Dr. Diana Wright, Psy.D.

4600 Kietzke Ln, C-124, Reno NV 89502 – 775-826-4400

PATIENT INFORMATION:

Please provide the following information and answer the questions below. Please bring this form to your first session. **Please note: The information you provide here is protected as confidential information.**

Patient's Full Name: ____Date: ________________________

Gender: Male _____Female _____ Non-Binary______Transgender_____Questioning_____

Date of Birth: _____/_____/_____ SS#: __________________ Age:_______

Mailing Address: ______________________________________City: _____________State: _____Zip: ________

Home Phone: ( )_____________Cell Phone: ( )_______________Work Phone Number: ( )_____________

Where would you prefer that we call you to remind you of an appointment time: Home: ____Cell: ___Work: ___

Can we leave messages on voicemail or with someone? YES _______ NO ______

Can we send mail correspondence to your mailing address? YES _______ NO ______

Please provide your email address for correspondence/billing purposes: ___________________________________

May we add you to our email list for any upcoming events, newsletters, etc.? YES _______ NO ______

How were you referred to our practice? ____

Patient's Employer: _________________________________Occupation: __________________________________

Relationship Status: (circle one)

Married_____ Separated_____ Divorced_____ Single_____ Widowed_____ Domestic Partnership_______

Full name of partner: ____SS#: _________________________

Partner's date of birth: _________________________

Person(s) you are currently living with: ___________________________________(significant other, roommate, etc.)

EMERGENCY CONTACT INFORMATION:

Full Name: _______________________________________ Relationship to patient: _______________________

Main Phone: ( )_________________________ Work Phone: ( )_________________________

Dr. Diana Wright, Psy.D.
4600 Kietzke Ln, C-124, Reno NV 89502 – 775-826-4400

PRIMARY INSURANCE INFORMATION:

Insured's Primary Insurance Company: ____________________________**I.D.#:** _______________________

Group #: __________________Policy #: _______________________Phone No: ( )______________________

Address: __________________________________City: ________________State: __________Zip: __________

PRIMARY INSURED/RESPONSIBLE PARTY INFORMATION:

Full name of insured: ______________________________________Relationship to patient: _________________

Occupation: ____________________________________SS#: ______________Date of Birth: _______________

Employer: _____________________________________Work Phone: ( )_______________________________

SECONDARY INSURANCE INFORMATION:

Insured's Primary Insurance Company: ____________________________**I.D.#:** _______________________

Group #: __________________Policy #: _______________________Phone No: ( )______________________

Address: __________________________________City: ________________State: __________Zip: __________

SECONDARY INSURED/RESPONSIBLE PARTY INFORMATION:

Full name of insured: ______________________________________Relationship to patient: _________________

Occupation: ____________________________________SS#: ______________Date of Birth: _______________

Employer: _____________________________________Work Phone: ( )_______________________________

Dr. Diana Wright, Psy.D.

4600 Kietzke Ln, C-124, Reno NV 89502 – 775-826-4400

OFFICE BILLING AND INSURANCE POLICY:

1. I authorize use of this form on all my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided in the event that my insurance company does not pay.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-PAY, CO-INSURANCE AMOUNT OR ANY OTHER BALANCES NOT PAID BY YOUR INSURANCE COMPANY THE DAY AND TIME OF SERVICE PROVIDED.

- There will be a **$50.00 service charge** on all returned checks.
- There will be a **$50.00 charge** to fill out any paperwork unless it can be done during your session
- Pursuant to the collection policy outlined in the Confidentiality Agreement, in the event that your account goes to collections, there will be a **40% collection** fee added to your balance.

Signature: ____Date: _________________________

Name (Print): ____

Dr. Diana Wright, Psy.D.
4600 Kietzke Ln, C-124, Reno NV 89502 – 775-826-4400

Once an appointment has been scheduled, you will be expected to keep the appointment. **Our office policy requires that sessions be cancelled at least 24 hours (*Monday through Friday*) prior to the scheduled appointment time to avoid being responsible for the charges.** If less than 24 hour notice is given (calls must be made during normal business hours when office staff is available and **does NOT include evenings, weekends, and/or holidays**), you will be charged for the appointment [unless we are able to fill your appointment time with someone on our waiting list, or
a patient who calls for an urgent session.] Appointment times are scheduled exclusively for each patient and generally cannot be rescheduled on short notice. *This office cannot bill your insurance company for "no shows" or late cancellations.* **You alone will be responsible for the full $100.00 fee for any appointments missed for *any reason*.**

I, THE UNDERSIGNED, HAVE READ AND UNDERSTAND MIND AND BODY COUNSELING ASSOCIATES' LATE CANCEL/NO SHOW APPOINTMENT POLICY.

Signature: ____Date: _________________________

Name (Print): ____

I, THE UNDERSIGNED, HAVE OBTAINED (FROM THE WEBSITE) AND REVIEWED THE NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE AND THE PSYCHOTHERAPIST/PATIENT SERVICE AGREEMENT AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.

Signature: ____Date: _________________________

Name (Print): ____

Dr. Diana Wright, Psy.D.

4600 Kietzke Ln, C-124, Reno NV 89502 – 775-826-4400

ASSIGNMENT OF BENEFITS

Patient Name: ______________________________

I hereby instruct and direct ____Insurance Company to pay by check made out and mailed to:

Diana Wright, Psy.D., LLC

Or

If my current policy prohibits direct payment to our office, I hereby also instruct and direct you to make out the check to me and mail it to:

Diana Wright, Psy.D., LLC

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
__________(initial)

A photocopy of this Assignment will be considered, as effective and valid as the original.
__________(initial)

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
__________(initial)

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
__________(initial)

____ ______________________
Signature of Patient/Claimant or Policyholder Date

Name (Print): _______________________________

Dr. Diana Wright, Psy.D.

4600 Kietzke Ln, C-124, Reno NV 89502 – 775-826-4400

CONFIDENTIAL HISTORY INFORMATION:

(Please fill out all sections completely)

Why are you here to see us?

____

____

List symptoms:

____

____

When did the problem(s) first start?

____

____

HEALTH HISTORY:

Please provide information about your Primary Care Physician:

Name: ______________________________ Telephone Number: ( )__________

Address: ____________________ City: __________ State: ______ Zip code: ______

Are you currently taking any prescription medication?

□ NO □ YES (List all current medications, the dosage, and how long you've been taking them):

____________________ ____________________

____________________ ____________________

Have you had any previous illnesses or operations? ____________________

____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ NO □ YES/previous therapist/practitioner: ____________________

Have you ever been prescribed psychiatric medication?

□ NO □ YES (Please list and provide dates)

___________________________________ ___________________________________

Are you currently experiencing any medical problems?

□ NO □ YES (Please explain):

____

What is your height? __________________ ***What is your weight?*** ___________________________

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems that you are currently experiencing:

____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems that you are currently experiencing:

____

How would you describe your energy levels?____

How many times per week do you generally exercise? ___________

What types of exercise do you participate in? ____

How would you characterize your eating habits? (ex. Healthy, organic, processed foods, etc.)

____

Please list any difficulties you experience with your appetite or eating patterns:

____

Have you had any recent changes in your weight?

□ NO □ YES (Please explain):

____

Dr. Diana Wright, Psy.D.

4600 Kietzke Ln, C-124, Reno NV 89502 – 775-826-4400

How would you describe your mood lately? ______________________________________

Are you currently experiencing overwhelming sadness, grief or depression?

□ NO □ YES (Please indicate for approximately how long)_______________________

Are you currently experiencing anxiety, panic attacks or have any phobias?

□ NO □ YES (Please indicate when you began experiencing this)__________________

Are you currently experiencing any chronic pain?

□ NO □ YES (Please describe)____

Suicide:

Have you ever thought about suicide?

□ NO □ YES (When was the last time?) _________________________________

Have you ever attempted suicide?

□ NO □ YES (When and how?) ______________________________________

Do you have thoughts of suicide now?

□ NO □ YES (Please describe) ______________________________________

Do you drink alcohol?

□ NO □ YES (Please describe)

How many drinks do you consume in an average day? _______________________

At what time of the day do you have your first drink? _______________________

What is the most you have had to drink in a 24-hour period? __________________

Have you ever been told, or have you ever felt, that you should cut down on your drinking?

□ NO □ YES

Smoking:

Do you currently smoke cigarettes/tobacco products?

□ NO □ YES (Please describe) ______________________________________

Packs per day? ___________________ What age did you start? ______________________

Do you currently use marijuana products?

□ NO □ YES

How often in any given day do you use marijuana? ___________________________

Do you currently, or have you ever, used any illegal drugs or substances?

□ NO □ YES (Please list and indicate if current or past use)

____

____

Dr. Diana Wright, Psy.D.

4600 Kietzke Ln, C-124, Reno NV 89502 – 775-826-4400

Do you gamble?

□ NO □ YES (Please describe)

How often do you gamble? ______________________________

At what time of the day do you start gambling? _______________________________

When was the last time you gambled? __________________________

Have you ever been told, or have you ever felt, that you should cut down on your gambling?

□ NO □ YES

Do you currently, or have you ever had, any addictions to any of the following? (please circle)

NONE / Drugs / Eating / Gambling / Sexual / Spending / Other (explain)___________________________________

Is there any history of domestic violence in your current relationship?

□ NO □ YES

Is there any history of domestic violence in your past relationships?

□ NO □ YES

Have you ever thought about hurting someone?

□ NO □ YES, When was the last time? ____

Have you ever hurt someone else?

□ NO □ YES, When and how? ____

Are you thinking about hurting someone now?

□ NO □ YES

Have you ever been in a physically, emotionally and/or sexually violent relationship?

□ NO □ YES

Are you currently in a physically, emotionally and/or sexually violent relationship?

□ NO □ YES

When you were growing up, did you witness or experience physical and/or sexual abuse from caretakers?

□ NO □ YES

Have you ever been sexually abused?

□ NO □ YES

What significant life changes or stressful events have you experienced recently: (please circle)

Married Engaged Separated Divorced Breakup of an important relationship

Child left home Death of a spouse, other Bad health (behavior) of a family member

Difficulties with a family member Personal injury, illness Retired Lost job Quit job

Owe money Surgery or illness Changed residence Legal difficulties Birth/adoption of a child

Infertility issues Other (please describe) _______________________

Dr. Diana Wright, Psy.D.
4600 Kietzke Ln, C-124, Reno NV 89502 – 775-826-4400

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please circle	List family member
Alcohol/Substance abuse	YES/NO	____________________
Anxiety	YES/NO	____________________
Depression	YES/NO	____________________
Domestic Violence	YES/NO	____________________
Eating Disorders	YES/NO	____________________
Obesity	YES/NO	____________________
Obsessive Compulsive Behavior	YES/NO	____________________
Schizophrenia	YES/NO	____________________
Bipolar Disorder	YES?NO	____________________
Suicide attempts	YES/NO	____________________

ADDITIONAL INFORMATION:

Do you have any children?
□ NO □ YES (What are their ages?)____________________

Are your parents living?
□ YES □ NO (Please list cause of death)____________________

Education:
What is the highest grade you completed in school? ________
Do you have a degree?
□ NO □ YES (What is your degree?)____________________

Do you enjoy your work?
□ NO (Please explain) □ YES____________________

Is there anything stressful about your current work?
□ NO □ YES (Please explain)____________________

Do you consider yourself spiritual or religious?
□ NO □ YES (Please describe your faith or belief) ____________________

LEGAL MATTERS:

Have you ever been convicted of a felony?
□ NO □ YES (Please describe)____

Do you have a pending lawsuit of any kind?
□ NO □ YES (Please describe)____

Did your attorney suggest that you see a therapist?
□ NO □ YES (Please describe)____

Have you applied for Social Security Disability benefits?
□ NO □ YES (Please describe)____

If NO, do you intend to apply for Social Security Disability benefits?
□ NO □ YES (Please describe)____

Do you intend to request this therapist to take you out of work for a short term disability or FMLA?
□ NO □ YES (Please describe)____

DRUG AND ALCOHOL SCREENING INFORMATION

Please respond to each item for yourself and your partner (circle one for each person):

1. **How often do you have a drink containing alcohol?**
   a. Hardly ever or never You • Your Partner •
   b. Once a week You • Your Partner •
   c. Once a day You • Your Partner •
   d. More than once a day You • Your Partner •

2. **How many drinks containing alcohol do you have on a typical day when you are drinking?**
   a. One You • Your Partner •
   b. Two to three You • Your Partner •
   c. Four to six You • Your Partner •
   d. More than six You • Your Partner •

3. **In a typical week in which you do drink, how many days do you have at least one alcoholic drink?**
   a. One You • Your Partner •
   b. Two to three You • Your Partner •
   c. Four to six You • Your Partner •
   d. More than six You • Your Partner •

4. **How often do you have six or more drinks on one occasion?**
   a. Never You • Your Partner •
   b. Once a year You • Your Partner •
   c. Two to six times a year You • Your Partner •
   d. More than six times a year You • Your Partner •

5. **Do you use drugs other than those required for medical purposes?**
   a. Never You • Your Partner •
   b. Rarely You • Your Partner •
   c. Occasionally You • Your Partner •
   d. Frequently You • Your Partner •

6. **Have you abused prescription drugs?**
   a. Never You • Your Partner •
   b. Rarely You • Your Partner •
   c. Occasionally You • Your Partner •
   d. Frequently You • Your Partner •

7. **Do you use more than one drug at a time?****
   a. Never You • Your Partner •
   b. Rarely You • Your Partner •
   c. Occasionally You • Your Partner •
   d. Frequently You • Your Partner •
   e. Always You • Your Partner •

8. **Can you get through a week without using drugs?****
   a. Never You • Your Partner •
   b. Rarely You • Your Partner •
   c. Occasionally You • Your Partner •
   d. Frequently You • Your Partner •
   e. Always You • Your Partner •

****What we mean by the term "drugs":**
Opiates (e.g., morphine, codeine, heroin)
Depressants (e.g., barbiturates)
Stimulants (e.g., cocaine, amphetamines)
Hallucinogens (e.g., LSD, Mescaline)
Marijuana, Hashish
Other illegal substances (e.g., Psilocybin, DMT, DET, PCE, PCP, TCP)