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

CODE:_____
(For office use only)

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 _____Age: _____Date of Birth: _____/_____/_____SS#: _____

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 voice mail or with someone: YES _____ NO _____

Please provide your e-mail 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? _____[sent ☐]

Patient's Employer: _____Occupation: __ _____

Marital Status: (circle one)

Married_____Separated_____Divorced_____Never Married_____Widowed_____Domestic Partnership_____

Full name of spouse: _____SS#: _____

Spouse's date of birth: _____

INSURED/RESPONSIBLE PARTY INFORMATION:

Full name of insured: _____Relationship to patient: _____

Occupation: _____SS#: _____Date of Birth: _____

Employer: _____Work Phone: ( )_____

INSURANCE INFORMATION:

Insured's Primary Insurance Company: _____I.D.#: _____

Group #: _____Policy #: _____Phone No: ( )_____

Address: _____City: _____State: _____Zip: _____

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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): _____

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 thru 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 DR. WRIGHT'S 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): _____

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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 the doctor, 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): _____

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CONFIDENTIAL HISTORY INFORMATION:

(Please fill out all sections completely)

Why are you here to see me?

_____

_____

_____

_____

List symptoms:

_____

_____

_____

When did the problem(s) first start?

_____

_____

_____

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 of your current medications along with the dosage):

_____ _____

_____ _____

_____ _____

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ NO ☐ YES/previous therapist/practioner: _____

Have you ever been prescribed psychiatric medication?
☐ NO ☐ YES (Please list and provide dates)

_____ _____

_____ _____

_____ _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

Are you currently experiencing any medical problems?
☐ NO ☐ YES (Please explain):
_____

What is your height? _____ What is your weight? _____

Have you had any recent changes in your weight?
☐ NO ☐ YES (Please explain):
_____

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 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:

_____

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)_____

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

Do you currently, or have you ever, used any illegal drugs or substances?
☐ NO ☐ YES (Please list and indicate if current or past use)

_____ _____

_____ _____

_____ _____

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, (circle all that apply)
Are you currently in a physically, emotionally and/or sexually violent relationship?
☐ NO ☐ YES, (circle all that apply)
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) _____

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) _____

Smoking:
Do you currently smoke cigarettes/tobacco products?
☐ NO ☐ YES (Please describe) _____

Packs per day? _____ What age did you start? _____

Do you currently smoke marijuana?
☐ NO ☐ YES

How often in any given day do you smoke marijuana? _____

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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)

_____

GOALS:

What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

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DRUG AND ALCOHOL SCREENING INFORMATION

Please respond to each item for yourself and your partner

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)