Account No.: _____

Psychological Associates, P.A.

Demographic Sheet

Client's Legal Name: _____ Date: _____
First Middle Last

Mailing Address: _____
Street City State Zip Code

Hm Ph: _____ *Cell*: _____ *email*: _____

DOB: _____ *SSN*: _____ *Sex*: Male ☐ Female ☐ *Race*: _____

Employer: _____ *Phone*: _____

Marital Status: Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Spouse's Name: _____ *Spouse's Employer*: _____

Contact (other than a member of your household):

_____
Name Relationship Phone

Party Responsible For Bill: _____ *Relationship*: _____

Billing Address: _____

Parent's Names (for clients under 18):

Father: _____ SSN: _____ DOB: _____

Mother: _____ SSN: _____ DOB: _____

Referred By: _____

Insurance Company: _____ *ID#* _____

Policy Holder/Insured: _____

Insured's Date of Birth: _____ *Insured's SSN*: _____

Insured's Relationship To Client: _____

Insurance Authorization

I hearby authorize Psychological Associates, P.A. to release to my insurance carrier or its representative any information needed concerning treatment rendered to me that is necessary to process an insurance claim. I also authorize and request payment of insurance benefits to be paid directly to Psychological Associates, P.A. This authorization is voluntarily given with understanding and knowledge of purpose.

_____ _____
Signature of Insured Date

Rev 5/3/2022

PSYCHOLOGICAL ASSOCIATES, P.A.
1120 N. Palafox St.
Pensacola, FL 32501
Phone (850)434-5033 · Fax (850)433-0268

Financial Policy

Thank you for choosing Psychological Associates. We are committed to your successful treatment, although there are no guarantees for emotional/behavioral outcome. The expense of treatment must be evaluated by the client. Our office requires payment at the time services are rendered. Accepted methods of payment include cash, check, Visa, Mastercard, & Discover. A $25 fee will be charged for all returned checks. Diagnostic testing and report preparation is an additional charge to regular office visit charges.

Your appointment time is reserved for you and it is necessary to charge for missed appointments (No Shows) or for appointments not cancelled with 24 hours notice (Late Cancellations). The no show/late cancellation fees are as follows: for therapy sessions $125, for med checks $30, for psychological testing that is to be conducted by doctor is $75 per hour reserved, for psychological testing to be conducted by the psychometricians, the charge is $25 per hour reserved and court related sessions are based on court fees. You are personally responsible for these charges since insurance will not cover No Show or Late Cancellation charges. Our answering service is available whenever our office is closed.

For those individuals who have insurance, payment of your patient portion is required at the time of each visit. We will bill your insurance for the balance. If payment has not been received from your insurance within 45 days, you will be responsible for the balance due, and agree not to withhold or delay payments because of any insurance problems or pendency of claims. Any charges partially paid or considered non-covered by your insurance will be your responsibility.

For patients who request telehealth services, we require a credit card on file. We will automatically charge the credit card on the date of service for the amount due.

I have read and understand this financial policy and agree to comply.

Client Name (Please Print)	Responsible Party
Client Signature (if 15 years or older)	Responsible Party Signature

Notice of Privacy Practices

A copy of Psychological Associates Notice of Privacy Practices is available upon your request.

Client Signature (if 15 years or older)	Responsible Party Signature
Witness Signature	Date

Rev 5-12-2022

PSYCHOLOGICAL ASSOCIATES, P.A.

1120 N. Palafox St. * Pensacola, FL 32501
Telephone (850) 434-5033 * Fax (850) 433-0268

CONSENT FOR SERVICES

Psychological Associates, P.A. provides treatment and assessment services. These services include individual, couples, and family and psychotherapy, psychological/neuropsychological testing, and medication management.
My signature below indicates that I have read and understand the following:

- My agreement to begin services with Psychological Associates is voluntary, of my own free will, at the request of the court system, or at the request of my attorney, and is free from undue influence or duress on the part of Psychological Associates.
- I may withdraw my consent for services now or at any time.
- Depending on my needs, my services provider may recommend that I begin additional services with another treatment provider (for example, for psychotherapy or medication management) in order to better serve my needs. I understand that I may refuse to engage in any or all services or service recommendations by Psychological Associates now or at any time during my treatment.
- I may ask questions and receive answers about the services that I am receiving at any time.
- Length of each session, anticipated length of services, and the individualized plan for my services will be discussed with my service provider.
- Treatment is expected to improve my symptoms; however, symptoms may briefly worsen prior to improving or may not improve at all. I should discuss potential side effects of my treatment with my treatment provider.
- Services at Psychological Associates are confidential to the fullest extent allowable by law. Legally, my service provider may be required to reveal necessary confidential information if any of the following circumstances exist:
    - We consider you a danger to yourself or someone else.
    - We are appointed by the court to evaluate you.
    - Your service is part of a legal proceeding to evaluate your competence.
    - You are a minor and we believe that you are a victim of abuse.
    - You are over the age of 65, and we believe that you are a victim of abuse.
    - You have filed a suit and have claimed mental, emotional or physical damage as part of the suit.
    - Your insurance or health care provider is pre-authorized by you to request information from your file.
    - You are involved in a child custody dispute and your record becomes relevant to the court's decision.
    - You are a minor and your parents request information that is appropriate and necessary for them to support or participate in your treatment. We define a minor as anyone under the age of 18 yrs.
- Occasionally, my service provider may find it necessary or helpful to consult with other professionals regarding my services.
- A staff member or trainee may be present during appointments.
- During business hours, Monday – Friday, 8am – 5pm, I may contact this office at 850-434-5033 with questions, concerns or needs. After business hours or on the weekends, an answering service is available to take messages. If there is any emergency that involves the potential for danger or bodily harm, I should go to the nearest emergency room, or if there is the potential for violence, I should call the police.
- I have received information regarding payment for my services.
- I understand that I may request a copy of this consent form to keep.

Client Name (print):_____

Responsible Person Name (if other than client):_____

Responsible Person Signature:_____Date:_____

*Service Provider Initials**:_____*(initials indicate that issues of informed consent were verbally reviewed with the client and that client questions were solicited and answered)*

Rev. 6/27/17

PSYCHOLOGICAL ASSOCIATES, P.A.

Patient Name:_____Date of Birth:_____

Date:_____Pharmacy:_____Pharm Ph #:_____

MEDICATION	DOSAGE/DIRECTIONS	PRESCRIBING PHYSICIAN

Provider's initials upon review:_____

Rev. 6/27/17

Psychological Associates, P.A.

ADULT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PATIENT INFORMATION

Name: (Last, First, M.I.)

☐ Single ☐ Separated ☐ Partnered ☐ Divorced ☐ Married ☐ Widowed

Sex: ☐ M ☐ F

Previous or Referring Doctor:

Date of Last Physical Exam:

MENTAL HEALTH HISTORY

What brought you here?: _____

Current Symptoms: (Please mark only the symptoms that apply to you)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Depressed mood	☐	☐	☐	Excessive fear or worry	☐	☐	☐
Loss of interest or pleasure	☐	☐	☐	Elevated heart rate	☐	☐	☐
Change in appetite or weight	☐	☐	☐	Sweating	☐	☐	☐
Sleep disturbance	☐	☐	☐	Shaking	☐	☐	☐
Decrease/Increase in physical activity	☐	☐	☐	Shortness of breath	☐	☐	☐
Fatigue or loss of energy	☐	☐	☐	Choking	☐	☐	☐
Feeling worthless or excessively guilty	☐	☐	☐	Chest pain	☐	☐	☐
Impaired concentration or distractibility	☐	☐	☐	Nausea	☐	☐	☐
Suicidal thinking	☐	☐	☐	Lightheaded	☐	☐	☐
Elevated or irritable mood	☐	☐	☐	Feeling of unreality	☐	☐	☐
Inflated self-esteem	☐	☐	☐	Numbness or tingling	☐	☐	☐
Pressure of speech	☐	☐	☐	Chills or hot flashes	☐	☐	☐
Racing thoughts	☐	☐	☐	Recurring unwanted thoughts	☐	☐	☐
Excessive spending	☐	☐	☐	Repetitive behaviors	☐	☐	☐
Acting out-home	☐	☐	☐	Reliving life-threatening events	☐	☐	☐
Acting out-school	☐	☐	☐	Delusional ideas	☐	☐	☐
Acting out-sexual	☐	☐	☐	Disorganized/Bizarre thoughts	☐	☐	☐
Acting out-stealing	☐	☐	☐	Auditory hallucinations	☐	☐	☐
Acting out-self-mutilation	☐	☐	☐	Visual hallucinations	☐	☐	☐
Hyperactivity	☐	☐	☐	Cognitive impairment	☐	☐	☐
Impulsivity	☐	☐	☐				
Withdrawn	☐	☐	☐				

The patient's major symptom is not included in this list. It is:

_____

_____

Prior Mental Health Treatment:

☐ **Inpatient**

☐ **Outpatient**

Prior Diagnoses (if known): _____

Providers **Treatment Year**

_____

_____

_____

Medications: (P: Prior; C: Current)

Antidepressant	P	C
Celexa		
Cymbalta		
Desyrel		
Effexor		
Lexapro		
Luvox		
Paxil		
Prestiq		
Prozac		
Remeron		
Serzone		
Sinequan		
Wellbutrin		
Zoloft		

Antianxiety	P	C
Ativan		
BuSpar		
Klonopin		
Librium		
Serax		
Topomax		
Tranxene		
Valium		
Vistaril		
Xanax		

Antiparkinsonian	P	C
Artane		
Benadryl		
Carb-levodopa		
Cogentin		
Levodopa		
Mirapax		
Requip		
Selegiline		
Sinemet		
Symmetrel		

Antipsychotic	P	C
Abilify		
Clozaril		
Geodon		
Haldol		
Risperdal		
Serentil		
Seroquel		
Zyprexa		

Mood Stabilizing	P	C
Depakote		
Lamictal		
Lithium		
Neurontin		
Tegreol		

Cholinesterase	P	C
Aricept		
Cognex		
Exelon Patch		
Galanterine		
Namenda		
Razadyne		

Psychostimulant	P	C
Adderall		
Concerta		
Cylert		
Dexedrine		
Ritalin		
Strattera		
Vyvanse		

Pt Refused Rx		
Pt Pregnant		

Other:

SOCIAL HISTORY

Who lives in your home?

Name *Age*

EDUCATION HISTORY

Education Level Completed (circle applicable):

7 8 9 10 11 12 GED HS BA/BS MA JD PhD MD

Location (School, College, University):

PERSONAL HEALTH HISTORY

Childhood Illnesses:

- ❑ Measles
- ❑ Mumps
- ❑ Rubella
- ❑ Chickenpox
- ❑ Rheumatic Fever
- ❑ Polio

Immunizations:

- ❑ Tetanus
- ❑ Hepatitis
- ❑ Influenza
- ❑ Pneumonia
- ❑ Chickenpox
- ❑ Measles/Mumps/Rubella

List any <u>Medical Problems</u> The Other Doctors Have Diagnosed:

Surgeries:

Year: *Reason:* *Hospital:*

Other Hospitalizations Or Emergency Room Visits In The Past 5 Years:

Year: *Reason:* *Hospital:*

Other Injuries (Loss-Of-Consciousness, Head Injury, Broken Bones, etc.):

Year: *Incident:* *Hospital:*

Primary Pharmacy:

Telephone Number: *Fax Number:*

List Your Prescribed and Over-The-Counter Medications, Including Herbs, Vitamins and Inhalers:

Name of the Medication: *Strength:* *Frequency Taken:*

Allergies to Medication:

Name of the Medication: *Reaction You Had:*

HEALTH HABITS AND PERSONAL SAFETY

Exercise:

❑ Sedentary (No exercise) ❑ Mild Exercise (i.e. climb stairs, walk 3 blocks, golf)
❑ Occasional Vigorous Exercise (i.e. work or recreation, less than 4x/week for 30min)
❑ Regular Vigorous Exercise (i.e. work or recreation 4x/week for 30 min)

Diet:

Are you dieting? ..... ❑ Yes ❑ No
If yes, are you on a physician-prescribed medical diet? ..... ❑ Yes ❑ No
Are you taking diet pills? ..... ❑ Yes ❑ No
# of meals you eat in an average day? _____

Caffeine:

❑ None ❑ Coffee ❑ Tea ❑ Soda ❑ Energy Drinks # of Cups/Cans Per Day? _____

Alcohol:

Do you drink alcohol? ..... ❑ Yes ❑ No
Have you ever felt you should cut down on your drinking? ..... ❑ Yes ❑ No
Have people annoyed you by criticizing your drinking? ..... ❑ Yes ❑ No
Have you ever felt bad about your drinking? ..... ❑ Yes ❑ No
Have you considered stopping? ..... ❑ Yes ❑ No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ..... ❑ Yes ❑ No

Tobacco:

Do you use tobacco? ..... ❑ Yes ❑ No
❑ Cigarettes—Pks/day _____ ❑ Chew—#/day _____ ❑ Pipe—#/day _____ ❑ Cigar—3/day # of Years? _____ or Year Quit _____

Drugs:

Do you currently use recreational of street drugs? ..... ❑ Yes ❑ No

Sex:

Are you sexually active? ..... ❑ Yes ❑ No
Do you have any concerns regarding your sexual life? ..... ❑ Yes ❑ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intraveneous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ..... ❑ Yes ❑ No

Personal Safety:

Do you live alone? ..... ❑ Yes ❑ No
Do you have frequent falls? ..... ❑ Yes ❑ No
Do you have vision or hearing loss? ..... ❑ Yes ❑ No
Do you have an Advance Directive and/or Living Will? ..... ❑ Yes ❑ No
Would you like information on the preparation of these? ..... ❑ Yes ❑ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ..... ❑ Yes ❑ No

FAMILY HEALTH HISTORY

Relative Medical Problems

Please specify pertinent health problems and age of death, if applicable.
In particular: heart disease, high blood pressure, diabetes, obesity, cancer, high cholesterol, genetic disease, mental illness, etc.

Mother: _____

Father: _____

Grandparents: _____

Sibling: _____

Sibling: _____

Sibling: _____

Child: _____

Child: _____

Child: _____