the Psychology clinic

PLEASE COMPLETE ALL PAPERWORK AND RETURN TO OUR OFFICE:

The Psychology Clinic
2000 Southwood Drive
Lake Charles, LA 70605

THANK YOU FOR CONTACTING OUR OFFICE

WE HAVE SET YOUR APPOINTMENT FOR:

PLEASE COMPLETE AND RETURN THE ENCLOSED FORMS TO OUR OFFICE BY:

IF WE ARE HOLDING AN APPOINMENT TIME AND DON'T RECEIVE THE FORMS 48 HOURS IN ADVANCE OF THE APPOINTMENT TIME WE'LL CANCEL YOUR APPOINTMENT. UPON RECIEIVING YOUR PAPER WO RK WE'LL THEN CONTACT YOU TO RESCHEDULE.

PLEASE ARRIVE 15 MINUTES EARLY SO WE CAN MAKE COPIES OF INSURANCE CARDS.

AGREEMENT TO PAY
ONCE AN APPOINTMENT IS SCHEDULED I UNDERSTAND IT'S MY RESPONSIBILITY TO NOTIFY THE OFFICE ABOVE 24 HOURS BEFORE THE SCHEDULED APPOINTMENT TIME IF I CHOOSE TO NOT KEEP THE APPOINTMENT OR IF I NEED TO RESCHEDULE DUE TO UNFORSEEN DIFFICULTIES. I AGREE TO PAY THE NON-REFUNDABLE FEE OF $50 (LCSW/LPC) or $75 (Ph.D) IF I GIVE LESS THAN 24 HOURS NOTICE OR IF I DO NOT SHOW UP FOR MY SCHEDULED APPOINTMENT.

_____ _____
(Print Name) (Date)

_____ _____
(Signature of Responsible Party) (Date)

Assignment of Insurance Benefits
Acknowledgement of Indebtedness
& Consent to Release Information

Insured Patient: _____
(Please Print)

For services provided, I hereby irrevocably assign and transfer to The Psychology Clinic of Lake Charles, LA, my rights and interest in all benefits due under the applied insurance policy or in my rights against any third party who might be held liable for the services described in the statements rendered by the hospital.

I hereby consent that The Psychology Clinic may release information concerning the above party and furnish copies of my records if requested by the insurance company. I hereby release The Psychology Clinic from legal responsibility or liability for furnishing such records or information to the extent indicated and authorized herein. I acknowledge that the Law of the State of Louisiana controls and governs the interpretation of this agreement.

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

_____ _____ _____
Date Signature Relationship to Patient

Person Responsible for Payment

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic of Lake Charles for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

I hereby stipulate and agree to pay all cost of collections or attorney fees and court fees should it become necessary to resort to court action or turn my account over to a collection agency.

_____ _____
Date Signature

In order to control our costs of billing, office visits are to be paid at the time the service is rendered.

the Psychology clinic

Patricia D. Post, Ph.D.
Jodie Guth, Ph.D.
Jerry Whiteman, Ph.D.
Brenda LaFleur, L.C.S.W.
Clarke McLaughlin, L.P.C., L.M.F.T., L.A.C.
Alice P.Williams, L.P.C., L.M.F.T.
Brenda Hollenbeck, L.P.C., L.M.F.T.

Privacy Consent

I understand that as a condition to my receiving treatment at The Psychology Clinic, The Psychology Clinic may use or disclose my protected health information for the purposes of 1) providing treatment and 2) obtaining payment for treatment, and 3) as necessary for the operations of The Psychology Clinic. These uses and disclosures are explained more fully in the Notice of Privacy Practices, which has been provided to me and which I have had the opportunity to review.

I understand that the privacy practices described in the Notice of Privacy Practices may be revised in the future, and that I have a right to request from The Psychology Clinic a copy of any revised Notice.

_____ _____

Name Date

_____ _____

Witness Date

2000 Southwood Drive · Lake Charles, LA 70605 · Phone 337-474-2682 · Fax 337-474-4601

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Adult Record

Date_____ Insurance: _____

Name: _____ DOB: _____ Age: _____ Sex: _____

SS#:_____ - _____ - _____

Address: _____City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Number: _____

Please circle marital status:

Single Married Widow Divorced Separated

Spouse:

Name: _____ DOB: _____ Age: _____ Sex: ____

SS#:_____ - _____ - _____ Employer: _____

Emergency Contact:

Name: _____ Phone Number: _____

Address: _____City: _____ State: _____ Zip Code: _____

List the members of your family & all others living in your home:

Name	Age	Relationship	Education/Grade

2000 Southwood Drive · Lake Charles, LA 70605 · Phone 337-474-2682 · Fax 337-474-4601

Insurance Information

Clinician: Appointment Date:

Patient Name: DOB: SSN:

Patient Address: City: State: Zip:

Phone: (_____) _____ Alternate Phone: (_____) _____

Insurance Company:_____ Phone: (_____)_____

Subscriber ID: _____ Group No: _____

Subscriber's Name: _____ DOB: _____ SSN: _____-_____-_____

Subscriber's Address: _____ City, State, Zip: _____

Phone: (_____) _____ Alternate Phone: (_____) _____

Employer:_____

OFFICE USE ONLY
Effective Date:_____

Co-Pay/Co-Insurance: _____

Deductible:_____ Deductible Met?:_____

No. of Visits:_____

Authorization:_____

Out of Pocket _____

Psychological Testing Covered the Same?_____

Mail Claims To:

_____

_____

PERSONAL HISTORY QUESTIONNAIRE

The following information will be helpful for Dr. Guth to complete your evaluation. Please bring this completed form to your first visit. You will have an opportunity to explain or clarify things that may be difficult to state in writing. Please provide as much of the requested information as possible but feel free to wait until your visit to discuss any sensitive information. Use the back of these pages or additional pages as needed.

DATE:_____ **NAME:** _____ **AGE:** ____ **Gender: M F**
Referred by: _____

Is English your first language? Circle Yes or No
What other languages do you speak? _____
Will you be comfortable reading and discussing this form in English? Circle Yes or No

Please select the main reason(s) that you are meeting with Dr. Guth:

_____ Psychological evaluation before surgery
Type of surgery:_____ Scheduled? Yes No Date:_____
_____ Coping with pain and/or disability
_____ Coping with anxiety or trauma
_____ Depression
_____ Sexual issues
_____ Weight or eating issues
_____ Legal issues
_____ Psychological testing associated with application for religious study
_____ Other (please describe) _____

Are you currently receiving psychological services? Y N Name of provider:_____

Please list all physicians who are currently providing treatment to you:

Physician's Name:	Medical Specialty (ex. Orthopedics, Family Medicine)
_____	_____
_____	_____
_____	_____
_____	_____

Please list your current medications: (Use back of page if necessary)

Medication:	Dosage	Prescribed for what condition?	Prescribed by:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your current dietary/nutritional practices (i.e., low carb, high protein, vegetarian, etc) and describe a typical day of eating: _____
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks/Supplements:_____
Do you enjoy cooking? Yes No What is your daily intake of caffeine?_____
What is your daily intake of soft drinks or beverages containing sugar? _____
How much water do you drink daily? _____
How often do you engage in physical exercise?_____ What type(s) of exercise?_____
_____
Do you have a history of binge eating? Yes No Purgative behaviors? Yes No

ILLNESS or ACCIDENT HISTORY

Please describe any illness or physical/emotional disability that you may currently be experiencing.

Date that illness/injury/disability began: _____

If the injury/pain/illness is due to an accident, please describe the accident from your perspective. Start with the events just before the accident and tell what happened just afterward. (Use the back of this page if needed.)

_____

_____

_____

_____

_____

_____

List all treatments/surgeries for the above physical or emotional illness or injury and indicate whether treatment was helpful.

Treatment/Surgery	Date of Treatment/Surgery	Doctor	Helpful
			Y or N
			Y or N
			Y or N

What other treatments or surgeries do you expect to have for this condition?

_____

Changes Associated with Physical or Emotional Injury

What was your work schedule BEFORE the illness/accident or trauma?

_____

What was your job title, who was employer, and what were your job duties at time of accident or injury?_____

_____

Has the injury affected your ability to return to work? Y N If yes, please describe:

_____

How has the injury affected your financial situation?_____

_____

How did you feel about your job before the accident, incident or trauma?

_____

How long had you been in that job before the accident? _____

How did you spend your family/recreational and social time BEFORE the illness/accident or trauma?

_____

_____

How has the accident/illness or trauma, affected your typical daily activities?

_____

_____

SINCE the accident/illness or trauma, what have your work schedule and work activities been like?

_____

SINCE the accident/illness or trauma, how do you tend to spend family/social time?

_____

_____

SINCE the accident/illness or trauma, what are your current interests/activities/hobbies?

_____

_____

OTHER MEDICAL HISTORY Current Height: _____ Current Weight: _____

What other medical conditions do you have?

_____
_____
_____

List all other surgeries you have had:

_____
_____
_____

Do you have any tattoos? Y N If yes, indicate number____
Do you have any body piercings Y N If yes, indicate number____

For females only: Age at first menses: _____ Age at first pregnancy: ____ Number of pregnancies:_____

NEUROLOGICAL

Have you ever had a seizure?..... Y N
Have you ever suffered a head injury, concussion or loss of consciousness?..... Y N
Are you currently experiencing problems with memory changes or confusion?..... Y N

Early Development: Are you aware of having had any medical problems in utero or infancy? .... Y N
To your knowledge, did you experience any delays in early motor, speech, or cognitive development? Y N

MENTAL HEALTH HISTORY

Have you recently lost or gained weight? (more than 5 pounds) .....Y or N
Are you having trouble falling asleep, staying asleep, or waking up for the day?.....Y or N
How many hours of sleep do you average per night? _____

Are you having any thoughts of suicide? .....Y or N
Have you ever intentionally tried to harm yourself or take your own life? .....Y or N
Have you ever engaged in cutting or other self-injurious behavior?.....Y or N
Are you having any thoughts of harm toward others?.....Y or N

Have you ever had outpatient mental health treatment (with a counselor, etc)?.....Y or N
If yes, provide approximate dates and provider name_____
Was the treatment helpful?.....Y or N
Have you ever been hospitalized for psychological reasons? .....Y or N
If yes, provide approximate dates and hospital name_____

Do you experience problems with: uncontrollable worry? .....Y or N
sudden surges in anxiety or feelings of panic? .....Y or N
social anxiety?.....Y or N
repetitive behaviors or thoughts that are difficult to control? .....Y or N
intrusive thoughts, nightmares or flashbacks? ... .Y or N

If you currently experience panic symptoms, how often does this occur? _____
What factors increase likelihood of panic for you?_____
What factors decrease likelihood of panic for you?_____
Have you ever been diagnosed with ADHD?.....Y or N
If so, have you had academic accommodations for attention related issues?.....Y or N
Have you ever taken medication for attention related issues? Y or N If so, was it helpful?.....Y or N

SUBSTANCE USE

How many alcoholic beverages do you currently drink per week? _____

Has your use of alcohol ever interfered with your health, relationships, work, school, or legal issues? Y or N

If yes, please explain: _____

Have you ever received a DWI? ..... Y or N

Have you ever had treatment for alcohol or substance abuse? ..... Y or N

Have you ever tried marijuana or other illegal drugs? ..... Y or N

List substances and dates of first and last use: _____ _____

_____

Do you smoke cigarettes? .....Y or N

If yes, when did you start smoking? _____ How much do you smoke per day?_____

If yes, have you ever quit before? .....Y or N How did you quit? _____

Are you interested in quitting now?.....Y or N

FINANCIAL HISTORY

How would you describe your current financial status?

___Comfortable; able to meet expenses and accumulate savings

___Adequate; able to meet expenses but no savings

___Stressed; not able to meet expenses

Indicate sources of financial support:____ _____

Do you currently have student loan debt? .....Y or N

Do you currently have consumer debt other than housing or car loans?.....Y or N

How much money do you spend on gambling activities per month? _____

Have you ever struggled with gambling debt in the past?.....Y or N

Have you ever declared bankruptcy?.....Y or N

FAMILY HISTORY

Where were you born? _____ Where were you raised? _____

Who were the adults in your household when you were growing up?

__Mother and father __Grandparent(s) __Other adult(s)_____

__Mother only __Mother and other caregiver_____

__Father only __Father and other caregiver_____

Describe your parents' marital history: (include number of marriages, separations, divorces, remarriages)

_____

_____

If your parents were divorced, how did you share time/visits with each of them?_____

_____

Did any member of your household experience problems with addiction or misuse of alcohol or drugs?...Y or N

Describe your Mother or closest caregiver: Age: _____ Occupation: _____

Physical Health Status: _____

Mental Health History:_____

Addiction History:_____

Legal History:_____

Personality Characteristics: _____

How would you describe your relationship with your mother or caregiver now?_____

Describe your Father or closest caregiver: Age: _____ Occupation: _____
Physical Health Status: _____
Mental Health History:_____
Addiction History:_____
Legal History:_____
Personality Characteristics: _____
How would you describe your relationship with your father or caregiver now?_____

How many brothers do you have? _____ How many sisters do you have? _____
Ages: _____, _____, _____, _____ Ages: _____, _____, _____, _____
How would you describe your relationship with your siblings now?_____

Complete: I am the _____ child out of ____ children in my family.

Describe the rules, routines, and responsibilities that you experienced in your household growing up:

How was conflict handled in your household?
___open, respectful discussion of feelings
___physical violence or threats of physical violence
___conflicts tended to be avoided and not addressed
___conflicts tended to be handled in open manner with compromise
In your opinion, were your financial and material needs met adequately when you were growing up?...Y or N
In your opinion, were your emotional needs met adequately when you were growing up?.....Y or N
In your opinion, have you ever experienced: physical abuse? .....Y or N
sexual abuse? .....Y or N
emotional abuse? .....Y or N

How was religion/spirituality handled in your upbringing?
____ No Religion ____Not very important ____Somewhat important ____Very important

What is the role of religion/spirituality in your life today?
____No Religion ____Not very important ____Somewhat important ____Very important
What is your religious affiliation? _____
Are you currently considering religious vocation?.....Y or N
If so, please provide a brief list of significant influences and supports in your discernment journey:

EDUCATIONAL HISTORY
Did you experience learning difficulties in school? .....Y or N
What were your favorite subjects in school?_____ Least favorite?_____
Did you ever repeat a grade? ..... Y or N
Were you ever suspended or expelled for behavior problems? ..... Y or N

Please list all schools attended:
Preschool(s)_____
Elementary School(s)_____
Middle School(s)_____
What school/church/sports/music/art activities did you participate in during high school?
_____
_____
_____

Did you graduate from high school? ..... Y or N
If yes, what year? _____Name of High School _____ GPA_____
Please provide highest ACT score: _____ highest SAT score:_____
If no, what was the highest grade that you completed? _____ Did you earn a GED? ....Y or N

List any college degrees or certifications:
Degree_____ College_____ Year_____ GPA___
Degree_____ College_____ Year_____ GPA___
Degree_____ College_____ Year_____ GPA___

OCCUPATIONAL HISTORY
Please list all full time and part-time jobs starting with the most recent. (Use back of page if needed)

Employer	Job Title	Years of Employment	Reason for Leaving Job

What are some of your hobbies and interests now?_____

RELATIONSHIP HISTORY
Are you currently sexually active?.....Y or N
At what age did you become sexually active? _____
Do you have children?.....Y or N

Child's Name	Child's Age	Child's Other Parent's Name:	Child Lives where/with whom?

Please list all marriages:

Spouse's Name	Duration of marriage	Reason for end of marriage:	Status of Communication now?

Do you have grandchildren?: Y N If so, how many? _____
Do you have great-grandchildren? Y N If so, how many? _____

LEGAL HISTORY

Have you ever been arrested or charged with a crime? .....Y or N
If yes, please explain. _____
_____

MILITARY HISTORY

Have you ever served in the US Military? ..... Y or N
If yes, what branch? _____ Dates of service: _____
Rank at discharge: _____ Was the discharge honorable? _____

DRIVING HISTORY

Do you currently have a valid driver's license?.....Y or N
Are you currently physically able to drive?.....Y or N

THANK YOU FOR COMPLETING THIS FORM!

Please write down any questions or concerns that you would like to discuss with Dr. Guth.

For Your Information

We have prepared this form because we want you to know your rights and responsibilities as a client. Please read this information and sign at the end. Your signature documents that you have read and that you understand this information. We will be pleased to answer any questions you have regarding this or any related material.

Fees & Payment

The fee for a 45-minute first appointment intake session is $150 for a LCSW/LPC or $1 90 for a Ph.D.; following appointments are $100 for a Clinician or $150 for a Ph.D. per visit. There may be charges for other services such as testing, court appearances or depositions, reports, phone calls exceeding ten minutes with you or third parties (attorneys, doctors, insurance carriers, managed care reviewers). Payment is expected at the time of service.

Missed Sessions

We will try to call you to verify your appointment a day in advance. It is your responsibility, however, to call and cancel an appointment at least 24 hours in advance to avoid being billed for missing a session. Missed session fees are half of the fee for a regular
sit: $50 for a LCSW/LPC and $75 Ph.D. Fees for a missed session are NOT covered by insurance.

Insurance

The charges for our services are covered to varying extents by most health insurance policies. Our billing office is happy to assist you in filing with your
nsurance carrier for reimbursement. Our contract for payment, however, is with the client and NOT with the client's insurance carrier.

Insurance coverage varies a great deal among different policies. We will be happy to contact your insurance carrier for you and verify your coverage. The basic questions to be answered include:

Is there a deductible to be met?
Are outpatient mental health benefits covered and is pre-certification necessary?
What percentage of the fee will the insurance cover, and is there a limit on the eligible charges?
Is there a limit on the number of sessions allowed?
Are reviews by managed care required?
If there is more than one insurance company, are there special rules to follow?

Clients must make full payment at the time service is rendered until the deductible has been met. Thereafter, clients must pay their co-payment amount and we will submit claims to the insurance company for the remaining amount. It is the client and NOT the insurance company who is ultimately responsible for payment.

Insurance companies require that a diagnosis be provided in order for a claim to be processed. In some cases, insurance companies will not pay for some certain diagnoses.

If you have any concerns about your insurance billing, please feel free to discuss them with our staff.

Confidentiality
Any information that you reveal to your therapist is considered "privilege communication", and it is your right to have that information kept confidential. Mental health professionals are not allowed to release any information about clients without a signed "Release of Information" form that permits the transfer of specific information to a specified individual. This form is valid for one year.

There are only rare situations in which information about clients may be released with or without the client's permission. These situations are as follows:

When a child is physically abused, neglected, or sexually abused, we are required by law to contact the proper authorities (Police, State Department of Family Services).

When a client or another individual is in clear and immediate life threatening danger as with homicide or suicide, we are required by law to take steps to insure their safety, even if it means contacting authorities without the client's permission.

In addition, there are situations in which the client is involved in civil or criminal litigation where the therapist and his/her records can be subpoenaed, particularly when the client is suing someone for damages based on emotional injury or when the client is involved in a child custody proceeding.

Emergency Coverage
Each therapist can be reached during office hours at (337)-474-2682. After ours, the phone will be transferred to an answering service that will locate either your therapist or the therapist on call for emergency situations. Please let the operator know if your call is an emergency. When your therapist is out of town, he/she will make arrangements for another therapist to cover crisis situations. In the unlikely event that your therapist and the on-call therapist cannot be reached quickly in an Emergency, you may consider calling your family physician, a local hospital, or the Lake Charles Mental Health Center at (337)-475-8022

I have read and I understand the office policy.

_____ _____

Signature Date

_____ _____

Witness Date