



The information you provide below will be used to plan your treatment and is held strictly confidential. You may leave any item blank if you do not feel comfortable answering it. Thank you in advance for your efforts.

Name: _____
Last, First

Date: ____/____/____

Highest Level of Education Completed: _____

Occupation: _____

Chief Concern

1. Please describe the major concern(s) you would like help with:

2. How long have you been dealing with the problem(s)? _____

5. How would you like things to be different? What do you hope to gain from treatment or what are your goals?

Quality of Life

1. Please rate your current overall health by marking an X on the line below:

|-----|
Terrible Excellent

2. Please rate your ability to perform daily activities (dressing, house chores, errands, etc.) during the past week by marking an X on the line below:

|-----|
Terrible Excellent

3. Who or what makes it harder for you to cope with your difficulties(s)? _____

4. What do you do for relaxation? _____

5. Who or what helps you cope with your difficulties(s)? _____

Previous Psychological Treatment

Dates

Reason

Outcome

<u>Dates</u>	<u>Reason</u>	<u>Outcome</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. If any of your immediate family members have had any major psychiatric issues (e.g., depression, bipolar disorder, schizophrenia, substance abuse), please describe the condition(s) and how that person is related to you.

Health Characteristics

1. Are you having any difficulties with sleep? No Yes a. If Yes, How long has this been a problem? _____
 Trouble falling asleep Trouble staying asleep Sleeping too much Not feeling rested
2. During the past two weeks, how many hours do you usually sleep per night? _____
3. Are you having any concentration or memory difficulties? No Yes How long? _____
4. In the past two weeks, how often have you thought you were better off dead or had thoughts of killing yourself?
 Daily/Nearly everyday 3-4 days/week 1-2 days/week 1-2 times Not at all
5. Difficulties with your appetite or eating habits? No Yes If Yes, how long has this been a problem? _____
 Eating more Eating less Restricting food intake Forcing self to eat
6. What do you currently do for exercise? _____
7. During the last month, how often do you exercise for ≥ 30 minutes?
 Daily/Nearly everyday 3-4 days/week 1-2 days/week < 1 day/week < 1 day/month

Substance Use

	Date of Last Use	Quantity & Frequency of use during last 30days
Caffeine (coffee, tea, energy drinks, pills):		
Alcohol:		
Tobacco (cigarettes, cigars, chew):		
Marijuana:		
Sleeping pills/Diet pills:		
Cocaine/Meth/Heroin/PCP/Hallucinogens/Ecstasy:		

Relationships

1. Who do you live with? _____
2. List children, if any, and their ages:

3. How often do you see or talk to friends? Daily Weekly 2-3 times/month < once per month Never
4. Who do you confide in? _____

Personal History

1. Birth order: _____ of _____ children born to biological parents
2. Where were you born and raised? _____
3. Please list all siblings (including step- if you lived with them) and their ages:

4. Describe any noteworthy family dynamics during childhood and/or currently:

5. Did you experience any unusual events (early/late development, traumatic life events, witness/victim of violence, stressful life changes, etc.) that occurred during:
Infancy No Yes _____
Childhood No Yes _____
Teenage years No Yes _____
Early Adult years No Yes _____
Adulthood No Yes _____



Dear Patient/Guardian:

We want you to have a clear understanding of Dr. Casey's policy concerning payment and insurance. To allow us to continue to serve you without disruptions in treatment, we require an active credit card to be kept on file to guarantee financial obligations are met. This credit card information is kept secure and confidential, with access only by Dr. Casey. Fees will be charged to this credit card in the following situations:

1. If we submit health insurance claims on your behalf for our services, we will notify you of any amounts your insurance fails to pay within ninety (90) days of the date of service. These amounts must then be paid within 30 days of your being notified. Any amount outstanding after one hundred twenty (120) days from the date of service will be charged to your credit card on file.
2. Any account balance must be paid within thirty (30) days of your being notified of the amount. Amounts outstanding after 30 days will be charged to your credit card on file.
3. Late Cancellation (less than 24 hours notice) fees (\$75) or No Show fees (\$100) will automatically be charged to your credit card on file if you fail to notify the office 24 hours in advance of your scheduled appointment and do not attend your appointment.

I hereby authorize **San Diego Behavioral Medicine** to maintain my credit card on file and charge my credit card for the outstanding balances as specified above.

Mastercard **Visa** **Discover** **American Express**

Patient's name: _____

Cardholder's name: _____

Cardholder's address: _____

City: _____ State _____ Zip Code _____

Card Holder's Phone number: _____

Credit Card Number: _____

Expiration Date: ____/____ Card Verification Number (last 3 digits on back of card): _____

Cardholder's signature: _____ Date: _____



Consent for Release of Confidential Information to PCP/Health Care Practitioners

Patient Name: _____

Date of Birth: ____/____/____

I hereby authorize Corinna Y. Casey, Ph.D. to release the medical information listed which pertains to my medical history, mental or physical condition or treatment, including information relating to my mental health diagnosis and treatment and medication management information to my health care practitioner:

(name of physician)

(organization)

(address)

(city/state/zip)

(telephone/fax number)

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care, which I may receive from specialists.

I understand that the information authorized by this release will be provided to the authorized recipients only. Additional information may be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation. I understand that I have the right to refuse consent and signing of this authorization and San Diego Behavioral Medicine (Dr. Casey) shall not condition my treatment upon this refusal.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information.

This authorization becomes effective on the date signed and shall remain in effect for one year from the date of execution.

Signature: _____ Date: _____
(patient or legal representative)

If legal representative, Printed name of Legal Representative: _____

Relationship to patient: _____

I refuse to release information to my PCP/health care provider.		Reason: _____
_____ Patient Signature	_____ Date	

A Xerox and/or facsimile copy of this authorization shall be valid as the signed original on file.



PATIENT NAME: _____

Date: _____

Please initial each line after you have read and understood each individual policy. Please ask for clarification of any issue that may concern you.

_____ **Psychological Treatment**

Psychological treatment is an investment in yourself and your health. It involves a large commitment of time, money, and energy, so you should think seriously and carefully about how you want this to work for you. If you have any questions about my procedures, please discuss them whenever they arise. There are no guarantees that treatment will be successful, although most patients do make significant progress. The length and outcome of treatment is based upon your motivation for treatment, how long you have had the symptoms, the skill of the therapist, and other factors.

_____ **Appointments**

Your initial consultation is approximately 60 minutes in length and includes a review of your chief concerns as well as any relevant interpersonal, developmental, and medical history. It may take more than one visit to gather sufficient information to form a diagnosis and treatment plan. Treatment sessions are forty-five minutes in length. We may agree to vary session length and frequency as needed (additional costs may apply). Once you schedule an appointment, that time is reserved exclusively for you. Please be prompt.

_____ **Late Cancellations/Missed Appointments**

If you are unable to keep your appointment, a minimum of **24 hours notice** is required to avoid a late cancellation fee. A late cancellation fee of \$75.00 will be charged if the office is not notified within 24 hours in advance of your appointment. A No Show fee of \$100.00 will be charged if you do not show up for your appointment and have not called to cancel within 24 business hours in advance. This fee is not covered by insurance and therefore will not be billed to your insurance company. Payment for these fees is due before your next appointment or will be automatically charged to your credit card on file after 10 days, whichever comes first.

_____ **Professional Fees**

My fee for psychotherapy sessions is \$150. Any psychological testing and interpretation that are performed will be billed at \$200 per hour. Assessments and interventions for behavioral management of a medical condition will be charged according to the medical fee schedule (available upon request). There is a \$25 charge for simple letters on your behalf or forms that need to be completed. Any other professional services that require 15 minutes or more such as telephone consultations, document review, report writing, preparation of treatment summaries, court proceedings even if I am compelled to testify by another party, or time spent performing any other services outside of your appointment that you may request will be prorated at \$200 per hour.

_____ **Billing and Payments**

Payment is due at the time of service, at the beginning of each appointment, unless we agree otherwise. Payment schedules for other professional services will be agreed to at the time these services are requested. If your account has payment overdue for over 30 days, I may secure payment through your credit card on file. I also have the option of using legal means to secure payment, including collection agencies or small claims court. In most cases, the only information I would be providing would be patient name, nature of services provided, and amount due.

_____ **Insurance Reimbursement**

Your health insurance policy is a contract agreement between you and your insurance company. It may provide some behavioral health coverage. As a courtesy, I and/or my insurance billing service will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, we are unable to obtain the exact details of payment until the claim is processed. You, not your insurance company, are responsible for full payment of the professional fees for services provided to you or the patient.

Please be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional clinical information such as treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, I will have no control over what they do with it. In some cases, they may share the information with a national medical information data bank.

_____ **Confidentiality**

In accordance with California law, the information disclosed by you in therapy is confidential and is not released or accessible to anyone else without your written permission. By law, the following exceptions apply and may require me to give relevant information to others: (1) danger to self, (2) danger to others, (3) when a child, disabled person, or elderly person is physically abused, sexually abused, or neglected, (4) when a court of law issues a legitimate subpoena, and (5) when a collection service is required for unpaid bills.

I may occasionally find it helpful to consult with other professionals. In these circumstances, I will make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential.

_____ **Contacting Me**

I will make every effort to return your call during regular business hours within one day of you making it with the exception of weekends and holidays. Please let me know if the call is urgent. My office line will forward calls to my cell phone whenever I am out of the office. If I will be unavailable for an extended period of time, I will provide you with the name of a trusted colleague whom you can contact if necessary.

If you are having an emergency and cannot reach me directly, please leave me a voicemail and then immediately call **9-1-1**, the **San Diego County Crisis Line (1-800-479-3339)**, or **your primary physician** and describe your circumstances. You may also consider going to your nearest Emergency Department.

With respect to electronic communications, I prefer using email only to arrange or modify appointments; I will not respond to any other form of electronic communication (e.g., text, chat, IM, Facebook, etc.). Please do not email me content related to your treatment sessions because email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Professional Records

Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to review a copy of the records, unless I believe seeing them would be emotionally damaging to you, in which case, I will be happy to provide them to an appropriate mental health professional of your choice. Because these records contain professional language, they can be misinterpreted or upsetting, so I recommend that we review them together so that we can discuss what they contain. I can also prepare an appropriate summary for review. Patients will be charged a prorated fee of \$200 per hour for any preparation time that is required to comply with an information request.

Consents

Your signature below indicates that you have **read** the policies described above, that you **agree** to abide by its terms during our professional relationship, and that you have received a copy of this office's HIPAA notice.

Patient/Guardian Name (please print)	Signature	Date

Your signature below indicates that: (1) you agree to pay for services provided to you (or this patient), (2) you agree to pay the stated fees for any late cancellations or missed appointments, and (3) you agree that you are responsible for the charges for services provided by Dr. Casey to you (or this patient), although other persons or insurance companies may make payments on your (or this patient's) account.

Patient/Guardian Name (please print)	Signature	Date



SAN DIEGO BEHAVIORAL MEDICINE

PATIENT INFORMATION

Name: _____ / _____
Last, First Middle Initial Preferred Name

Birthdate: ___ / ___ / ___ Age: ___ Sex: F / M Marital Status: Single Married Divorced Widowed

Address: _____
Number and Street City State Zip Code

Preferred Phone: (____) _____ - _____ Alt. Phone: (____) _____ - _____ E-mail: _____
home work mobile home work mobile Please be aware email may not be confidential

Special instructions when calling: _____

Current/Last Occupation: _____ Employer/School: _____

Employment Status: F/T P/T Disabled Unemployed Retired # Years of School completed: _____

Emergency Care Information

Primary Physician: _____ Phone: (____) _____ - _____

Emergency Contact: _____ Relationship: _____

Phone: (____) _____ - _____ Address: _____
Number and Street City State Zip

Parents/Guardian (if applicable): _____

Phone: (____) _____ - _____ Address: _____
Number and Street City State Zip

Medical Information

Current medical conditions: _____

Allergies: _____

Current Medications	Dose	Frequency	Purpose
1.			
2.			
3.			
4.			
5.			

Insurance Information

Insurance Plan: _____ Phone # for benefits: (____) _____ - _____ Authorization# _____

Insurance ID#: _____ Group #: _____ \$ _____ met of \$ _____ deductible Co-pay\$ _____

Subscriber: _____ Subscriber Birthdate: _____ Relationship: _____

Subscriber address (if different from Patient): _____
Number and Street City State Zip Code

Subscriber Phone (____) _____ - _____ Subscriber's Employer: _____

Subscriber's Employer Address: _____
Number and Street City State Zip Code

I authorize both the release of medical or other information necessary to process insurance claims and the payment of medical and/or government benefits to San Diego Behavioral Medicine for services described.

Patient/authorized person's signature: _____ Date: ___ / ___ / ___

HIPAA

Your signature below indicates you have read and understand the Notice of Privacy Practices policy for this office.

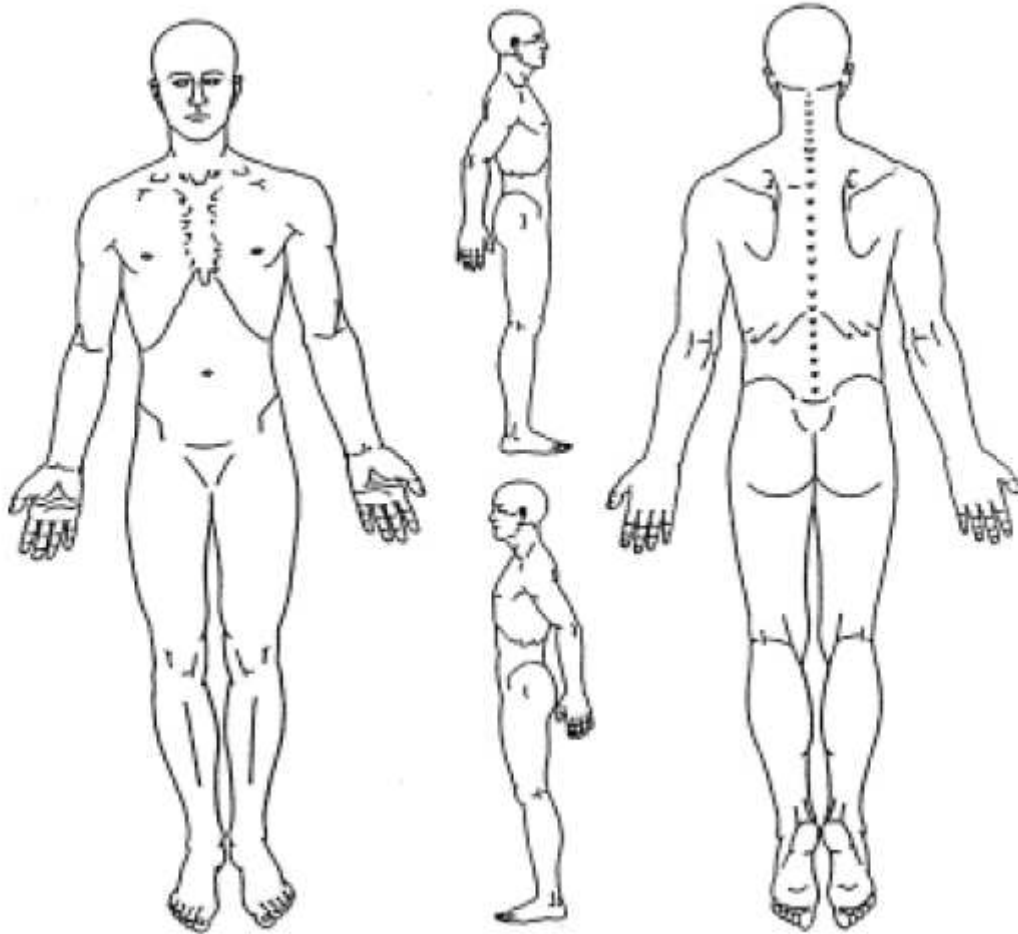
Patient/authorized person's signature: _____ Date: ___ / ___ / ___

Referral Information

How did you find out about our services? _____



Please shade the areas of your body where you are experiencing pain.



Mark below your current level of pain

No pain | Unbearable