WILLIAM ALANSON WHITE
I·N·S·T·I·T·U·T·E
of Psychiatry, Psychoanalysis & Psychology

Accepting Applications for in person Psychoanalysis and Psychotherapy in the Fall

Thank you for taking the time to fill out this application for treatment at the William Alanson White Institute. Our goal is to match you as quickly as possible with a therapist; we will process your completed application within one week. Please note that treatment is by appointment only and we are unable to offer crisis intervention. If you need an immediate consultation, we recommend that you contact your local hospital emergency center.

Beginning psychotherapy is a big step and we would like to make the process as comfortable as possible. There are some limitations to our clinic, however, that are important to know in order to help you decide whether to seek treatment here. Our fees are adjusted to help people with financial limitations and we have a sliding scale to cover the portion of the clinic fees not paid by your insurance. Unfortunately, we cannot accept Medicaid, Medicare or managed care plans (although we do have a list of Institute graduate therapists who accept Medicare and managed care). Since our facilities are limited, we cannot see everyone who applies and we may have periods when our waiting time for a therapist may be too long for your needs. If we cannot assign you a clinic therapist we will provide you with other referrals. Please know that our inability to match you with a therapist is not a reflection of your ability to benefit from treatment.

Please detach this letter and retain for future reference.

Best regards,

Stacey Nathan-Virga, Ph.D.
Director, Clinical Services

Date: Name:

Please check which service is of interest. Please call (212) 873-7070 if you have any questions about our clinic.

◯ PSYCHOTHERAPY SERVICE:

Individual psychotherapy, once or twice per week, up to forty weeks, is available at affordable fees ranging from $50.00 to $150.00. Sessions are available from 8:00 a.m. - 9:00 p.m. with fees adjusted on a sliding scale. After forty weeks, you may decide with your therapist if you would like to continue in the therapist's private practice. If you are unable to afford our minimum fee, please call the clinic to discuss your budget before filling out the application.

◯ PSYCHOANALYTIC SERVICE:

Provides low cost treatment for people who would like to work intensively for a minimum of three times per week for at least one to two years. Patients may be seen in the clinic or therapist's private office. Fees are adjusted to the patient's resources and begin at $15.00 per session.

SPECIALTY SERVICES:

- ◯ Couples Treatment
- ◯ Eating Disorders, Compulsions and Addictions
- ◯ Later Lifespan Development
- ◯ LGBT Psychotherapy Service
- ◯ Living with Medical Conditions Service
- ◯ Psychoanalytic Psychotherapy for Artist
- ◯ Sexual Abuse Service
- ◯ Group Psychotherapy
- ◯ Young Adult Treatment Service

Before initiating psychotherapy it is essential that you have a complete physical exam in order to rule out any medical complications. Please let us know the date of your most recent physical and the results of the exam:

Physician: Date of Exam:

CLINICAL SERVICES APPLICATION

Application Date

Last Name First Name MI:

Home Address

City State Zip Code

Mailing Address

City State Zip Code

E-Mail Address

Home Phone Work Phone

☐ *It is okay to call me at home* ☐ *It is okay to call me at work*

Emergency Contact:

Name: Phone Number

Referred by (individual, agency, hospital):

Name: Phone Number

Address:

City State Zip Code

☐ I require wheelchair access

Are you able to schedule appointments **between 9:00 am and 5:00 pm?** ◯ Yes ◯ No

If No, which hours may be possible? ◯ Before 9:00 am ◯ After 5:00 pm

1. Date of Birth: 2. Age at Last Birthday:

3. Gender: Male Female Other (Please Specify)

4. How would you identify your sexual orientation?

Heterosexual Bisexual Gay/Lesbian Other (Please Specify)

5. Ethnicity:

African-American Asian Caucasian Latino Native American

Other (Please Specify)

6. Highest level of education completed:

Graduate training (masters or doctorate) College (received four-year academic degree)

High School/Trade School Eighth Grade

7. Are you currently attending school? (If yes, specify school/major):

Full-Time Part-Time Not a Student

8. Are you currently employed? (If yes, specify employer/field):

Working Full-Time Working Part-Time Volunteer Work Unemployed

Other (Please Specify)

9. Relationship Status:

Single Married Separated Divorced

Other (Please Specify)

10. How many people are living in your household? Include spouse, partner, parents, siblings, children, and roommates.

Age: Relationship: Age: Relationship:

Age: Relationship: Age: Relationship:

Age: Relationship: Age: Relationship:

11. My relationships with family members (check one):

Provide extensive emotional support

Provide an average amount of emotional support with occasional conflict

Provide less than adequate emotional support with frequent conflict

Do not provide emotional support

No contact with family

12. My relationships with friends (check one):

- ◯ Provide extensive emotional support
- ◯ Provide an average amount of emotional support with occasional conflict
- ◯ Provide less than adequate emotional support with frequent conflict
- ◯ Do not provide emotional support
- ◯ No friends

13. Please describe any medical or emotional problems of your parents or siblings:

14. Please check all the reasons you are seeking psychotherapy:

- ☐ Anxiety
- ☐ Bereavement
- ☐ Confusion about self-image, goals, etc.
- ☐ Decreased performance at work, home, or school
- ☐ Depression
- ☐ Health status of myself
- ☐ Health status of someone I care about
- ☐ Memory problems
- ☐ Relationship problems
- ☐ Planning the future
- ☐ Concerns about abuse *(specify /physical/emotional):*
- ☐ Aftermath of a trauma *(specify):*
- ☐ Anorexia/Bulimia/Overeating *(specify):*
- ☐ Concerns about substance use/abuse ◯ self ◯ other ◯ past ◯ present
- ☐ Other *(specify):*

15. Have you been in psychotherapy previously?

◯ No ◯ Yes, Once ◯ Yes, 2-4 times ◯ Yes, 5+ times

15b. How many different therapists have you worked with? _____

16. If yes, when were you most recently in psychotherapy?

◯ Within the last 6 months ◯ 6-12 months ◯ 12-24 months ◯ Over 2 years ago

17. Why did you stop therapy?

18. What was the longest time you spent in any one psychotherapy?

◯ Less than 1 year ◯ 1+ year ◯ 2+ years ◯ More than 4 years

19. Please list your most recent therapists (WE WILL NOT CONTACT THEM WITHOUT YOUR CONSENT).

Name: Phone Number

Address:

City State Zip Code

Name: Phone Number

Address:

City State Zip Code

20. Are you taking any medication? ◯ Yes ◯ No

21. If Yes, please specify medications and dosage:

22. Have you ever been hospitalized for emotional or mental problems?

◯ No ◯ Yes *(please specify number of hospitalizations):*

23. If yes, when was your most recent psychiatric hospitalization?

◯ Within the last 6 months ◯ 6-12 months ◯ 12-24 months ◯ Over 2 years ago

24. Yes Have you ever had suicidal thoughts?

◯ Never ◯ Sometimes ◯ Frequently

25. Have you ever made a suicide attempt?

◯ No ◯ Yes *(please specify number of attempts):*

26. If yes, when was your last suicide attempt?

◯ Within the last 6 months ◯ 6-12 months ◯ 12-24 months ◯ Over 2 years ago

27. Are you **currently** using non-prescription drugs? ◯ Yes ◯ No

28. Have you used non-prescription drugs **in the last year?** ◯ Yes ◯ No

29. If yes to 27 or 28, please specify **type of drug** and **frequency** of use:

30. Do you drink alcohol? ◯ Yes ◯ No

31. If yes, please specify: *Amount:* _____ *Frequency/week:* _____

32. Do you ever wonder if you have a problem with drugs or alcohol?

◯ No ◯ Yes ◯ Uncertain

33. Have you ever been treated for a drug or alcohol problem?

◯ No ◯ Yes *(specify program and date)* _____

34. Do you currently smoke cigarettes?

◯ No ◯ Yes *(please specify packs per day):* _____

35. Do you binge on food, purge, or use laxatives?

◯ No ◯ Yes *(specify which one and frequency)* _____

36. Are you now in a 12-step program? (e.g., A.A., N.A., O.A., S.A., S.I.A.)

◯ No ◯ Yes *(specify program)* _____

37. Have you ever been in a 12-step program? (e.g., A.A., N.A., O.A., S.A., S.I.A.)

◯ No ◯ Yes *(specify program and date)* _____

38. Thinking about different aspects of your life--your work, your health, what goes on at home, how you spend free time-- Please circle the number that indicates how satisfied you are with the quality of your life within the last month.

Completely satisfied, couldn't be better ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 Completely unsatisfied, couldn't be worse

39. Please circle the number that represents the amount of stress you have been feeling.

No stress ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 A great deal of stress

40. I look forward to the future with hope and enthusiasm:

◯ True ◯ False ◯ Both

41. Would you say your current physical health is:

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

41b. Have you received two doses of the Moderna or Pfizer Vaccine or one dose of the Johnson and Johnson Vaccine? ____ Yes ___No

42. Would you say your physical health throughout your life has been:

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

43. Present or past disabilities or serious illnesses? ◯ No ◯ Yes

Disability or Illness	Age of Onset	Disability or Illness	Age of Onset

44. Medical problems that required surgery or serious accidents? ◯ No ◯ Yes

Surgery or Accident	Age of Onset	Surgery or Accident	Age of Onset

45. Have you ever been arrested? ◯ No ◯ Yes

If Yes, please explain:

46. Do you own a weapon? ◯ No ◯ Yes

If Yes, please explain:

47. In general, how would you describe your ability to control your anger:

◯ Very good ◯ Not well (smash, break objects)

◯ Okay (worry about it sometimes) ◯ Problematic (have hit people)

Please Explain:

48. Has there ever been a period of time when you were not your usual self and...

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? ◯ Yes ◯ No

...you were so irritable that you shouted at people or started fights or arguments? ◯ Yes ◯ No

...you got much less sleep than usual and found you didn't really miss it? ◯ Yes ◯ No

...thoughts raced through you head or you couldn't slow your mind down? ◯ Yes ◯ No

...you were so easily distracted by things around you that you had trouble concentrating or staying on track? ◯ Yes ◯ No

...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? ◯ Yes ◯ No

...spending money got you or your family into trouble? ◯ Yes ◯ No

49. Please state in detail what your present difficulties are, how long they have existed, and your reasons for seeking treatment at this time. Use as much space as you need.

INCOME AND OTHER RESOURCES

We will set your weekly therapy fees based on a formula 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 set your clinic fees please fill out the following:

Net Income (Weekly): $ _____ Your partner's/spouse's net income (Weekly) $: _____

Other Income: $ _____ Savings: $ _____

Monthly rent: (if you share the rent, state your proportionate share): $ _____

List the relationship and ages of those persons who are financially dependent on you.

Age: _____ Relationship: _____ Age: _____ Relationship: _____

Age: _____ Relationship: _____ Age: _____ Relationship: _____

Age: _____ Relationship: _____ Age: _____ Relationship: _____

Please list the type and amount of any unusual debts, expenses, and/or financial obligations you have:

How much financial support per week could you receive from family members for psychotherapy? _____

How much could you afford to spend out-of-pocket per week toward psychotherapy? _____

Do you have any of the following benefits:

- ☐ Privately paid health insurance
- ☐ Health insurance paid through you employment
- ☐ Medicare
- ☐ V.A. Benefits
- ☐ SSD
- ☐ SSI
- ☐ Unemployment
- ☐ Other *(specify):* _____

If you have health insurance: Name of Plan _____ Phone _____

Is insurance contingent upon employment? ◯ No ◯ Yes

Does your insurance cover treatment only by in-network providers? ◯ No ◯ Yes

If No, please answer the following questions about out-of-network benefits:

Deductible: $ _____ Maximum number of sessions per year covered by insurance: _____

Maximum dollar limit of mental health per year covered by insurance: $ _____

Maximum fee per session or % of fee covered by insurance: $ _____

CONSENT FORM

I, ________________________, have consented to psychotherapy/psychoanalysis with a candidate, psychology postdoctoral fellow, psychiatry resident or social work/ psychology intern/extern at the William Alanson White Institute. Many of our therapists have completed their graduate degrees and are licensed. Others are earning degrees or are completing licensing requirements. I understand that the Institute serves educational purposes and that professionals who render the services are required to participate in clinical supervision and classes with licensed and highly qualified professional supervisors approved by the Institute. I further understand that these educational experiences require reporting of clinical data, and I give my permission for this to occur under conditions that will maintain the utmost confidentiality.

Patient Signature: ____ **DATE**_______________

Therapist Signature: ____ **DATE**_______________

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I HEREBY AUTHORIZE THE RELEASE OF INFORMATION FOR MY MEDICAL RECORDS TO:

THE WILLIAM ALANSON WHITE INSTITUTE
20 West 74th Street
New York, New York 10023

I UNDERSTAND THAT THE INFORMATION TO BE RELEASED IS CONFIDENTIAL AND PROTECTED FROM DISCLOSURE; THAT I HAVE THE RIGHT TO CANCEL MY PERMISSION TO RELEASE INFORMATION AT ANY TIME; THAT MY CONSENT TO RELEASE INFORMATION WILL EXPIRE ONE YEAR FROM THIS DATE IF NOT ACTED ON PRIOR TO THAT TIME.

THE INFORMATION TO BE DISCLOSED INCLUDES THE NATURE AND EXTENT OF MY PROBLEMS AND IS TO BE USED BY THE ABOVE AGENCY TO ASSESS MY NEEDS AND AID IN PLANNING MY TREATMENT.

Witness: ____

Patient's Signature: ____ Date: ______________________

Printed Name: ____