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:_____

Psychological Associates, P.A.

CHILD 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:

BEHAVIORAL ISSUES

Does your child show any of the following:

__ Overeats or undereats
__ Trouble falling asleep
__ Nightmares
__ Seems to need too little/too much sleep
__ Complains of frequent aches and pains
__ Fakes being sick
__ Tired most of the time
__ Doesn't speak well
__ Clumsy or accident-prone
__ Wets the bed or him/herself
__ Soils pants

__ Few or no friends
__ Has many friends
__ Is picked on or teased
__ Picks on or teases others
__ Hangs around with a "bad crowd"
__ Has sex play with other children
__ Has unusual knowledge of sex
__ Fights with other children
__ Has poor social skills

__ Gets along well with siblings
__ Follows family rules
__ Defies parents
__ Much more active than other children
__ Can't focus on activities
__ Can't entertain self

__ Seems depressed
__ Low self-esteem
__ Numerous fears or phobias
__ No longer seems interested in hobbies
__ Has talked about harming self
__ Previous attempt to harm self
__ Has been abused by an adult

__ Runs away from home
__ Sets fires
__ Uses drugs or alcohol
__ Cruel to animals
__ Violent
__ Lies
__ Breaks things (destructive)
__ Steals
__ Been in trouble with the law

Who referred you to us?: _____

What concerns bring you to us for assistance?:

_____

_____

PREGNANCY/EARLY CHILDHOOD

List complications of pregnancy (including any illnesses that mother had):

_____

Were prescription medications, drugs or alcohol used during pregnancy? Y _____ N _____
If yes, please list:

_____

Length of pregnancy: _____ (Premature by _____ weeks, full-term, overdue by _____ weeks)

Type of delivery: _____ Birth weight: _____

Complications of delivery (e.g., forceps used, baby in distress, meconium aspiration, oxygen used, severe jaundice, incubator used) _____

Was baby discharged at same time as mother? Y _____ N _____

How old was your child when:

Walked by self _____ Said first words _____ Said short (2-3 word) sentences _____ Was toilet trained _____

FAMILY HISTORY

List all people (including parents) currently living in primary/custodial household:

Name	*Age*	*Gender*	*Relationship*	*Last Grade Completed*	*Occupation/School*

List all people (including parents) currently living in secondary/non-custodial household:

Name	*Age*	*Gender*	*Relationship*	*Last Grade Completed*	*Occupation/School*

List other important family members not living at home:

Name	*Age*	*Gender*	*Relationship*	*Last Grade Completed*	*Occupation/School*

Is the child adopted? Y_____ N_____ If yes, at what age? _____ Open or closed? _____

PERSONAL HEALTH HISTORY

Child's physician: _____ Last visit: _____

Indicate if your child has had any of the following:

	Yes/No	Age	Type of problem
Allergies			
Asthma			
Injuries or broken bones			
Operations			
Head injury or knocked out			
High fever (104 degrees for a day or more)			
Many ear infections			
Hearing/vision problems			
Seizures			
Other neurological problems			
Diabetes			

Other (list all severe illness, diseases, or medical problems) _____

_____

List current medications and dosage: _____

_____

Previous medications (other than antibiotics or over-the-counter): _____

_____

Surgeries:

Year: *Reason:* *Hospital:*

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

Year: *Reason:* *Hospital:*

Primary Pharmacy:

Telephone Number: *Fax Number:*

PSYCHOLOGICAL HISTORY

Has the child ever been to see a counselor, psychologist, psychiatrist? ____ Y ____ N

Name of Provider: *Date of Service:* *Reason:*

Has any family member ever been treated for psychological/mental disorder, drug or alcohol problem? ____ Y ____ N
If yes, please explain: _____

EDUCATIONAL HISTORY

School _____ Grade _____ Teacher _____

List previous schools attended, if any: _____

Has the child repeated a grade? Y _____ N _____ Grade: _____
Is child enrolled in Special Education? Y _____ N _____
Type: Learning Disability ____ Emotional Handicap ____ Slow Learner/Retarded ____ PATS/Academically Talented ____
Has child been tested by school psychologist? Y _____ N _____ Grade: _____ Results: _____

Does your child have any of these school problems:

- ❑ Received poor grades (D's or F's)
- ❑ Suspended
- ❑ Won't obey school rules
- ❑ Difficulties concentrating
- ❑ Doesn't stay seated/fidgets a lot
- ❑ Afraid or refuses to go to school

HOME ENVIRONMENT CHECKLIST

A. Routines

Your child's current use of computer, DVD, TV (circle the number of hours spent each week):

Computer	0-2	3-5	6-8	9-11	12+	*Computer in child's bedroom?*	yes	no
Facebook		yes	no			*Cell phone*	yes	no
Television	0-2	3-5	6-8	9-11	12+	*Television in child's bedroom?*	yes	no
Video Games	0-2	3-5	6-8	9-11	12+	*Content of video games:* _____		

Number of days that family eats together _____ per week Eats with TV on _____ with TV off _____

List any involvement in community groups, sports or activities:

_____

_____

Child gets up at: _____am on weekdays, _____ on weekends

Describe morning behavior/routines (ex. wakes easily, difficult to wake, morning conflicts):

_____

_____

Child's bedtime: _____pm on weekdays, _____ on weekends

Describe bedtime behavior/routines:

_____

_____

Appetite/Mealtimes (note any issues or concerns):

_____

_____

B. Current Legal Status

DJJ History: yes no Probation Officer: _____

DCF History: yes no Case Worker: _____

Currently involved in custody dispute? yes no _____

Court orders relevant to custody? yes no _____

If divorced, describe the relationship with the ex-spouse/partner (parent's and child's): _____

_____

_____

How often does the child see non-custodial parent? _____

C. Current Employment/Vocational Issues:

Child is employed: yes no Where: _____

Vocational interest: _____

D. Current Alcohol/Drug Use Patterns:

	First Use	Current Use	Frequency
Cigarettes			
Alcohol			
Marijuana			
Cocaine/Crack			

Completed by: _____ Date: _____