



Castle Hills

ALGOS BEHAVIORAL HEALTH SERVICES, INC.
NEW PATIENT INFORMATION RECORD

Today's Date:		Referred By:	
Patient Full Legal Name:			
Date of Birth: / /		Age: Male / Female (circle one please)	
SSN: / /		Marital Status: Single / Married / Divorced / Separated / Widowed	
Address (physical):		Drivers License#:	
City:		State:	
Zip Code(9 digits):			
Home Phone: ()		Cell Phone: ()	
Work: ()		EXT#	
Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, which is best: cell / home / work			
Email Address:			
Employer's Name:		Occupation:	
Address:		City:	
State:		Zip:	

PRIMARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Primary Insurance:		Phone # <i>(Located on the back of card)</i>	
Subscriber ID#:		Group # :	
Name of Policy Holder:		DOB:	
Insured's Address:		<input type="checkbox"/> same as patient	
City:		State:	
Zip Code(9 digits):			
Policy Holder's Employer:			
Patient Relationship to Policy Holder: SELF / SPOUSE / CHILD / PARTNER			

SECONDARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Secondary Insurance:		Phone # <i>(Located on the back of your card):</i>	
Subscriber ID#:		Group # :	
Name of Policy Holder:		DOB:	
Insured's Address:		<input type="checkbox"/> same as patient	
City:		State:	
Zip Code(9 digits):			
Policy Holder's Employer:			
Patient Relationship To Insured: SELF / SPOUSE / CHILD / PARTNER			

EMERGENCY CONTACT PERSON

Name:		Relationship: Spouse / Brother / Sister / Mother / Father / Other:	
Home Phone: ()		Work Phone: ()	
EXT:			

ALGOS BEHAVIORAL HEALTH SERVICES, INC.

Financial Policy

Thank you for choosing Algos Behavioral Health Services, Inc as your health care provider. The following is a summary of our financial policies. Please read the information carefully and sign or initial where noted below. We must obtain a copy of your driver's license and a current, valid insurance card. Failure to provide a current, valid insurance card and/ or information prior to your visit will result in payment due in full at the time of visit.

Initial below please:

_____ 1. **PAYMENTS. All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment.**

Initial We accept cash or credit card (Visa, MasterCard, or Discover). Unpaid accounts may be referred to an outside collection agency.

_____ 2. **CANCELLATIONS.** To reserve the hour of the clinician's time, we request a credit card to assure you of the availability of the doctor. There is a fee of **\$50.00** for a missed appointment or late cancellation. You can avoid this charge if you cancel 24 or more hours prior to the appointment. Your insurance carrier will not cover this fee.

_____ ** When applicable, for individuals scheduled for a testing appointment – you will be charged **\$50.00** for every hour of testing that is missed or not cancelled within 24 hours. For example, if you are scheduled for 3 hours of testing, and you cancel or do not show for that appointment time, you will be charged \$150.

_____ 3. **CHANGE OF INFORMATION.** You are responsible to provide us with any change regarding your address, phone number or insurance information as soon as possible.

_____ 4. **PRIVATE INSURANCE AUTHORIZATION AND INFORMATION RELEASE.**

Initial I, the undersigned, authorize payment of mental health benefits to Algos Behavioral Health Services, Inc for any services rendered. **I understand that I am financially responsible for any amount not covered by my insurance policy including but not limited to co-payments, co-insurance and deductibles.** Any payments denied by the insurance company will be forwarded to the undersigned, and the undersigned will be held responsible for payment. I also authorize Algos Behavioral Health Services, Inc to release to my insurance company any information concerning health care, diagnosis or treatment provided to me. This information will be used only for the purpose of evaluating and administering claims of benefits.

_____ 5. **POTENTIAL NON COVERAGE**

Initial Although other medical services may be covered by your insurance, this psychological service may not be covered and, in that case, you will be fully responsible for the entire amount. If the clinician is *out-of-network* with your insurance policy, you will be required to pay the full amount of the service rendered. We will NOT file claims for out-of-network services.

_____ 6. **NON-COMPLIANCE.** We reserve the right to discontinue care with you for non-compliance with any of the above policies.

_____ 7. The undersigned agrees that in the event of **default in payment** or if the account is placed with a collection agency for collection, he/she is responsible for reasonable attorney's fees, miscellaneous costs of collection, collection agency fees, and court costs, at the interest rate of 18% per annum.

**For all services rendered to minor patients, the adult accompanying the patient, or the policy holder, is responsible for payment.*

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X _____
Signature of Patient OR Responsible Party if a Minor

Date: _____

Printed Patient Name

I WILL NOT BE USING INSURANCE FOR THIS SERVICE AND WILL PROVIDE ANOTHER FORM OF PAYMENT.

SIGNED: _____

DATE: _____

Algos Behavioral Health Services, Inc.

Karri Zumwalt, Psy.D., Seán G. Connolly, Ph.D., Geetanjali Sharma, Psy.D., Sandy Zamora, LPC-S

Health Insurance Portability and Accountability Act (HIPAA) Consent

General Notice

When seeking psychological consultation and/or treatment in this practice, **Protected Health Information (PHI)** will be gathered about you. This information may include a clinical history, medical history, personal information, and possibly performance/responses on psychological testing instruments.

Notice to Protect the Privacy of Your Health Information

A complete description of how your **PHI** may be used and disclosed is available for your review in the **“HIPAA Notice of Privacy Practices.”** A copy of this document is available at the reception desk. You may request a copy for your records.

Individual Rights

You have the right to restrict the uses and disclosures of your **Protected Health Information (PHI)** for the purpose of treatment and health care. A signed consent form is usually required. This practice is not required to agree to requested restrictions, but is bound by any restrictions to which it agrees.

You have the right to revoke this consent in writing, except to the extent that our practice has taken action on the reliance on this consent. You have the right to refuse to sign this consent. This practice has the right to refuse to provide the clinical services requested, if you refuse to sign the consent or if you revoke this consent at any time.

Your signature below acknowledges:

- You have read and understand this consent;
- You have agreed to have your **Protected Health Information (PHI)** used by this practice for the purposes of your consultation and treatment, to secure payment for your treatment, and for this practice’s psychological care operations;
- Prior to signing this consent, you were given the opportunity to review the practice’s **“HIPAA Notice of Privacy Practices;”**
- You are aware that you may now, or at any time in the future, request restrictions to the use and disclosure of your **Protected Health Information (PHI)**;
- This consent may be terminated at any time, with written request, except to the extent that this practice has taken action in reliance of the consent.

X _____
Signature of Client/Patient or Representative

Date

Authorization Form to Release Protected Health Information (PHI)

This form when completed and signed by you authorizes this psychological clinic to release Protected Health Information (PHI) from your clinical record to the person(s) you designate.

I hereby authorize my psychologist and/or clinical associate, Karri Zumwalt, Psy.D., Seán G. Connolly, Ph.D., Geetanjali Sharma, Psy.D. or Sandy Zamora, LPC-S and their practice management company, Algos Behavioral Health Services, Inc. and/or their administrative and clinical staff to release *the following specific clinical record and/or administrative/payment information:* (please list which information you want released)

_____ results of the psychological evaluation _____

**This information should be released to only the person(s) below:

I am requesting the release of this information for the following reasons:

at the request of the individual for continuing care for public agency use
 legal purposes other: _____

This authorization shall remain in effect until _____ (date),
or until _____
(specific purpose).

You have the right to revoke this authorization in writing at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist or clinical associate generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

X _____

Signature of Patient

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Algos Behavioral Health Services, Inc.

**Karri Zumwalt, Psy.D., Seán G. Connolly, Ph.D.,
Geetanjali Sharma, Psy.D., Sandy Zamora, LPC-S**

CONSENT TO TREATMENT AND CLINICAL ASSESSMENT SERVICES

This is to certify that I give permission to Karri Zumwalt, Psy.D., Seán G. Connolly, Ph.D., Geetanjali Sharma, Psy.D. or Sandy Zamora, LPC-S at Algos Behavioral Health Services, Inc. to provide psychological and behavioral health services for myself and/or child(ren), or for an adult child for whom I am the legal guardian.

I have reviewed the **Statement of Office Policies for Clinical Practice** and the specific assessment and/or treatment procedures have been explained to me.

- Service:**
- | | |
|--|---|
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Couple Psychotherapy |
| <input type="checkbox"/> Psychoeducational Evaluation | <input type="checkbox"/> Group Psychotherapy |
| <input type="checkbox"/> Neuropsychological Evaluation | <input type="checkbox"/> Family Psychotherapy |
| <input type="checkbox"/> Behavioral Health Assessment | <input type="checkbox"/> Individual Psychotherapy |
| <input type="checkbox"/> Biofeedback Therapy | <input type="checkbox"/> Group Behavior and Health Intervention |
| <input type="checkbox"/> Other: _____ | |

The specific treatment has been described in the written **Statement of Office Policies for Clinical Practice** and/or explained by the clinician. If applicable, alternatives to treatment have been explained to me. Due to the complex nature of psychotherapy and other behavioral health services, including discussing past and present emotional pain and the stresses in life, it is quite common for persons entering this type of treatment to have periods of time when they experience their feelings as more intense, and perceive their condition as possibly worse. This should be discussed as part of the treatment, and is usually temporary. Please note that it is impossible to guarantee any specific results regarding psychological treatment. However, every effort will be made to achieve the best possible results for you. Maximum benefits occur with regular attendance and your active emotional investment in the process.

The issues of confidentiality have been reviewed, and I have been assured that all communications between a professional and a client are held in strict confidence. However, I also understand that there are exceptions to those laws and regulations. I understand it is the clinician’s legal responsibility to disclose certain issues for my protection and that of others, and these situations have been clarified to me. Every reasonable effort will be made to resolve issues through discussion and planning within the clinical setting, and I will be notified of any anticipated compromise of the client-therapist relationship.

I have the right to terminate the therapeutic relationship at any time that I desire, without fault, and I have the right to seek and obtain a second opinion on the procedures and/or treatment process.

I understand that I am fully financially responsible for my treatment provided by the clinician, and for any balance that is not covered by my insurance company. A billing service may be used for the

collection of insurance reimbursement and co-pay fees. Psychologists have the right to seek the services of a collection agency to obtain payment of past due balances.

My signature certifies that I have read and understand all the information provided by Algos Behavioral Health Services Inc., about the clinicians, the treatment to be provided, and the expense to be incurred. I hereby voluntarily give my informed consent for treatment. A copy of this authorization shall be considered valid. I understand that I will be informed of any changes concerning what is in this document and my consent will be obtained regarding these changes.

You are assured that the services will be provided in a professional manner, consistent with the rules and regulations of the Texas State Board of Examiners of Psychologists and the ethical principles of the American Psychological Association. Every effort will be made to provide services in a caring, supportive and trustworthy environment.

In addition to the specified procedure checked above, the initial goals of treatment will be established after the first or second session.

My signature certifies that I have been provided the opportunity to read/review the following relevant documents:

- **Notice of Privacy Practices**
- **Statement of Office Policies for Clinical Practice: Psychotherapy, Psychological or Neuropsychological Testing and Behavioral Health Assessments**

My signature certifies that I voluntarily give my informed consent to the clinical services offered by this psychological practice.

X _____
Signature of Client/Patient

Date

Signature of Responsible Party (if client is a minor)

Date

CLINICAL HISTORY: ADULT

All information provided is treated in strict confidence, according to HIPAA regulations. Give as much information as you can. The clinician will go over the details with you.

Name: _____ DOB: _____ Age: _____
Address: _____ Today's date: _____
SSN: _____ Ph#: _____
Education: _____

Name of person assisting patient to complete this form (Please include relationship i.e. spouse, friend, sister/brother etc.): _____

Personal and Family Information:

Current Living Situation: Please check all that apply

- Single Significant Other Common law marriage (How long? _____)
- Married (How long? _____) Divorced (How recently? _____) Separated (How long? _____)
- Married in the past (Times? _____) Widowed (How long? _____)

Children: Yes No Ages: _____

With whom are you currently living? _____

*If children are not living with you, do you have regular contact with them? Yes No *How often?

_____ ; Particular concerns with children? Yes No *If yes, please explain- _____

_____ Any other information about your current living situation? _____

Growing up experiences:

Where were you born? _____ Where have you lived most of your life? _____

How long have you lived here? _____ How many children in your family growing up? _____

What was your position (e.g. #1, #4) in the family? _____

Who raised you? _____ If you were raised by someone other than parents, why was this? _____

Were your parents divorced? Yes No

Did you have regular contact with each parent during childhood? Yes No

If not, why? _____

How was your family life growing up? _____

Any history of abuse as a child or teenager? Yes No Any abuse as an adult? Yes No

Please check all that apply.

Physical (By whom and how long? _____)

Emotional / Verbal/ Mental (By whom and how long? _____)

Sexual (By whom and how long? _____)

Neglect (By whom and how long? _____)

Other trauma (significant death/ fire/ scare/ or any other major life event, please explain)? _____

Education:

How far did you go in formal school? _____ What high school did you attend? _____

What grades did you make in school? _____ If you dropped out of school, why? _____

In school, were you in: (please check) regular education classes Special Education classes Both

What classes were special education? _____

Did you have a Learning Disability? Yes No *If yes, what type? _____

If you didn't finish high school, did you earn a GED? Yes No

Have you attended: (Please check) Vocational Technical Business Trade Course(s) None

What school(s) did you attend _____ Did you complete the program? Yes No

Have you attended college? Yes No *What college(s) have you attended? _____

What area(s) did you study in college or other school? _____

Do you have a college degree? Yes No *What year did you receive it? _____

NOTES: _____

Work History:

What kinds of jobs have you had? _____

Are you employed now? Yes No How long have you been out of work? _____

Why did you leave your last job? _____

Have you been seeking employment? Yes No

NOTES _____

Physical Health History: *(Please DO NOT address depression, anxiety, ADHD, or other mental health conditions here)*

How is your physical health? (Please check) Excellent Good Fair Poor Very Poor

What health problems do you have? _____

NOTES: _____

What treatment(s) have you had for these problems? Medication Surgery None

Treating physician(s) _____

Any other injury, accident or surgery in life? _____

Have you had a brain trauma? (Please check all that apply) Head injury Stroke Brain surgery

Seizures Electrical shock Loss of oxygen Unconsciousness Other impact to the brain

Emotional Health/Psychological Information: *(Focus on symptoms only in this section. Treatment comes next)*

How do you feel emotionally? *(Please check)* Excellent Good Fair Poor Very Poor

Frequent moods: *(Please check all that apply)* Depression Anxiety and stress Excessive anger

DETAILS: _____

Thoughts of suicide in your lifetime? Yes No ; Past Present (If yes, when and how many times?) _____

If you have attempted suicide, how have you tried to kill yourself? _____

Were you taken to the hospital because of the suicide attempt(s)? Yes No If yes, what treatment(s) did you receive? _____

Date of most recent suicide attempt? _____

Serious consideration/plans of suicide at this time? Yes No *If Yes, Explain: _____

Have you had any hallucinations? *(Please check all that apply)*

Auditory Visual Tactile (touch) Other: _____

If auditory, whose voice did you hear (male or female)? _____

How many voices? _____ How often? _____

What was being said? _____

When did you begin to have auditory hallucinations? _____

If visual, what did you see? _____ How often? _____

If tactile what do you feel? _____

Do you still have these experiences? Yes No When did they begin? _____

Do you have delusions (strange ideas about yourself, like you were somebody else)? Yes No

What are/were they about? _____

Do you still have them? Yes No How often do you have these thoughts? _____

When did the delusions begin? _____

NOTES: _____

If you have panic attacks, how often do you have them (times per week/month)? _____
(Check all that apply)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> racing heart | <input type="checkbox"/> sweating | <input type="checkbox"/> trembling or shaking | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> sense of choking | <input type="checkbox"/> fear of dying | <input type="checkbox"/> agitation | <input type="checkbox"/> chills |
| <input type="checkbox"/> sense of terror | <input type="checkbox"/> nausea | <input type="checkbox"/> hot flashes | <input type="checkbox"/> chest pain or discomfort |
| <input type="checkbox"/> dizziness or lightheadedness | <input type="checkbox"/> fear of losing control | | |
| <input type="checkbox"/> Other (please explain) _____ | | | |

How do you manage these episodes? _____

Treatment for emotional problems:

Have you ever seen a mental health professional? (please check all that apply)

- Psychiatrist Psychologist Counselor Therapist

Name: _____ When did you see him/her? _____

Are you seeing someone now? Yes No If yes, who? _____

What psychiatric **diagnosis/diagnoses** have you been given? _____

Who diagnosed you? _____ When were you diagnosed? _____

Have you ever been hospitalized for psychiatric treatment? Yes No *If yes, give details (name of hospital, year, length(s) of stay) _____

Past medication use for emotional problems? _____

Current medications for emotional problems? _____

Who prescribes it? _____ *When did you start taking it? _____

Is your treatment effective now? Yes No How is it helping you? _____

NOTES: _____

Current stressors in your life that contribute to your emotional problems -

(Check all that apply):

- Financial problem Inability to pay bills Unemployment Relationship problems
- Marriage problems Recent divorce Health problems Disabling condition
- Lack of family support Single parenting Living alone No child support
- Transportation problems Past trauma Inactivity Social isolation
- Loss of career Chronic pain Physical restrictions No health insurance
- Children/family problems Inability to be productive Slow/no medical progress
- Change in quality of life Recent death(s) (who? _____)
- Other stressors: _____

Have you had any history of Attention Deficit/Hyperactivity Disorder (ADHD/ADD)? Yes No

When were you diagnosed? _____ Who diagnosed you? _____

- Which medication(s)? Ritalin Adderall Dexedrine Vyvanse
- Metadate Concerta Strattera None Other _____

Are you still on medication? Yes No

Symptoms of ADHD/ADD that you have: (Please check all that apply)

- Attention span/concentration problems Impulsivity (doing things without thinking of consequences)
- Overactivity/ hyperactivity Social aggressiveness Other symptoms? _____

NOTES: _____

Substance Abuse History:

Do you smoke cigarettes? Yes No *How many, how often? _____

How long have you smoked? _____ Date you quit smoking? _____

Do you drink alcohol? Yes No *How much and how often? _____

Any abuse of **alcohol** in your lifetime? Yes No Are you an alcoholic? Yes No

For how long have you abused alcohol? _____ When did you stop? _____

Have you been in treatment for alcoholism? Yes No

If yes, name of treatment center and when? _____

Are you in an active recovery program now? Yes No Name of program: _____

Do you go to treatment at present (e.g. AA, group meetings, individual sessions)? Yes No

Have you had relapses? Yes No If yes, how often? _____

Do you or have you abused **street drugs** or **medication** in your lifetime? Yes No

When did you start? _____

Which drugs? (please check all that apply)

Marijuana Cocaine Heroin Methamphetamine

Prescription Drugs Other (Please list): _____

Do you use drugs now? Yes No *Which ones? _____

If yes, how much and how often? _____

When did you stop using drugs? _____

Have you been in chemical dependency treatment? Yes No *How many times? _____

Current recovery program? _____

Any relapses? Yes No

Have you ever been **arrested**? Yes No *How many times? _____

If yes, what were the charges you were arrested for? (include dates) _____

Have you been to prison? Yes No *How many times? _____

Where? _____ When were you last released? _____

Are you currently on probation or parole? Yes No *For how long? _____

Any legal problems pending (i.e. court dates, warrants, etc.)? Yes No

Please explain: _____

Comments: _____
