

Client Name: _____

Driskill and Bates Psychology, P.A.
5212 75th Street
Lubbock, TX. 79424
(806) 794-3393
Fax: (806) 794-3733

Confidential Client Information-Adult

Date: _____

Client Name: _____ Date of Birth: _____ Age: _____

Single Married Widowed Separated Divorced

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Prefer to be called at: Home Cell Can we leave a message? Yes No

In case of emergency, who should be notified? _____ Phone: _____

Medical Information:

I consider my current health to be: excellent good fair poor

List any significant medical problems or allergies: _____

List all current medications and give dose: _____

Primary Care Physician: _____

Are you now or have you ever seen a psychiatrist, counselor, or other professional? Yes No

If yes, Name of Clinician: _____

Client Name: _____

Date(s) of Treatment: _____

Reason for Treatment: _____

Background Information:

Spouse' Name _____ Age: _____

Occupation: _____ How would you describe your relationship? _____

Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Father's Name _____ Age: _____

Occupation: _____ How would you describe your relationship? _____

Mother's Name: _____ Age: _____

Occupation: _____ How would you describe your relationship? _____

In your family is there a history of (Please check all that apply):

- Alcoholism Substance Abuse Physical Abuse Domestic Violence
- Depression Anxiety Sexual Abuse Mental illness
- Mental Retardation Prolonged Physical illness (what kind) _____

Have you experienced any major changes, traumas, or major events in the last 12 months? Yes No

If yes, please describe: _____

Have you experienced any of the following:

None

- Physical Abuse/Assault as adult Physical abuse or neglect as a child
- Sexual Abuse/Sexual Assault as adult Sexual abuse as a child
- Domestic Violence as adult Domestic violence as a child
- Problems with alcohol or drugs as adult Problems with alcohol or drugs as an adolescent or in your family as a child

Other Trauma, please explain briefly: _____

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Current Concerns

What are your major concerns or reasons for seeking psychological services at this time?

Other problems or concerns: _____

What do you hope to accomplish in therapy or from the evaluation; what are your goals? _____

Below is a list of problems people can experience. Please check any items of concern for you

| | | |
|--|--|---|
| <input type="checkbox"/> Unsatisfied with my work | <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Ill at ease with people |
| <input type="checkbox"/> Feeling left out of things | <input type="checkbox"/> Too little social life | <input type="checkbox"/> Not knowing what I want |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Difficulty finding or keeping a job | <input type="checkbox"/> Not reaching the goals I've set for myself |
| <input type="checkbox"/> Tired too much of the time | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Moodiness |
| <input type="checkbox"/> Feeling inferior | <input type="checkbox"/> Irritability | <input type="checkbox"/> Feeling guilty about things |
| <input type="checkbox"/> Unhappy too much of the time | <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Loss of interest in activities |
| <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Problems with eating |
| <input type="checkbox"/> Wishing I had never been born | <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Past suicide attempt(s) |
| <input type="checkbox"/> Feelings are hurt too easily | <input type="checkbox"/> Fearing failure | <input type="checkbox"/> Feelings of being mistreated |
| <input type="checkbox"/> Often feeling worried/anxious | <input type="checkbox"/> Feelings of "panic" | <input type="checkbox"/> Disturbing thoughts |
| <input type="checkbox"/> Having periods of time I can't remember | <input type="checkbox"/> Concerns about alcohol or drug use | <input type="checkbox"/> Speaking or acting without thinking |
| <input type="checkbox"/> Poor self-esteem | <input type="checkbox"/> Lacking self-control | <input type="checkbox"/> Difficulty with anger control |
| <input type="checkbox"/> Legal concerns | <input type="checkbox"/> Concerns about body image | <input type="checkbox"/> Wanting to lose/gain weight |

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Driskill and Bates Psychology, P.A.
Patricia Driskill, Ph.D./Julie Bates, Ph.D.
5212 75th Street
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FINANCIAL POLICY

We are committed to providing your child with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy. We must emphasize that as mental health providers, our relationship is with YOU, not your insurance company. While the filing of insurance claims is a courtesy we extend to our families, **all charges are your responsibility from the date services are rendered.**

You are responsible for checking with your insurance company regarding their coverage prior to starting regular therapy. You will be held responsible for charges for treatments rendered that your insurance denies as detailed in your therapy services agreement, including initial assessments. Depending on your individual insurance coverage, a deposit may be required before your course of therapy begins.

Payment schedules and co-pays will be issued based on insurance coverage estimates. Our estimates are subject to final approval by your insurance company. Therefore, the amount due is subject to change. We cannot guarantee payment by your insurance company even after they give us the estimated payment. If they do not pay the full fee, you are responsible for any amount unpaid up to the full cost of the evaluation. Please confirm this full cost before completing the appointment.

I, the undersigned, do agree that if my insurance does not pay my claim for any reason within 45 days, I will be responsible to pay the balance in full to Driskill and Bates Psychology within 15 days. My failure to do so can result in my account being turned over to a collection agency. This collection address will affect my credit rating.

Unless prior arrangements have been made, all deductibles and co-payments are due at the time of service. We accept cash, checks, and credit cards for your convenience. A \$15 fee will be charged for all returned checks.

I understand if my insurance declines payment for any reason, I am responsible for the full cost of the evaluation.

Please sign below if you have read and understand and agreed to this financial policy.

Signature

Printed name

Date

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INSURANCE CLIENT ACKNOWLEDGEMENT STATEMENT

I understand that the service or items that I have requested to be provided to me MAY NOT be considered by my insurance carrier or third party payer to be REASONABLE AND MEDICALLY NECESSARY for my care or my child's care.

I understand the services provided to me or my child by Driskill and Bates Psychology may be considered NON-COVERED SERVICES by my insurance carrier or third party payer.

I understand that I am responsible for payment of the services or items I request and receive at the time services are provided. If the services or items are

- Not paid by my insurance carrier or third party payer
- Considered not reasonable or medically necessary
- A non-covered service
- Other reason for non-payment

I understand that I am responsible for payments or services provided by Driskill and Bates Psychology even if payment is initially received by a third party payer and then later recouped by payer from Driskill and Bates Psychology for any reason.

Signature **Printed name** **Date**

ASSIGNMENT OF BENEFITS

I authorize Driskill and Bates Psychology to bill my insurance for services they provide and accept assignment of those benefits. I further authorize Driskill and Bates to exchange any information pertaining to the patient necessary to ensure payment by my insurance carrier.

Signature **Printed name** **Date**

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Informed consent for psychological testing

This form will provide information about our psychological assessment services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your clinician or his/her Supervisor. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment.

We utilize both Licensed Psychologists and Psychology interns to complete the assessment process. Psychology interns are doctoral level clinicians under the supervision of Licensed Psychologists with expertise in psychological, educational, and cognitive assessment.

TESTING

Through the use of a variety of standard psychological tests, we will attempt to answer the questions that have brought you for this assessment. Throughout the assessment process, you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations.

The assessment process consists of three sections: intake, testing session, and a feedback session to review the results. Although it is sometimes possible to complete the testing in one sitting, at times clients will be asked to return for another session to finish the assessment battery.

Once testing is completed, the data will be analyzed and a comprehensive report will be written. You will then have the opportunity to meet with a Licensed Psychologist to discuss the results and receive a copy of the report. Typically, this feedback session will take place approximately 2-3 weeks from the time that all psychological testing is completed.

LATE/CANCELLATION POLICY

Due to the number of billable hours allotted/scheduled for your assessment, it is important that you keep your scheduled appointment. Please note that we require a 48 business hours (2 business days) notice for a cancellation. Otherwise, your appointment may not be rescheduled.

RELEASE OF RECORDS

Written records are released *only* after a consent form is signed by the client or their Parent/Legal Guardian.

INFORMED CONSENT

I understand that the information obtained in this evaluation is confidential and will not be released to any person or organization without my written permission. *(This release is available in our office or may be completed with any individual whom you wish to give such access, and*

Client Name: _____

then provided to us.

The only exceptions to this policy are rare situations in which you are required, but law, to release information with or without my permission. These are 1) if there is evidence of physical and/or sexual abuse of children or abuse to the elderly; 2) if you judge that I am in danger of harming myself or another individual; and 3) if my records are subpoenaed by the court. In the rare event of any of these situations, you would attempt to discuss your intentions with me before an action is taken, and you would limit disclosure of confidential information to the minimum necessary to ensure safety. **Please initial** _____

I understand that I have the right to discontinue the evaluation process at any time. However, I understand that DB may be unable to provide feedback of the test results if testing is terminated, and that **I will still be responsible for payment of any testing, scoring, and evaluation time provided up until that point.** **Please initial** _____

By my signature below, I acknowledge that I consent to a psychological evaluation by Driskill Bates Psychology.

YOUR SIGNATURE BELOW INDICATES YOU ARE THE LEGAL PARENT OR GUARDIAN OF THE MINOR CHILD AND THAT YOU HAVE THE LEGAL RIGHT TO CONSENT TO PSYCHOLOGICAL SERVICES FOR THAT CHILD. If parents are not the legal guardians or if parents are separated or divorced, you may be asked to provide a copy of the legal document indicating your right to consent to treatment before the child can be seen. (Exception if the child has been placed in foster care or a foster care/ residential treatment facility.)

Your signature below indicates that you have read the information in the PATIENT AGREEMENT, have been given a copy, and agree to abide by its terms during our professional relationship. Your signature also serves as an acknowledgment that you have been provided the HIPAA NOTICE FORM.

Client Signature

Print Name

Date