DAMOUS PSYCHOLOGICAL SERVICES

CLIENT INFORMATION

CLIENT NAME: ____ TODAY'S DATE:_____________

ADDRESS: ____

STREET CITY STATE ZIP

PHONE: _______________/__________________/__________________/___________________________________

HOME WORK CELL E-MAIL

GENDER: ____MALE ____ FEMALE AGE: _______ BIRTH DATE: _______________ SS #: ____________________

CLIENT'S EMPLOYER/SCHOOL ____

HIGHEST LEVEL OF EDUCATION: _________________________ OCCUPATION: _____________________________

MARITAL STATUS: _______________ SPOUSE'S NAME: ____

DESCRIBE REASONS FOR SEEKING HELP: ____

____

____

____

____

WHO REFERRED YOU TO THIS OFFICE: ____

PRIMARY CARE PHYSICIAN/PEDIATRICIAN: ____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING

CHILD'S SCHOOL: ____ GRADE: ___________________

IS CHILD RECEIVING SPECIAL SERVICES? YES/NO IF YES, WHAT TYPE? _________________________________

FATHER'S NAME: ____ AGE: _______ EDUCATION: _______________

ADDRESS (IF DIFFERENT): ____ PHONE: _________________________

FATHER'S OCCUPATION: _______________________________EMPLOYED AT:______________________________

MOTHER'S NAME: ____AGE: _______ EDUCATION: _______________

ADDRESS (IF DIFFERENT): ____ PHONE: _________________________

MOTHER'S OCCUPATION: ______________________________EMPLOYED AT:______________________________

ARE PARENTS: ___MARRIED ___NEVER MARRIED ___SEPARATED (WHEN _____) ___DIVORCED (WHEN____)

GUARDIAN'S NAME: ____ AGE: _____ EDUCATION: _______________

ADDRESS (IF DIFFERENT): ____ PHONE: _________________________

GUARDIAN'S OCCUPATION: ____________________________EMPLOYED AT:_____________________________

PLEASE LIST ALL OTHERS LIVING IN YOUR HOME:

NAME	AGE	BIRTH DATE	RELATIONSHIP	OCCUPATION/GRADE

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH ARE A PROBLEM:

AGGRESSIVE-physical	DEPRESSED	HEALTH	MARRIAGE	STEALING
AGGRESSIVE-verbal	DESTRUCTIVE	HYPERACTIVE	MEMORY	STRESS
ANGER	DISTRACTIBLE	IMPULSIVE	MOTOR SKILLS	WITHDRAWN
ANXIOUS	DIVORCE	INATTENTIVE	NIGHTMARES	WORK
APPETITE	ENERGY LEVEL	SPEECH/LANGUAGE	SEXUAL ISSUES	
CAREER CHOICES	FEARFUL	LEARNING	SHY	ALCOHOL USE
CONCENTRATION	FINANCES	LEGAL PROBLEMS	SLEEP	SUBSTANCE USE
DEFIANT	FRIENDS	LYING	SUICIDAL THOUGHTS	

STRANGE IDEAS (explain): ____

____

____

STRANGE BEHAVIOR (explain): ____

____

____

OTHER: ____

PREVIOUS OR CURRENT PSYCHIATRIC/PSYCHOLOGICAL SERVICES: __YES __NO

IF YES, WHEN____

WHERE ____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED

____PHONE ______________

HEALTH HISTORY

Have you (client) ever had any of the following:

CONDITION	AGE IT FIRST OCCURRED	STILL PRESENT?

ALLERGIES/ASTHMA ____

HEART PROBLEMS ____

SEIZURES ____

HIGH BLOOD PRESSURE ____

SERIOUS HEAD INJURY (LOSS OF CONSCIOUSNESS?) ______________________________

LEAD POISONING ____

BROKEN BONES ____

MAJOR SURGERY ____

MIGRAINE HEADACHES ____

THYROID CONDITION ____

DIABETES ____

PROBLEMS WITH VISION ____

PROBLEMS WITH HEARING ____

When were you last examined by a physician? ______________________________

Any other serious medical problems, now or in the past: __Yes __No Explain: ______________________

____

Are you currently taking any medications? ___Yes ___No Who prescribes: ______________________

If yes, List them: ____

____

____

I, THE UNDERSIGNED, GRANT PERMISSION FOR DAMOUS PSYCHOLOGICAL SERVICES, PLLC TO PROVIDE PSYCHOLOGICAL SERVICES TO THE ABOVE-NAMED INDIVIDUAL.

______________________________________/____________

CLIENT/RESPONSIBLE PERSON DATE

(PARENT OR LEGAL GUARDIAN IF CLIENT IS A MINOR)

______________________________________/____________

CLIENT/RESPONSIBLE PERSON **2 (IF APPLICABLE)** DATE

(PARENT OR LEGAL GUARDIAN IF CLIENT IS A MINOR)

______________________________/____________

WITNESS DATE

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT – NAME: ______________________________

RELATION TO CLIENT: ______________ BIRTH DATE: __________ SS#:__________

ADDRESS IF DIFFERENT FROM ABOVE: ______________________________

CITY ______________________________ STATE _____ ZIP __________

RESPONSIBLE PERSON'S EMPLOYMENT (IF DIFFERENT) ______________________________

PRIMARY INSURANCE COMPANY______________________________

NOTE: MEDICAID INSURANCE CARDS MUST BE PRESENTED AT EACH VISIT. PRIVATE INSURANCE CARDS MUST BE AVAILABLE FOR PRESENTATION UPON REQUEST.

SECONDARY INSURANCE

IS CLIENT COVERED BY ADDITIONAL INSURANCE? ___ YES ___ NO

SECONDARY INSURANCE COMPANY ______________________________

SUBSCRIBER'S NAME ______________________________

RELATION TO CLIENT: ______________ BIRTH DATE: __________ SS#:__________

ADDRESS IF DIFFERENT FROM ABOVE: ______________________________

CITY ______________________________ STATE _____ ZIP __________

*****IMPORTANT NOTE*****

If we are not informed of any secondary insurance coverage and/or if coordination of benefits information for secondary insurance has not been kept updated by the responsible person; then fees will be expected to be paid in full if original charges are denied by the primary insurance carrier. The responsible person must file the secondary insurance claim. If you have any questions please ask at the front desk.

PLEASE NOTE:

If your account is more than 60 days past due and arrangements for payment have not been agreed upon; then Damous Psychological Services, PLLC has the option of using legal means to secure the payment which may involve the use of a collection agency or small claims court. This may require some disclosure of otherwise confidential information.

ALL COPAYS, DEDUCTIBLES, AND NON-REIMBURSIBLE FEES MUST BE PAID AT THE TIME SERVICES ARE RENDERED.

Ask about our payment plan.

I, the undersigned, certify that I (or my dependent) have insurance coverage with

______________________________________ and ______________________________________
Primary Insurance Secondary Insurance

and assign all insurance benefits directly, if any, to Damous Psychological Services, PLLC otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Damous Psychological Services, PLLC to release all necessary information to secure payment of benefits. I authorize the use of this signature on all insurance claim applications.

*****PLEASE NOTE*****
IF YOU ARE UNABLE TO KEEP AN APPOINTMENT AND DO NOT NOTIFY THE OFFICE WITHIN 24 HOURS,
YOU WILL BE CHARGED A $50 NO SHOW FEE DUE AT THE TIME OF YOUR NEXT VISIT.
THERE WILL BE A $100 NO SHOW FEE FOR PSYCHOLOGICAL TESTING.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION IN THIS DOCUMENT AND AGREE TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP.

____/___________
CLIENT/RESPONSIBLE PERSON DATE
(PARENT OR LEGAL GUARDIAN IF CLIENT IS A MINOR)

____/___________
CLIENT/RESPONSIBLE PERSON **2 (IF APPLICABLE)** DATE
(PARENT OR LEGAL GUARDIAN IF CLIENT IS A MINOR)

__________________________________/____________
WITNESS DATE

MEANS OF COMMUNICATION RELEASE

____
CLIENT NAME

This form provides us direction in how we may communicate with you for appointment reminders, returned phone calls, written reports, etc.

I prefer to be contacted in the following ways:

HOME TELEPHONE:

_____ Leave message with detailed information.

_____ Leave call back number only.

_____ Leave no messages.

WORK TELEPHONE:

_____ Leave call back number only.

_____ Leave no messages.

_____ Do not call work.

Returning telephone calls may be delayed due to client volume or the schedule for the day. Calls will be returned as quickly as possible. E-mail may be a quicker way to communicate with therapists. We provide a confidential e-mail system. Check with front desk for further information.

____ **E-Mail:** ____

WRITTEN COMMUNICATION:

_____ Mail to my home address.

_____ Fax: ____________________________

_____ Mail to another address: ____

____

____/____________
CLIENT/RESPONSIBLE PERSON DATE
(PARENT OR LEGAL GUARDIAN IF CLIENT IS A MINOR)

____/____________
CLIENT/RESPONSIBLE PERSON **2 (IF APPLICABLE)** DATE
(PARENT OR LEGAL GUARDIAN IF CLIENT IS A MINOR)

__________________________________/_____________
WITNESS DATE

DAMOUS PSYCHOLOGICAL SERVICES

GEORGE M. DAMOUS, M.A., Ed.S.
Licensed Psychologist / School Psychologist

218 D Street • South Charleston, West Virginia 25303 • Phone 304-720-3835 • Fax 304-720-3836

I have reviewed a copy of the Client Rights (posted in bulletin board) and my questions have been answered.

(Physical copy of Client Rights available upon request)

______________________________ __________________

CLIENT DATE

______________________________ __________________

PARENT OR LEGAL REPRESENTATIVE DATE

______________________________ __________________

PARENT OR LEGAL REPRESENTATIVE **2 (IF APPLICABLE)** DATE

If signed by the Personal Representative of the Client, please describe the Personal Representative's authority to act for the Client by checking below:

_____ Parent _____ Legal Guardian

_____ Health Care Power of Attorney _____ Court Appointed Legal Guardian

_____ General Power of Attorney _____ Surrogate Decision Maker

_____ Executor of the Estate _____ Next of Kin or Family Member

_____ Other – Please describe: ____

____

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Your signature below serves as an acknowledgement that you have reviewed the <u>NOTICE OF PRIVACY PRACTICES</u> (posted in bulletin board) as required by the Health Insurance Portability and Accountability Act (HIPAA).

(Physical copy of <u>NOTICE OF PRIVACY PRACTICES</u> available upon request)

____/____________
CLIENT/RESPONSIBLE PERSON DATE
(PARENT OR LEGAL GUARDIAN IF CLIENT IS A MINOR)

____/____________
CLIENT/RESPONSIBLE PERSON **2 (IF APPLICABLE)** DATE
(PARENT OR LEGAL GUARDIAN IF CLIENT IS A MINOR)

____________________________________/____________
WITNESS DATE