1500 W. 38th Street, Suite 53 • Austin, TX 78731
Austin Psychiatric Consultants
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AUSTIN PSYCHIATRIC CONSULTANTS

Psychological Assessment, Individual, Group, Couples, Family, & Play Therapy

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A division of Psychiatric Consultants of Ft. Worth, PA
Serving the mental health needs of Texans since 1979

PATIENT INFORMATION SHEET – 2 SIDED FORM

We are required to obtain some of the following information due to the Health Insurance Portability and Accountability Act (HIPPA) of 1996. For more information on this act and how you and your Protected Health Information (PHI) are affected, see our NOTICE OF PRIVACY PRACTICES Form.

_____

Last Name **First Name** **Middle Initial**

_____ **May we mail correspondence to this address? Y N**

Street Address **City** **State** **ZIP**

Home Phone: (_____) _____ ✓ - can leave message ☐ **Work Phone: (_____) _____** ✓ - can leave message ☐

Alternate Phone: (_____) _____ ✓ - can leave message ☐ **Date of Birth: _____ SS#: _____-_____-_____**

Relationship Status: _____ Spouse's/Sign. Other's Name: _____ # of Children: _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Referred By: Dr. _____ ● Yellow Pages ● Insurance ● other: _____ ● May we thank this source? **Y N**

How should we call you in the waiting room? *1st name only* ● *Dr./Mr./Ms.* _____ ● *other*: _____

In the event that a family member/caretaker is present at your appointment, and is <u>in the room</u> with the person providing treatment, may we freely discuss your condition, treatment, and/or diagnosis with that person? Y N

With whom may we <u>NOT</u> discuss/release information about your care? _____

<u>If you *would* like us to discuss your care with any individual, you must fill out a Release of Information</u>

INSURANCE/INSURED INFORMATION

Name of Insured: _____ Rel. to Patient: _____ ID#: _____

SS#: _____-_____-_____ DOB: _____ Phone #: _____ Group Name/#:_____

Name/Address/PHONE # of Carrier:_____ Precertification Required? Y N

Name/Phone of Employer: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/COPAYMENTS

I agree to contract with Austin Psychiatric Consultants (APC) for an <u>initial session</u> only. At that time, we will jointly determine the appropriateness of continuing the therapeutic relationship. If we decide to continue at that point, this document will remain valid. I hereby authorize APC to release any information deemed necessary by my insurance carrier for the processing of my insurance claim and/or certification of care provided. I authorize APC to receive payment directly on any medical benefits otherwise payable to me for services as described on the attached claim form not to exceed the reasonable and customary charge for those services. I am aware that any copayment or deductible due by me is to be made at the time of the visit. **If I am not the insured/responsible party, I authorize APC to exchange information with the insured/responsible party for billing purposes only.**

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**

PLEASE FILL OUT INFORMATION ON BACK OF FORM

The following information is optional, but will assist us in knowing how to best help you.

Date of last physical exam: _____ **name of primary care physician:** _____

List any drugs/medications you currently on & who prescribed:

_____ _____
_____ _____
_____ _____
_____ _____

List any known drug allergies/adverse drug reactions: _____

Current/past medical conditions & treating physicians:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

How often do you use: tobacco: _____, drugs/alcohol: _____, other: _____

Please check any of the following items which concern you:

___ Self-esteem, self-confidence
___ Family conflicts or pressures
___ Anxiety, nervousness, fears
___ Friendship conflicts
___ Angry, hostile feelings
___ Loneliness
___ Traumatic experience
___ Depression
___ Relationship/marital concerns
___ Procrastination or motivation
___ Health problems
___ Gay/Lesbian issues
___ Eating or appetite problems
___ Suicidal feelings or behaviors
___ Alcohol or drug problems
___ Stress
___ Sexual concerns
___ Shyness, being assertive
___ Sleep problems
___ Self-control
___ Parent-child problems
___ Work or career concerns
___ Other: _____
_____

Did the following occur in your family?

____ Parents divorced/ separated before you were 18
____ Family frequently moved
____ Parent(s) unemployed for an extended period of time
____ Frequent, hostile arguing among family members
____ Death of parent(s) before you were 18
____ Parent(s) with a drinking/drug problem
____ Physical/sexual abuse in your family
____ Rape/sexual assault of yourself or family member
____ Family member hospitalized for emotional problems
____ Family member diagnosed with a mental disorder
____ Family member attempted/committed suicide
____ Family member with an eating problem
____ Family member with debilitating illness, injury or handicap
____ Family member prosecuted for criminal activity

Name(s) of previous therapist(s) and dates seen: _____

Briefly describe the main concern(s) that brought you here: _____
_____
_____
_____

Is there any information you'd like us to have that hasn't been addressed in this form? _____
_____
_____