**WILSON PSYCHOLOGICAL ASSOCIATES, PLLC**
**417 East Silas Street**
**Bartlesville, Oklahoma 74003**
**(918) 337-6050 Phone**
**(918) 337-6061 Fax**

## NEURO/PSYCHOLOGICAL EVALUATION PATIENT AGREEMENT AND CONTRACT- ADULT

This contract is designed to explain the policies, procedures, risks, benefits, and patient responsibilities for psychological evaluation at Wilson Psychological Associates, PLLC. Please note that there is a separate agreement for treatment/counseling. Please thoroughly review this document as it contains information that is important for you to know.

While the detail included in this document may seem tedious, I believe it is important that you understand from the beginning how situations will be handled in the typical work encountered in my practice. I believe you have the right to know the parameters of our relationship at the outset of our work together. *Please initial each page* and *sign the final page* if you are in agreement with the terms presented.

### Process of the Evaluation

The evaluation takes place in three primary stages:

1. Diagnostic Interview: to obtain history, review concerns, and to discuss the reason for the evaluation, to determine what testing should be done, and review informed consent, patient agreement, and evaluation procedures.
2. Testing: may take place in a single multi-hour session, several 1- or 2-hour appointments, or other arrangements based on your needs as determined during the Diagnostic Interview.
3. Feedback: to provide feedback about testing results, diagnostic impressions, and disposition and treatment recommendations, about 1-3 weeks after the completion of the testing process. This appointment is optional in accordance with your preference.

Scoring, interpretation, and professional report writing by the psychologist will also be completed. In addition to the stages of the evaluation described above, other services are sometimes needed. It is often helpful for the doctor to speak with other professionals who have worked, or who are working with you. This could include physicians, mental health therapists or counselors, teachers/professors, speech and language therapists, occupational therapists, or other individuals. If this is necessary, you will be asked to sign additional written consent(s).

The doctor will spend several hours scoring and interpreting the test results, and writing the professional report. In truth, you will only be charged for a portion of these hours. As with most medical testing, only sometimes is the written report provided to the patient, but most often the report is inappropriate for dissemination to laypersons and will be released only to your physician or therapist. If you desire a report of the results for your use, you will be charged additionally for the preparation of the lay report as most insurance carriers do not cover the writing of additional reports for patient use. The rationale for this stipulation is that professional psychological evaluation reports are written in technical language and could be easily misunderstood or even damaging to untrained readers; consequently, mental health

records are held under a separate legal standing than typical medical records and are therefore not accessible routinely by you as the patient without sitting down with the evaluator to discuss the contents. The evaluation includes one copy of the evaluation report to be sent to the professional of your choosing (physician, therapist, etc.). If you require multiple copies of the report, they will be sent upon receipt of the typical record copy charge of $2.00 for the first page and $1.00 for each additional page, which must be paid prior to the distribution of the additional copies.

## Benefits and Risks of Evaluation

The primary benefits of evaluation include diagnostic clarification, appropriate treatment recommendations to handle challenges and maximize strengths, written documentation to facilitate services in both medical and educational settings, and gaining insight into the nature of the strengths and weaknesses the patient may possess. Nonetheless, there may be some risks involved. Although most individuals respond positively to the evaluation procedure, some patients and/or their parents, guardians, or loved ones may experience some discomfort such as frustration, anxiety, or embarrassment. It is possible the evaluation will not answer all your questions and further evaluation by the doctor or another professional may be needed. While the testing and recommendations are based on best practices, you and/or others may not agree with the clinical decisions and diagnoses. Ultimately, it is your decision whether to follow the recommendations generated during the evaluation.

## Appointments and Scheduling

*Private Insurance or Private Pay Cancellation Policy*: For those insured by private insurance, Medicare, or who pay privately, you are obligated to provide notice at least forty-eight (48) hours (or by Friday at noon for a Monday appointment of if a holiday falls on Monday) prior to your *scheduled diagnostic interview or feedback appointment* or you will be charged a late cancellation/no-show fee of $100.00. If the office is closed or if someone is unable to answer the phone when you call, you MUST leave a message on the secure voicemail indicating that you are cancelling the appointment.

With regard to the scheduled evaluation appointment(s) (the second phase of the process), as these appointments block a significant portion of the schedule, the late cancellation deadline is by forty-eight (48) hours prior to the testing appointment(s), or by noon Friday preceding a Monday appointment (or if a holiday falls on a Monday). If you do not provide sufficient notice of cancellation, the late notice/missed visit fee is $100.00 per hour scheduled. Late cancellation/missed visit fees must be paid in full before appointments may be rescheduled. By entering into this agreement, you agree to not contest these fees as "unauthorized" with your bank or credit card issuer. If you contest these charges with your bank, an additional $100.00 gratuitous contested fee charge will be added to your account.

*Public Insurance*: We do not accept adult Soonercare/Medicaid for psychological testing.

***Testing Appointment Reminders: You will receive a call from the WPA office staff approximately 48 hours prior to the testing appointment. If you do not answer your phone a message will be left on your voicemail. You <u>MUST</u> call the office to confirm your appointment. If you do not call the office to confirm, the appointment will be cancelled. It is the responsibility of the client to make sure there is a working voicemail box on your phone of choice.***

## Confidentiality and Limits to Confidentiality

In general, the privacy of all communications between a client and a psychologist or counselor is protected by law, and I can only release information about our work to others with your written authorization(s). *But, there are a few exceptions*.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if s/he determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another person, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I strive to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

Finally, if you drive to my office in an altered state of consciousness, such as intoxication with recreational drugs or alcohol, or are observably over-medicated with prescription medication, I reserve the option of contacting a family member, friend, or the authorities to arrange transportation and to ensure your safety and the safety of those whom you may encounter. This situation has also rarely occurred in my practice.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

## Consultation with Your Medical Physician

Often in the course of the evaluation or after it, I deem it helpful to consult with my clients' primary care physician and/or psychiatrist in order to best serve their health care needs; with some insurers (e.g., Medicare), this communication is *required*. This information will be limited to the minimum amount necessary to accomplish your best health care. Typically, before I contact your physician, I will discuss my impressions with you and the reasons I think it would be helpful to speak with him/her. If you have questions about this, we should discuss them at our next meeting. ***Your signature on this document***

***serves as your agreement to this disclosure of Protected Health Information for the purpose of healthcare coordination. If you <u>REFUSE THE RELEASE OF THIS INFORMATION UNDER HIPPA</u>, please initial here _____. (If you refuse, it may make it impossible for us to serve you due to insurance regulations.) Your signature on this document, minus any initial on the line above, authorizes us to release information to your healthcare providers for the purpose of healthcare coordination.***

## Financial Policy

Obtaining a psychological evaluation is a substantial financial commitment on your part, so it is important for you to know exactly what your financial obligations will be. Because you are seeking this evaluation for yourself or your child, you are responsible for ensuring that all of the associated fees are paid. This means that if you think that another person/entity, such as another parent or your insurance company, will cover the charges and the person/entity does not do so, you are financially responsible. Please note that the person calling to request services is generally considered the guarantor of the account. If for any reason your account is delinquent, this office will pursue collections action, including but not limited to using our contracted collection agency or action in small claims court.

*Fee Structure*:

| | | |
|---|---|---|
| 90791 | Diagnostic Interview to begin Evaluation | $200.00 |
| 96101 | Psychological Assessment (Psychologist) | $190.00 |
| 96102 | Psychological Testing (Computer) | $150.00 |
| 96103 | Psychological Testing (Technician) | $170.00 |
| 96105 | Testing for Aphasia (per hour) | $220.00 |
| 96116 | Chart Review, Scoring of Instruments (per hour) | $190.00 |
| 96118 | Neuropsychological Testing (Psychologist) | $220.00 |
| 96119 | Neuropsychological Testing (Technician) | $200.00 |
| 96120 | Neuropsychological Testing (Computer) | $190.00 |
| 97770 | Cognitive Rehabilitation (per hour) | $190.00 |
| 90889 | Preparation of Psychological Report (per hour) | $190.00 |
| 90889 | Preparation of Neuropsychological Report (per hour) | $220.00 |
| 99373 | Telephone Consultation (per hour) | $190.00 |
| 99075 | Legal Partic, Deposition, Testimony, Preparation, Att. (per hour) | $775.00 |
| 99049-P | Missed Visit, PSY(per scheduled hour) | $100.00 |
| 99049-N | Missed Visit, NEUROPSY(per scheduled hour) | $100.00 |

Document Fees for Record Copy, Preparation, and Recording: $2.00 first page; $1.00 for each additional page.

*Private Insurance/Private Pay Patients*: Before the evaluation appointment(s), you will receive a written estimate of the charges, including testing with the client, scoring the testing, reviewing records, conducting the Feedback Session, and writing the report. At times, though not frequently, data is obtained in the evaluation that may necessitate addition testing beyond that originally estimated. If the testing process takes longer than estimated for any reason, you will be responsible for paying any additional fees prior to the feedback session. An advance deposit is required to reserve your testing evaluation.

After making the testing appointment, if you decide to cancel without rescheduling to another date, you will forfeit the testing deposit. Therefore, please do not schedule testing unless you are certain you want to go through with the evaluation and will have the funds available when they are due.

## Payments

Payment is preferred by cash, personal check, or money order made payable to Wilson Psychological Associates, PLLC. Payment is also accepted by way of Visa, Mastercard, Discover, or American Express. Payment plans for evaluations will be granted only for extenuating circumstances and only when a valid credit/debit card is provided to which charges may be made through the course of the payment plan. There will be a fee that will be associated with setting up a payment plan and the amount of fee will depend upon the terms of the plan.

If a personal check is returned, you will be notified that an alternative means of payment is required immediately, along with a $30.00 returned check fee that will be added to your account. Continuation of the psychological evaluation cannot occur until the situation has been rectified. Wilson Psychological reserves the right to refuse personal checks as method of payment after a check has been returned for insufficient funds or closed account. Your account must be current before any professional report, lay report, or other correspondence will be distributed.

## Additional Services

There is a $25.00 document charge for completion of short forms, preauthorization forms, or brief letters that are needed (over and above the professional report produced as a result of the evaluation), such as letters to insurance companies for justification of diagnosis(es), evaluation or treatment; letters or forms needed for schools or state agencies regarding diagnosis, treatment, or information for IEP planning; letters to other professionals, etc. Lengthy letters, forms, or layperson evaluation reports will be billed at $190.00 per hour for psychological evaluations or $220.00 per hour for neuropsychological evaluations. Payment must be made before the correspondence will be distributed. Please be aware that, in most cases, the doctor will not be able to provide letters or complete forms on the same day they are requested; in some instances, there may be a seven day turnaround period for completion of forms or letters. However, the doctor will make every effort to be as prompt as possible in addressing your request(s).

The doctor is most often not immediately available by phone due to the nature of the work. Consequently, if you need to speak directly to the doctor, phone calls lasting less than five (5) minutes may be scheduled through the office manager on most clinic days. If you require a phone call that will last longer than five minutes, those calls must be scheduled in advance and will be during the typical clinic day as the doctor's schedule permits. Calls lasting longer than five minutes will be prorated and charged at the psychological assessment rate ($190.00 per hour) or the neuropsychological evaluation rate ($220.00 per hour). This fee must be paid at the next appointment, or if no future appointments are scheduled, a valid credit card number must be provided prior to the phone call.

Due to the difficulty of court-related services, the hourly rate for those services is $775.00 per hour. Fees are charged for travel time, record review, consultation, phone calls, and any other time needed, in addition to time away from the office for court proceedings. There is a minimum of 4-hour charge for time away from the office. Due to the nature of the services associated with legal cases, a $5,000 retainer

deposit will be required at the outset of legal involvement (i.e., at first notification of the doctor's required or requested participation), from which the associated fees will be deducted. Regardless of whether you or another party associated with you requires my participation in legal proceedings, you as the guarantor of your account will be responsible for the court-related fees associated with my participation as my professional relationship with you will necessitate my involvement in the legal proceeding. When the legal fund reaches $2325.00, another $3,000 deposit will be required, and so on, until the completion of the legal involvement, at which time any remaining balance will be refunded to you along with a detailed summary of charges and expenses. In addition to fees associated with time for the doctor's participation, any expenses will also be deducted from the legal deposit, including, but not limited to travel, lodging, meals, legal consultation, copies, phone, etc. As insurance does not cover court-related costs, the deposit and fees *MUST be paid in advance* of any work being conducted.

## Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the follow policy. This is because the use of various types of electronic communication is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

*Email Communications*

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

*Text Messaging*

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

*Social Media*

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it

with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

*Websites*

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

*Web Searches*

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for the matter, please discuss this with me during our time together so that we can deal with and its potential impact on your evaluation.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me, please share it with me so we can discuss it and its potential impact on your evaluation. Please do not rate my work with you while we are working together on any of these websites. This is because it has a significant potential to damage our ability to work together.

## Informed Consent for Evaluation

It is very important that you have read, or had read to you, the information contained in this document so that you will understand all the office policies, procedures, and responsibilities outlined herein. *Your signature below indicates that*:

1. You have had sufficient opportunity to read and understand this document.
2. You have asked the doctor to clarify anything you did not understand if needed.
3. You agree to abide by the terms of this agreement in their entirety.
4. You understand that this form applies only to the policies and procedures for TESTING with the doctor. A separate consent and agreement is needed for treatment/therapy.
5. You are giving the doctor your consent to conduct an evaluation with you.

Client Signature:_____ Date of Birth: _____

Printed Name of Client: _____

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OFFICE USE ONLY

My signature below indicates that I have answered any questions raised by the client/parent/guardian. I have been told and believe that the person understands all of the issues discussed in this form, and I find no reason to believe that this person is not fully competent to give informed consent to the evaluation.

_____

K. Spencer Wilson, Ph.D.
Oklahoma Licensed Psychologist #966
Health Service Provider

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**CONFIDENTIAL CLIENT INFORMATION**
**Initial Information Form**

Please take a few moments to fill out this form as completely as possible. From this history, valuable information may be realized by examining areas such as the Presenting Picture (current symptoms and what precipitated them); the History of Present Problems; Your History (past issues that may be important now). In brief, this is what has led you to this place today.

Name:_____Date:_____

Name of Referral Person/Source to the Practice: _____

Name of person completing this form (if other than patient): _____

**PRESENTING PROBLEM (Current symptoms and what precipitated them)** I am a ____ year old ___ [M] or ___[F] who lives in _____ (town/city). If I had to describe my major symptom(s), it/they would be ___Depression ___Anxiety ___Obsessive Worries ___Panic Anxiety ___Times of Confusion ___Drug Abuse ___Inattention/Hyperactivity ___Mood Swings ___Loss of Memory ____ Sexual compulsivity ___ Relationship problems ____Other_____ (name). The major stressor(s) that precipitated my symptom is/are ___Marital Issues ___Parent/Child Issues ___Job Issues ___Health Issues ___Relationship Issues ___Financial Issues ___Issues of Past (___Guilt ___Abuse ___Family of Origin) ___Other_____ (name).

My symptom(s)/problem(s) approximately began: _____ (date).
My symptoms(s)/problem(s) increased: _____ (date),
or, _____ it/they has/have not increased.

My biggest concern in life at the present time is: _____

I am _____ (OR) I am not _____ concerned at this time that I have been having suicidal and/or homicidal thoughts or impulses.

**II. HISTORY OF PRESENT PROBLEM: (Current symptoms: Please check one frequency for all that apply)**

**FREQUENCY KEY:** **Occ'l** – ***Occassionally*** **Wkly** – ***Weekly*** **Daily** - ***Daily***

| Occ'l | Wkly | Daily | Psychological/Physical Symptoms |
|---|---|---|---|
| ___ | ___ | ___ | Increased crying |
| ___ | ___ | ___ | Sad mood |
| ___ | ___ | ___ | Lack of motivation |
| ___ | ___ | ___ | Poor concentration |
| ___ | ___ | ___ | Sleep Pattern (More) or (Less) |
| ___ | ___ | ___ | Appetite changes |
| ___ | ___ | ___ | Weight changes |
| ___ | ___ | ___ | Lack of interest |
| ___ | ___ | ___ | Decreased self-esteem |
| ___ | ___ | ___ | Sad affect |
| ___ | ___ | ___ | Hopeless/Helpless feeling |
| ___ | ___ | ___ | Nightmares |
| ___ | ___ | ___ | Other:_____ |
| ___ | ___ | ___ | Inattention |
| ___ | ___ | ___ | Hyperactivity |
| ___ | ___ | ___ | Delusions/Paranoia |
| ___ | ___ | ___ | Hallucinations (hearing voices/music that no one else hears) |
| ___ | ___ | ___ | High with racing thoughts, increased speech, decreased sleep, and increased activity |
| ___ | ___ | ___ | Energy level |
| ___ | ___ | ___ | Chest discomfort |
| ___ | ___ | ___ | Abdominal (Stomach) distress |
| ___ | ___ | ___ | Feeling dizzy |
| ___ | ___ | ___ | Fear of going crazy |
| ___ | ___ | ___ | Startled response |
| ___ | ___ | ___ | Chills or hot flashes |
| ___ | ___ | ___ | Outburst of anger |
| ___ | ___ | ___ | Anxiety in general |
| ___ | ___ | ___ | Restlessness, keyed up, fatigued, decreased concentration, irritability, muscle tension, decreased sleep |
| ___ | ___ | ___ | Hypervigilance – excessive attention and focus on all internal and external stimuli |
| ___ | ___ | ___ | Obsessions/compulsions – constant checking, washing, or counting type behaviors; unrelenting worries |
| ___ | ___ | ___ | Avoidance of stimuli associated with a trauma |
| ___ | ___ | ___ | Agoraphobia – anxiety of places or inescapable situations |
| ___ | ___ | ___ | Specific phobia – marked and persistent fear of certain objects or situations |
| ___ | ___ | ___ | Social phobia – marked and persistent fear of social or performance situations where embarrassment may occur |

| Occ'l | Wkly | Daily | |
|---|---|---|---|
| ___ | ___ | ___ | Traumatic experience(s) |
| ___ | ___ | ___ | Intense fear |
| ___ | ___ | ___ | Rapid heartbeat |
| ___ | ___ | ___ | Increased sweating |
| ___ | ___ | ___ | Shortness of breath |
| ___ | ___ | ___ | Withdrawn |
| ___ | ___ | ___ | Isolating self from all contact with others |
| ___ | ___ | ___ | Amnesia |
| ___ | ___ | ___ | Running away |
| ___ | ___ | ___ | Truancy |
| ___ | ___ | ___ | Memory impaired with trouble organizing and sequencing |
| ___ | ___ | ___ | Somatizaton – undue health worries with no adequate medical explanation |
| ___ | ___ | ___ | Agitated – irritable (easily annoyed and provoked to anger) |
| ___ | ___ | ___ | Alcohol abuse (Drinks per day/month):_____ |
| ___ | ___ | ___ | Drug abuse (I've used):_____ |
| ___ | ___ | ___ | Behavioral problems – Name:_____ |
| ___ | ___ | ___ | Developmental problems – Name:_____ |
| ___ | ___ | ___ | Self-mutilation – Name:_____ |
| ___ | ___ | ___ | Legal Issues – Name:_____ |
| ___ | ___ | ___ | Sexual Issues – Name:_____ |
| ___ | ___ | ___ | Eating Issues – Name:_____ |
| ___ | ___ | ___ | Impulsive |
| ___ | ___ | ___ | Aphasia, apraxia, agnosia |
| ___ | ___ | ___ | Disturbance of executive functioning |
| ___ | ___ | ___ | Suspiciousness/Paranoia |

**III. PAST HISTORY: (Past issues that may be important now)**

A. Have you had similar and significant symptoms(s) in the past? Yes No
If yes, when:_____
Did they recently increase? Yes No
If yes, what caused the increase?_____

B. Name three past stressful events in your life that precipitated the original symptom(s):
_____

C. Prior psychiatric hospitalization? Yes No If yes, where:_____
Reason hospitalized:_____
Prior outpatient counseling? Yes No
If yes, therapist(s)/dates(s):_____

D. Substance abuse history. Yes No If yes, when did it begin?_____
Substances_____
Drug(s) of choice:_____
Any treatment Yes No Date(s):_____

E. Medical Problems, Past Surgeries, Hospitalizations: _____

_____

_____

My Current Primary Care Physician is: _____

My last appointment with my primary care physician was: _____(Date)

I think my primary care physician _____ is _____ is not meeting my medical needs. If not, please explain why:

_____

I _____ am (or) _____ am not under the care of a psychiatrist: _____ (name).

I _____ am (or) _____ am not under the care of a neurologist: _____ (name).

I _____ have (or) _____ have not had brain/head imaging (e.g., CT, MRI) on _____ (date). (If yes, please provide a copy of the report.

I _____ have (or) _____ have not had other neurological evaluation (e.g., EEG study) on _____.

E.1.Current Medication and Dose: (Or, you may provide a current medication list with prescribed doses)

| **Current Medicine & Dose** | **Date Began** | **Side Effects** | **Effective? Y/N** |
|---|---|---|---|
| | | | |
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| | | | |

F. Any known drug allergies_____

G. Family of origin:

1. Father – what was he like?_____
2. Mother – what was she like?_____
3. Bothers/Sisters – how many of each?_____
4. Where did you fit in birth order?_____
5. What type of relationship did you have with your sibling(s)?_____

6. How far did you go in formal education?_____

And, your grades? ____ Failing ____ Below Average _____ Average ____ Above Average ____ Superior

7. Marriages – how many?_____ Please list beginning and ending date(s) (if applicable):

_____

8. Children – how many?_____

Names, ages and sex of each?_____

_____

I. I was born in: _____ (city, state). I lived in the following city/states from between the associated ages (e.g., Bartlesville, ages 0 – 3 years):

_____

_____

_____

My birth and early development was ___Normal ___Abnormal (Please Explain if Abnormal):

My childhood overall was: ____Painful ___Uneventful ___Good

J. I have an history of: ___Abuse ___School problems ___Abandonment ___Relationship problems ___Disability ___Job problems ___Legal ___Other (Name)_____

K. I presently live: ___Alone ___With Spouse ___With parents ___Other_____
My current support system is ___Good ___Fair ___Poor

L. Psychiatric history – Name(s) of past psychiatrist(s) and/or therapist(s) and dates seen and if the treatment was or was not successful:

_____

_____

M. I ___ have ____ have not been hospitalized due to psychiatric reasons. The hospitalization _____ was ____ was not with my consent. Dates/Facilities: _____

_____

N. I _____ have _____ have not attempted suicide in the past. If yes, please list each attempt with approximate date(s) and method used:

_____

_____

O. I ____ have ____ have not had a psychological/neurpsychological evaluation in the past. (If yes, please have the evaluating psychologist forward copies to my office as soon as possible.)

P. Job history and current job_____

_____

Q. Religious/spiritual history: ____ Christian ____ Jewish ____ Mormon _____ Muslim ____ Native _____

Other: _____ _____ None

R: Race:_____ Asian _____ Black _____ Caucasian _____ Latino/a _____ Other: _____

Please use the space below to include any other information you believe may be helpful in gaining an understanding of you and/or your concerns (s).

## INSURANCE/PAYMENT INFORMATION

**Responsible Party**

Last Name_____ First Name _____ M.I._____

Address_____

City_____ State_____ Zip_____ Home Phone (____)_____

Date of Birth_____ SSN_____ Relationship to Patient _____

Employer_____ Address_____

Occupation_____ Business Phone (____)_____

Spouse Name_____ Spouse's SSN_____

**Primary Insurance Co**_____ Effective Date_____

Insured's Name_____ DOB_____ SSN_____

Address (if different)_____

Policy No._____ Group No_____ Relationship to Patient _____

**Secondary Insurance Co**_____ Effective Date_____

Insured's Name_____ DOB_____ SSN_____

Address (if different)_____

Policy No._____ Group No_____ Relationship to Patient _____

Declaration: I (we) authorize payment of medical benefits to the provider herein for all psychological services rendered. I (we) authorize the provider or Wilson Psychological Associates to release any information required to process my insurance claims. I (we) authorize my insurance benefits to be paid directly to Wilson Psychological Associates. I (we) understand that I (we) am (are) financially responsible for payment of any insurance deductible, copayments, and non-covered charges or services. A photocopy of this signature is valid as the original.

Signature of Responsible Party_____ Date_____
Signature of Spouse*_____ Date_____
(*required if marital therapy)

**Please provide us with your insurance card so that we may have a copy on file. Please notify us of any changes to your insurance. We reserve the right to require you to file your own insurance if we are not made aware of insurance changes within two visits of the policy change. Thank you for your consideration in this matter.**

## Patient Health Questionnaire – PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling/staying asleep, sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself – or that you are failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

If you have been bothered by any of the 9 problems listed above, please answer the following:
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Please circle the answer)

Not difficult at all  Somewhat Difficult  Very Difficult  Extremely Difficult

## Generalized Anxiety Disorder 7-item (GAD-7) scale

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all sure | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____