

Robert S. White, MD - PATIENT INFORMATION

(Please print and fill out completely)

PATIENT'S NAME _____ Today's Date ____ / ____ / ____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate ____ / ____ / ____ Sex ____ Age ____ Marital Status ____ Occupation _____

Employer/School _____ Social Security # _____ - _____ - _____

Spouse's Name _____ Social Security # _____ - _____ - _____

IF PATIENT IS A MINOR, PARENTS' NAMES AND ADDRESS(ES) _____

Who referred you to us? _____

INSURANCE INFORMATION (copy of insurance card will substitute)

Primary Insurance Name, Address, and Phone Number _____

Name and Birthdate of Person Insured _____ / ____ / ____

I.D. # _____ Employer or Group No. _____

Secondary Insurance Name, Address, and Phone Number _____

Name and Birthdate of Person Insured _____ / ____ / ____

I.D. # _____ Employer or Group No. _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name _____ Phone _____ Relationship _____

Please list all who currently live in patient's home:

NAME SEX AGE RELATIONSHIP OCCUPATION/EDUCATION

Family members not living at home:

What is your reason for seeking help? _____

Please circle any of the following problems which pertain to patient:

- | | | | | |
|---------------|-----------------|-------------------|-------------------|----------------------|
| nervousness | depression | fears | behavior problems | education |
| shyness | sexual problems | suicidal thoughts | being a parent | career choices |
| separation | divorce | finances | my thoughts | health problems |
| drug use | alcohol use | friends | children | loneliness |
| anger | self-control | unhappiness | appetite | concentration |
| sleep | stress | work | medical problems | inferiority feelings |
| relaxation | headaches | tiredness | temper | marriage |
| legal matters | memory | ambition | nightmares | making decisions |
| energy | insomnia | | | |

PERSONAL MEDICAL HISTORY

Patient's physician:

Name _____ Phone _____

Address _____

Patient's therapist or psychiatrist:

Name _____ Phone _____

Address _____

1. Current medical problems _____

2. Significant past medical problems _____

3. Past operations _____

4. Allergies to medications _____

4. List all current medications with doses _____

5. Date of last physical exam _____ by Dr. _____

6. Have you had any **medical or psychiatric hospitalizations**? (Please list the year of hospitalization, name of hospital, reason for hospitalization, and length of stay) _____

7. How much **caffeine** do you have per day? (Include coffee, tea, colas, chocolate)

8. How much do you **smoke**? _____

9. How much do you drink **alcohol**? _____

10. How much do you use Other **drugs**? _____

11. Significant past **drug** or **alcohol** use? _____

12. Have you received counseling or psychological help in the past? (Please list therapists and dates)

ROBERT S. WHITE, MD - CONSENT FOR EVALUATION AND TREATMENT

I provide psychiatric evaluation and treatment services to adolescents, and adults. I am medically licensed by the State of Connecticut to evaluate and treat emotional, behavioral, and mental problems.

I will meet with you for one to three sessions to assess your problems. I will then discuss the results of the evaluation and the recommended treatment plan.

While I hope to be of help to you, I cannot guarantee treatment outcome. When you have questions or concerns about your work with me, please feel free to discuss them.

You may seek a second opinion or withdraw from treatment at any time, and I will make every effort to facilitate your consultation with or transfer to another therapist. I will offer that same referral help in the event that I find it necessary to end my work with you.

If you are covered by a managed care contract, the fee schedule is set by the insurance company. You will be responsible for deductibles and co-payments, due at the time of the appointment. If co-payments or deductibles are billed, there will be a 2% charge added each month for unpaid balances. If you are not using insurance, you and I will discuss and set fees, and when payment is expected.

Please keep in mind that most insurance policies cover only treatment that the insurer defines as "medically necessary" ; therefore, therapy used for "personal growth" or "support", etc. may not be covered.

A fee will be charged for appointments missed or cancelled without 24 hours advance notice. Your insurance will not pay for any missed appointment charges. Repeated no-shows or cancellations may be grounds for ending treatment.

Full session \$60

Half session or medication \$35

In addition to direct services for psychotherapy or medication, it may be necessary to provide a range of **indirect case management services**. Your insurance company will not pay for such services. The charge for office-based case management services is \$110 per hour prorated. Specific case management services may include but not limited to:

1. Letters written on your behalf.
2. Written reports after the initial evaluation
3. Any phone or written contact with your insurance company beyond normal treatment reviews.
4. Travel to and attendance at any required treatment meetings or extended phone consultations with other professionals.

Returned checks will be charged \$20.

Treatment may be ended if you fail to pay any charges accrued. Overdue accounts may be turned over to a collection agency, and you will be responsible for all reasonable associated costs.

Please discuss the information on this statement with your psychiatrist or therapist before signing. **My signature indicates that I have read and understand this document and have been given a copy. I am voluntarily requesting evaluation and treatment services from Laurel Health Services. I agree to abide by payment and cancellation policies. I have been given a copy of the Notice of Privacy Practices for Protected Health Information.**

Printed name _____

Signature and Date _____

Witness _____

I authorize the release of any medical or other information necessary to process my insurance claim.

Signed _____ Date ____/____/____

I authorize payment of medical benefits to the treating physician or therapist for services rendered.

Signed _____ Date ____/____/____

For Medicare or Medicaid only: I authorize my physician or therapist to release to the Health Care Financing Administration or the State of Connecticut any information necessary to determine these benefits.

Signed _____ Date ____/____/____