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/lnsured: _____

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)*

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Pensacola, FL 32501
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## 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.

## CHILD HEALTH HISTORY QUESTIONNAIRE

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

### PATIENT INFORMATION

| Name:<br>(Last, First, M.I.) | □Single □Married □Partnered □Separated □Divorced □Widowed | Sex:<br>M ☐ F ☐ |
|---|---|---|
| Previous or Referring Doctor: | Date of Last Physical Exam: | |

### BEHAVIORAL ISSUES

Does your child show any of the following:

__Overeats or under eats
__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 of 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 the same time as the 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? _____ Was the adoption Open or Closed? _____

## PERSONAL HEALTH HISTORY

Child's Physician: _____ Last visit: _____

*Please 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 or vision problems | | | |
| Seizures | | | |
| Other neurological problems | | | |
| Diabetes | | | |

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

_____

### Medications

List current medications and dosage: _____

_____

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

_____

### Surgeries

Year:_____Reason:_____Hospital:_____

_____

_____

_____

Other Hospitalizations or Emergency Room Visits within the Past 5 Years:

Year:_____Reason:_____Hospital:_____

_____

_____

_____

_

### Pharmacy Information

Primary Pharmacy: Telephone Number: Fax Number:

_____

## PSYCHOLOGICAL HISTORY

Has the child ever been to see a counselor, psychologist or 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 _____ If yes, which Grade(s)? _____
Is the child enrolled in Special Education (Exceptional Student Education) program? Y _____ N _____
Type: Learning Disability____ Emotional Handicap___ Slow Learner/Retarded___ PATS/Academically Talented____
Has child been tested by a 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 9-12 12+ Computer in child's bedroom? Yes No

Television 0-2 3-5 6-8 9-12 12+ Television in child's bedroom? Yes No

Cell Phone 0-2 3-5 6-8 9-12 12+

Video Games 0-2 3-5 6-8 9-12 12+ Content of video games:_____

Uses Facebook, Twitter, Snap Chat, Instagram, *other social media*, etc.: Yes No

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: _____A.M. on weekdays, _____ on weekends

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

_____
_____

Child's bedtime: ____P.M. on weekdays, _____ on weekends

Describe bedtime behavior/routines:

_____
_____
_____
_____

Appetite/Mealtimes (note any issues or concerns):

_____
_____

**B. Current Legal Status**

DJJ History: Y ___ N ___ Probation Officer: _____

DCF History: Y ___ N ___ Case Worker:_____

Currently Involved in custody dispute: Y ___ N ____

Court orders relevant to custody? Y ___ N ____

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

_____
_____

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

Current Employment/Vocational Issues:

Child is Employed: Y___ N___ If yes, where? _____

Vocational Interest: _____

**C. Current Alcohol/Drug Use Patterns:**

| | First Use | Current Use | Frequency |
|---|---|---|---|
| Cigarettes | | | |
| Alcohol | | | |
| Marijuana | | | |
| Cocaine/Crack | | | |

Completed by: _____ Your relationship to the child: _____

Date: _____