Account No.: _____

Psychological Associates, P.A.

Demographic Sheet

Client's Legal Name: Date: _____ 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 hereby 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. 01/12/26

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, 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)*

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

Financial Policy

Please read this document carefully and discuss any questions or concerns you may have with the front desk.

Payments: Accepted methods of payment include cash, check, Visa, Mastercard, & Discover. A $25 fee will be charged for all returned checks.

Credit Card on File: We require a credit card on file for all telehealth services/fees. For your convenience, we will also maintain a credit card on file for in-office services/fees. For all credit cards on file, the patient responsibility and up to an additional $50 of any remaining balance on your account from prior unpaid services/fees will be charged on the day of your appointment.

Fees for Service:

Psychotherapy Evaluation $225
Psychotherapy per hour- individual $215
Psychotherapy per hour-family $185
Psychiatric Evaluation $305
Medication Management $160

Diagnostic testing and report preparation is an additional charge to regular office visit charges.

No Show and Late Cancellation of Appointments: Our office requires payment at the time services are rendered. Your appointment time is reserved just for you. If you are unable to make your appointment for any reason, you must notify our office at least 24 hours in advance. If we do not receive 24-hour notice, you will be charged a no show/late cancellation fee as follows: $125 for therapy sessions, $75 for med checks, $75 per hour reserved for psychological testing that is to be conducted by doctor, $25 per hour reserved for psychological testing to be conducted by the psychometricians. Court related sessions are based on court fees. You are personally responsible for these charges since insurance will not cover them. Our answering service is available whenever our office is closed.

Health Insurance: Our office accepts most major health insurance plans. Copay, coinsurance and deductible is required at the time of service as part of the health insurance contract. We will submit a claim to your insurance and if payment has not been received from your insurance within 60 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. **You are responsible for any balance not covered or paid by your health plan for any reason.**

I have read and understand this document and agree to comply. I authorize Psychological Associates, P.A. to retain my credit card information, when provided, for the purpose of payment as described herein, without additional authorization. I understand that I must keep all card information current and provide an additional payment method when the card does not have an available balance.

_____ _____
Patient Name (Please Print) Responsible Party

_____ _____ Date_____
Patient Signature (if 15 years or older) Responsible Party Signature

Notice of Privacy Practices

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

_____ _____ Date_____
Patient Signature (if 15 years or older) Responsible Party Signature

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	Sever		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-threating events			
Acting out-school				Delusional ideas			
Acting out-sexual				Disorganized/Bizarre thoughts			
Acting out-self-mutilation				Auditory hallucinations			
Hyperactivity				Visual hallucinations			
Impulsivity				Cognitive impairment			
Withdrawn							

The patient's major symptom(s) are not included in this list. It/they are:

_____

_____

Prior Mental Health Treatment

☐ **Inpatient**

Prior Diagnoses (if known):

_____

☐ **Outpatient**

Providers **Treatment Year**

_____

_____

_____

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: Reason: 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 HABITSAND 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 30 min.)

☐ Regular Vigoriuos (i.e. work or recreation 4x/week for 30min.)

Diet:

Are you dieting?..... ☐Y ☐N

If yes, are you on a physician-prescribed medical diet?..... ☐Y ☐N

Are you taking diet pills?..... ☐Y ☐N

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		
Topamax		
Tranxene		
Valium		
Vistaril		
Xanax		

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

Antipsychotic	P	C
Abilify		
Clozaril		
Geodon		
Haldol		
Risperdal		
Serentil		
Seroquel		
Zyprexa		

Mood Stabilizing	P	C
Depakote		
Lamictal		
Lithium		
Neurontin		
Tegreol		

Cholinesterase		
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 (circle all that are applicable):

Measles Mumps
Rubella Chickenpox
Rheumatic Fever Polio

Immunizations (circle all that are applicable):

Tetanus COVID Hepatitis Influenza
Pneumonia Chickenpox
Measles/Mumps/Rubella

List any Medical Problems The Other Doctors Have Diagnosed:

# of meals you eat in an average day?

Caffeine:

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

Alcohol (circle **Y** for Yes and **N** for No):

Do you drink alcohol..... **Y N**
Have you ever felt you should cut down on your drinking? ..... **Y N**
Have people annoyed you by criticizing you drinking? ..... **Y N**
Have you ever felt bad about your drinking? ..... **Y N**
Have you considered stopping? ..... **Y N**
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ..... **Y N**

Tobacco:

Do you use tobacco?..... **Y N**

☐ Cigarettes – Pks/day _____ ☐ Chew – #/day ☐ Pipe - #/day ☐ Cigar - #/day # of Years? ____ or Year Quit _____

Drugs (please circle Y for Yes or N for No):

Do you currently use recreational street drugs? ..... **Y N**

Sex (please circle Y for Yes and N for No):

Are you sexually active?
Do you have any concerns regarding your sex life?
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with our provider about your risk of this illness? ..... **Y N**

Personal Safety:

Do you live alone?
Do you have frequent falls?
Do you have vision or hearing loss?
Do you have an Advance Directive and /or Living Will?
Would you like information on the preparation of these?

Physical and/or mental abuse have also become major public health issues in this county. 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?

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:

Child:

Child:

PSYCHOLOGICAL ASSOCIATES, P.A.

Patient Name: _____ Date of Birth: _____

Date: _____ Pharmacy: _____ Pharmacy Phone # _____

MEDICATION	DOSAGE/DIRECTIONS	PRESCRIBING PHYSIAN

Provider's initials upon review_____

Revised: 01/13/2026