

PLEASE CONTACT OUR OFFICE IF YOU ARE INTERESTED IN SCHEDULING YOUR PSYCHOLOGICAL EVALUATION



Algos Behavioral Health Services, Inc.

MONDAY-FRIDAY 8am-4:30pm

Karri (Zumwalt) Lusk, Psy.D.
Sean Connolly, Ph.D.
Geetanjali Sharma, Psy.D.
Sandy Zamora, LPC-S

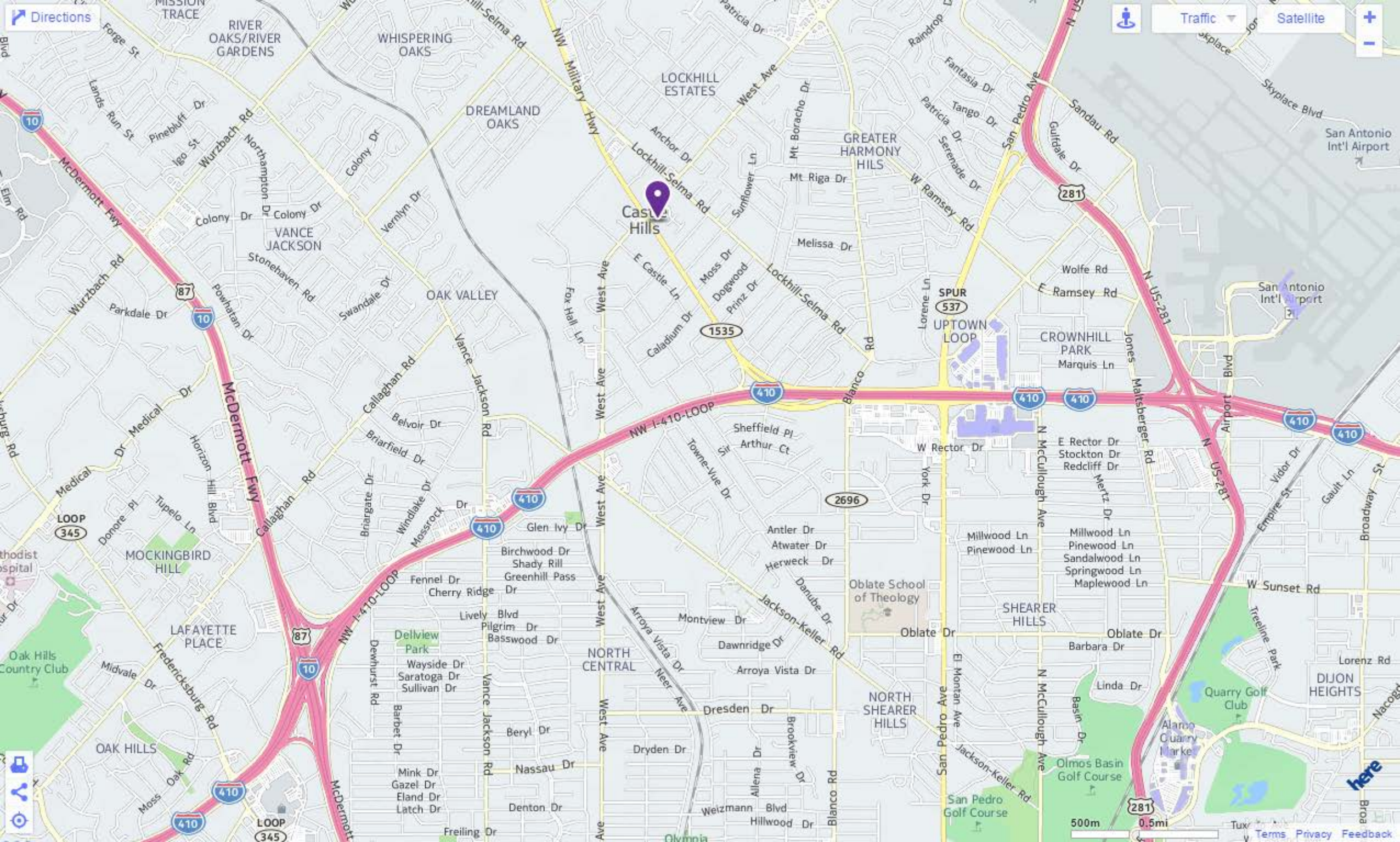
Behavioral Health Consultation for Surgery Candidates

You have been referred by your physician for a **Behavioral Health Assessment (BHA)** as part of evaluating your candidacy for **Bariatric Surgery**. This is a routine step for candidates for this type of surgery. Surgical treatment for clinically severe obesity is a major invasive procedure and requires a Behavioral Health Assessment. This step will assist your physician in determining your suitability and readiness for the procedure as well as identify personality and behavioral factors that will help assure a positive and desired outcome. The pre-operative assessment can identify possible psychosocial risk factors for surgical outcomes and make recommendations to both the patient and the surgical team that are aimed at facilitating the best possible outcome for the patient.

The underlying factor here is that the surgery will change your body, but it will not change personality, behavior, or your social environment. The purpose of this assessment is to identify and evaluate psychological factors that will need to be addressed if you are to achieve your desired goal of losing weight. This team of behavioral health specialists will be partners with you to assist you before and after the surgery. The surgeon addresses the medical and physical aspects of weight loss, the nutritionist will assist you with foods and dietary precautions, and the behavioral health specialist provides assistance with the emotions, thoughts and behaviors that have brought you to this point. The psychologist's consultation is not to determine whether you can handle the surgery, or because your physician thinks your weight problem is "psychological." The purpose is to evaluate what emotions, behaviors and environmental issues will need to be addressed before and after the surgery to ensure that the surgery will be as successful as possible. Your physician and clinical support team want to make the best clinical judgments for you.

The **BHA** will consist of a clinical interview, including a review of your personal history and past life experiences, a review of your medical record, and completion of some psychological testing instruments and questionnaires. You will have the opportunity to discuss with the psychologist/clinical associate any questions or concerns you may have. This BHA usually takes 3-4 hours to complete. Some of the paperwork can be completed at home prior to the appointment, in order to expedite the process. Some insurance companies require us to do the interview first and then request the testing procedures. If this is so, it may require a follow-up visit to our office.

Standard ethical and professional guidelines to assist with these clinical judgments will be utilized. Every effort will be made to complete the assessment as conveniently and efficiently as possible.



Castle Hills

NW I-410 LOOP

McDermott Fwy

500m 0.5mi

here

Terms Privacy Feedback

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) Lusk, 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) Lusk, 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) Lusk, 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) Lusk, 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

CLINICAL HISTORY: Bariatric Surgery Candidates

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

NAME _____ TODAY'S DATE _____

DOB: _____ AGE _____ Last 4 of SSN _____

Referred by: _____, M.D., Your Bariatric Surgeon

HISTORY OF WEIGHT DIFFICULTIES:

How long have you had a weight problem? _____
What have you done to lose weight? --- Various diets? _____; Consult nutritionist? _____; Exercise? _____;
Weight Watchers? _____; Medications? _____; Consult Counselor/Therapist? _____; Consult a Physician? _____;
Other Programs? _____
How successful have you been? _____; What has seemed to help you in losing weight? _____
What has made it difficult for you to lose or maintain weight loss? _____
How long have you been thinking about the surgery? _____
What are your reasons for seeking surgery? _____
Health reasons? _____; Lifestyle reasons? _____
What do you think led to your weight problems? _____
In reflecting on your eating behaviors, have you had a pattern of:
____ overeating ____ emotional eating ____ night eating ____ grazing
____ undereating ____ impulsive eating ____ excessive snacking ____ poor portion control
____ other eating patterns you will need to change? Describe _____

Do you have a history of an eating disorder? --- Anorexia? _____; Bulimia? _____; Binge eating? _____; Purging? _____;
Other eating disorder? _____

BEHAVIOR ISSUES:

Do you see yourself as prone to addictive/compulsive behaviors? _____; What and how? _____
Do you notice obsessive thoughts about your weight issues? _____
How much and how often do you use the following:
tobacco/nicotine _____ alcohol _____
coffee _____ tea _____
sodas _____ carbonated/sparkling water _____
energy drinks _____ supplements/meds _____
straws _____ gum _____
Do you experience cravings for certain foods? _____ If so, do you satisfy cravings, eat something else? _____
How dependent do you believe you are on the items listed above? _____
Describe any other habits and changes in habits _____
How successful have you been in making any behavior changes in these areas? _____
What will be your greatest behavior challenge after surgery? _____

If you have any **history of alcohol or drug abuse/addiction**, please complete the following; if not, skip

Any **abuse of alcohol** in your lifetime? _____; How long (did) have you abused alcohol? _____; Are you still drinking? _____ OR When did you stop? _____ If you have been in treatment for alcoholism, where & when? _____; Current Status? _____

Any **abuse of street drugs or medication** in your lifetime? _____; Which drugs? _____

What was your drug of choice? _____

Have you been in chemical dependency treatment? _____; Where, when, for how long? _____

Current Status _____

Have you had any **legal problems** (arrests)? _____ What type, when? _____

Any involvement in lawsuits? _____

INFORMED CONSENT AND READINESS FOR COMPLIANCE

Do you understand the details of the surgery? _____; Any concerns you have **not** discussed with your physician? _____; How do you think the surgery will help you? _____

Have you made changes in eating behaviors since you made the decision to have surgery? _____ What changes? _____

Are you aware that noncompliance can put you at risk for complications? _____; Do you have enough information to give informed consent? _____

* Some of the necessary changes include: reducing portion size _____; no liquids with meals _____; diet _____ eating slowly and chewing _____; no snacking _____; water consumption _____; exercise _____; monitoring protein intake _____; lifelong vitamins _____

What other changes do you anticipate? _____

What family patterns and customs will you have to change? _____

Have you informed your family of your decision? _____; If not, why? _____

Do you have a family support system during surgery and afterwards? _____; How does your spouse/partner/family member(s) feel about your decision to have surgery? _____

How do you expect spouse/partner/family relationships might be changed? _____

What stresses/issues do you anticipate with your children? _____

OVERALL RATINGS

How would you rate the following?

Your emotional readiness for the surgery:	Poor	1	2	3	4	5	6	7	8	9	10	Very Good
Readiness for behavior changes:	Poor	1	2	3	4	5	6	7	8	9	10	Very Good
Capability of making behavior change:	Poor	1	2	3	4	5	6	7	8	9	10	Very Good
Challenge of life changes for you:	Easy	1	2	3	4	5	6	7	8	9	10	Very Difficult

Are you physically active? _____ What plans do you have for exercising regularly? _____

What will you have to change in your lifestyle to accomplish this? _____

MEDICAL HISTORY:

List any medical conditions/diagnoses _____

Any injury, accident, or major surgery in your life? _____

Ever had a head injury, concussion, or other brain trauma? _____

PERSONAL AND SOCIAL INFORMATION:

Current living situation: With whom are you living? _____
Single _____ or Married _____, For how long? _____ OR Divorced _____ or Widowed _____
Common law marriage(s)/Partner _____; Currently separated? _____ For how long? _____
Married in the past? _____, # of times _____; Have children? _____, Ages _____
Home stressors _____
Any family stresses/conflicts that will cause you concern after surgery and could distract you from achieving your goal of weight loss? _____

Growing up experiences: Where were you born? _____; Where have you lived most of your life? _____; How long have you lived here (current location)? _____
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? _____; Did you have regular contact with each parent during childhood? _____
Any additional information _____
How was family life while growing up? _____
Any history of abuse as a child? Physical _____ by whom? _____
emotional/verbal/ mental _____ by whom? _____; sexual _____ by whom? _____
Any neglect? _____ by whom? _____; Other trauma (significant death/fire/scare/or any other major life event)? _____
_____; How long did the abuse/trauma go on, and how did it affect you? _____

Any other important life experiences? _____

Have you experienced: the death or loss of – a spouse? _____ a child? _____ a parent as a child? _____
a sibling? _____ another significant person in your life? _____

Have you experienced: a major loss of – a home? _____ career? _____ family? _____
support system? _____ OR experienced losses through a – flood? _____ hurricane? _____ tornado? _____ fire? _____

Have you experienced a – sexual assault? _____ date rape? _____ kidnapping? _____ physical assault? _____
been victim of a crime? _____ home invasion? _____ assault or harassment at work? _____ burglary? _____
other significant emotional experience? _____

On a scale of 1 to 10, with 1 being limited, and 10 meaning extensive, how would you rate the following?

- A. The emotional trauma of the event then: 1 2 3 4 5 6 7 8 9 10
- B. The emotional trauma of the event now: 1 2 3 4 5 6 7 8 9 10

• Your efforts to heal the trauma since : _____

EDUCATION AND WORK HISTORY:

Education: How far did you go in formal school? _____ in City/State _____ **OR** GED? _____
How did you do in school (grades)? _____
Since you got out of middle/high school, have you attended any vocational or technical programs (where, when, certificates)? _____
College experience (degree, name of college, when)? _____

Any other educational or training information? _____

Employment History: Are you employed now? _____ What kind of work do you do? _____
What kind of jobs have you had in the past? _____

Have you had any difficulty keeping jobs? _____ Have you been able to maintain stable employment? _____
Has your weight affected your work and/or career in any way? _____

EMOTIONAL HEALTH/PSYCHOLOGICAL INFORMATION:

Current Moods: How would you describe your emotional health in the **last few months**? _____
If you have had emotional struggles in your life, have they been – Mild _____ Moderate _____ Severe _____
Frequent moods: Depression _____ Anxiety and stress _____ Excessive anger _____ Panic attacks _____
What is the history of these experiences? _____

What symptoms have you experienced **most days for the last month**?

- _____ loss of sleep/insomnia _____ low self-esteem/self-confidence
- _____ excessive sleep _____ irritability/getting upset with people easily
- _____ overeating behaviors _____ loss of enjoyment in life
- _____ loss of appetite _____ fatigue/always tired
- _____ excessive appetite _____ loss of sexual interest or desire
- _____ crying episodes _____ concentration problems
- _____ social withdrawal/wanting to be alone _____ forgetfulness/memory problems
- _____ loss of energy and motivation to do things _____ manic behavior
- _____ loss of interest in enjoyable activities _____ sad feelings
- _____ mood swings/rapid changes in mood _____ excessive feelings of guilt
- _____ agitation/restlessness _____ weight loss/gain
- _____ negative/pessimistic thoughts _____ indecisiveness/difficulty making decisions
- _____ sense of worthlessness _____ inability/difficulty in thinking clearly
- _____ sense of hopelessness _____ thoughts of dying
- _____ lack of friends/friendships _____ dissatisfaction with life
- _____ a sense of helplessness _____ frequent sense of discouragement

_____ other symptoms (*please explain*) _____
_____ thoughts of suicide; if so, how frequently _____
_____ any suicide attempts in your lifetime? If so, when & how many times? _____

How did you attempt suicide? _____
What was the outcome? _____

How recent was the **last suicide thought or attempt**? _____

If you have panic attacks, how often do you have them? _____

Which symptoms?

____ racing heart ____ fear of dying ____ dizziness or lightheadedness
____ sweating ____ sense of terror/panic ____ chills
____ trembling or shaking ____ chest pain or discomfort ____ fear of losing control
____ shortness of breath ____ agitation ____ hot flashes
____ sense of choking ____ nausea ____ avoidance of people

Others (please explain) _____

How do you manage/get over these attacks? _____

Have you ever been diagnosed with any mental health condition? _____ If so, when? _____

What is/was the diagnosis? _____

How do you feel your weight struggles have affected you emotionally, and/or how much are your struggles with depression and/or anxiety related to your weight problems? _____

Treatment for emotional problems

Have you ever seen a mental health professional (psychiatrist/psychologist/counselor/therapist)? _____

When, and how often? _____

Who have you seen? _____

Have you ever been hospitalized for psychiatric treatment? _____ If yes – where, when, length(s) of stay: _____

How recent was the last psychiatric hospitalization? _____

Medications for emotional problems in the past? _____

Current medications for emotional problems? _____

Is your treatment effective now? _____ How is it helping you? _____

Psychosocial stressors in your life...what causes/contributes to your stress and any emotional problems?

____ Weight concerns ____ Health concerns ____ Work stress/environment
____ Marriage difficulties ____ Relationship problems ____ Recent divorce
____ Financial problems ____ Disabling condition ____ Lack of family support
____ Children/family problems ____ Single parenting ____ Living alone
____ Job loss ____ Transportation problems ____ Past trauma
____ Social isolation ____ Unable to be productive ____ Inactivity
____ Loss of career ____ Slow/No medical progress ____ Change in quality of life
____ Physical restrictions ____ Recent death(s) – (Who? _____)

Other stressors or experiences that have contributed to your life situation: _____