a treatment recommendation to me, involving either psychoanalytically oriented treatment through the EUPI or, if it is more appropriate, referral to other treatment resources in the community. The cost of this initial evaluation will be $100, payable by check or cash at the initial evaluation.

____ I understand that my clinician may use written notes, without any identifying information, from his or her work with me for educational purposes. I will have opportunities to discuss these educational purposes during my initial evaluation.

____ I have responded to the questions that have been posed to me in the following section of the application.

____ The treatment will be privately arranged with my clinician and will occur in the private office of my clinician.

____ In order for my treatment to begin, I will need to sign a Patient Informed Consent form in the presence of my clinician. (Please see sample Patient Informed Consent on www.atlantapsychoanalysis.com). I will have the opportunity to discuss and ask questions about the informed consent process during my initial meetings with my clinician.

**NARRATIVE QUESTIONS:**

Please provide written responses to the following three questions to help us learn more about you.

1. Why are you seeking treatment?

2. Describe your understanding of psychoanalytic treatment and the psychoanalytic process:

3. Tell us about a current relationship that is important to you:

| _____ | _____ | _____ |
|---|---|---|
| Name (please print) | Signature | Date |

Name _____ Date _____

Address _____ Age _____

_____ D.O.B. _ _/ _ _/ _ _

Telephone Home: ( ) _____ Okay to Leave a Message? **Y N**

Cell or Work: ( )_____ Okay to Leave a Message? **Y N**

Email: _____ Okay to email about scheduling? **Y N**

**Emergency contact information** (Who may we contact in the event of an emergency?)

Name: _____Phone: ( )_____ Relationship to you:_____

**EMPLOYMENT / SCHOOL:**

Occupation, employer, & number of hours worked per week _____

Are you in **school**? YES ___ NO___ Where?_____ H**igh school**/**undergrad**/**graduate** (circle)

What **year** are you in? _____ **Full Time** or **Part Time**? (Circle one)

What is your Major/Department/Degree Program?

_____

**TREATMENT HISTORY / CURRENT NEEDS:**

What is the longest time you have been in continuous counseling or psychotherapy in the past?
___ None ___ < 1 month ___ 1-3 months ___ 3-6 months ___6-12 months ___ More than one year

How frequently did you meet with your prior therapist? _____

Have you worked with multiple psychotherapists in the past? YES ___ NO___ If so, how many?_____

If you have had counseling or psychotherapy, how recently?
___ < 6 months ___ 6-12 months ___ 12-24 months ___More than one year ___ More than two years

Who was your recent psychotherapist?_____ (We will not contact them without your permission.)

Why did you stop counseling or psychotherapy?

How long have you been concerned about the problem that brings you to treatment now?
___ < 1 month ___ 1-3 months ___ 3-6 months ___ 6 -12 months ___ 1-2 years ___ > 2 years

Do you **currently** have suicidal feelings? _____ Have you been suicidal **in the past**? _____

Have you attempted suicide? **YES NO**

If yes, please list approximate date(s):

Have you ever been in a hospital related to your mental/emotional health? **YES NO**

If yes, please list date(s):

**SUBSTANCES:**

What is your history with of the following substances?

Alcohol: Quantities/Frequency in Past: _____
Quantities/Frequency Now: _____

Street/Recreational Drugs (which?): Quantities/Frequency in Past: _____
Quantities/Frequency Now: _____

Caffeine: Quantities/Frequency in Past: _____
Quantities/Frequency Now: _____

Cigarettes/Nicotine: Quantities/Frequency in Past: _____
Quantities/Frequency Now: _____

**PARTNERSHIP STATUS:**

How do you describe your sexual identity? _____

How do you describe your gender identity? _____

How would you describe your relationship status? (e.g., partnered, married, single, separated, widowed, etc.)

_____

Do you have children? YES_____ NO_____ How many/how old?_____

Have you recently experienced a relationship loss? (e.g., death, divorce, breakup) _____

**MEDICATION / MEDICAL HISTORY:**

Have you ever been given a psychiatric diagnosis (e.g., major depression, anxiety disorder, etc.)? Please list:

_____

Please list all medications (both psychiatric and non-psychiatric) you are <u>currently</u> taking, the dosage, and name of physician who prescribed it:

Name_____ Dosage_____Who Prescribed?_____
Name_____ Dosage_____Who Prescribed?_____
Name_____ Dosage_____Who Prescribed?_____
Name_____ Dosage_____Who Prescribed?_____
Name_____ Dosage_____Who Prescribed?_____
Name_____ Dosage_____Who Prescribed?_____

Please list all physical health problems that you are <u>currently</u> experiencing:

_____

**FAMILY HISTORY:**

What is your ethnic background?_____

How do you identify in terms of religion or spiritual practice? _____

Is there a diagnosed or suspected family history of psychiatric illness? Please describe: _____

_____

**INCOME AND OTHER RESOURCES**

We will set your weekly treatment fees after a discussion of: 1) your insurance coverage; 2) financial help from family members; and 3) your weekly income. Please call your insurance company and ask them to review the coverage for "outpatient psychotherapy" with an "out-of-network provider". To help us to consider your fees, please complete the following:

Net income (weekly):

If applicable, your partner's income (weekly):

Other weekly income:

Savings:

Monthly rent (if you share rent, please list your share):

Relationship and ages of financial dependents:

Debts or financial obligations:

How much financial support could you receive from family per week to support your treatment?

How much could you afford to pay out of pocket per week for treatment?

Do you currently receive any of the following benefits?

| | **Yes** | **No** |
|---|---|---|
| Privately paid health insurance | | |
| Employer paid health insurance | | |
| Medicare | | |
| VA Benefits | | |
| SSI | | |
| SSD | | |
| Unemployment | | |
| Other | | |

If you have insurance, what is the name of your insurance provider:

Does your insurance cover treatment by only in-network providers? YES NO

What is your out-of-network deductible:

What is the maximum number of sessions per year:

What is the maximum amount or percentage covered per session: