Thomas C. Fain, Ph.D., M.P.A.P.
10641-1 Hillary Court
Baton Rouge, LA 70810
(225) 387-3325

Receipt of Notice of Privacy Practices

This is to certify that the HIPAA Notice of Privacy Practices has been made available to me regarding me as a patient or regarding my child, for whom I am a legal guardian.

_____
Signature of Patient or Authorized Party

_____
Date

_____
Witness

CONSENT FOR TREATMENT

I, _____, hereby consent to diagnosis and treatment of myself by **Thomas C. Fain, Ph.D., M.P.A.P.** In entering into this agreement, I understand that all mental health care, diagnosis and treatment is provided by the licensed professional person named above and not by Psychological Evaluation & Treatment Services.

I accept responsibility for payment of all usual and customary professional fees charged, **or** insurance deductibles and copayments set by my insurance carrier, managed care company, or other third party administrator, **and** that I am responsible for any expenses incurred that are not covered by such other entities (i.e. un-authorized procedure, telephone communications to third parties or yourself, filling out of forms or other documents, letters, reports or other written communications, etc.). I understand that payment is due at the time services are rendered, unless other arrangements have been made in advance.

I understand further that all communications shall be held in professional confidence except for those circumstances provided by law or when I have given permission in writing for release of information on my behalf to a third party. Examples (**not a complete list**) of legal exceptions to the patient's privilege of confidentiality include the following:

* When you have filed a lawsuit placing your mental status at issue;

* When you have signed an agreement with some other person or company, such as your insurer, authorizing release of information;

* When your condition poses a danger to yourself or someone else;

* When evidence of abuse is revealed.

Cancellation of sessions, and re-scheduling of sessions, must be done at least 24 hours in advance. Answering service available 7 days a week, 24 hours a day. ***If you do not cancel/reschedule at least 24 hours in advance, you will be billed $80 for that session.*** *If you are going through an insurance company, you should know that they will not pay this cancellation fee; it will be an out-of-pocket expense for you.*

_____ _____

Date Signature

_____

Witness

THOMAS C. FAIN, PH.D., M.P.A.P.

Client Information

****Please fill out entire form to the best of your ability****

Patient Name _____ **Today's Date** _____

Birthdate _____ **Age** _____ **Height** _____ **Weight** _____

Mailing Address _____

City _____ **State** _____ **Zip code** _____

Home Phone (_____)_____ **Cell** (_____)_____ **SSN#** _____-_____-_____

Email Address _____

Employer/Occupation _____ **Work Phone** (_____)_____

Highest Grade Completed or Degree _____ **School** _____

Military History _____

Marital Status Single _____ Married _____ (Date _____) Widowed _____ (Date _____)

Separated _____ (Date_____) Divorced _____ (Date _____)

Spouse Name _____ **Birthdate** _____ **Age** _____

Telephone (_____)_____ **Cell** (_____) _____

Employer/Occupation _____ **Work Phone** (___)_____

Children (names and ages) _____

_____

Parents _____ **Marital Status** _____

Address _____

Brothers/Sisters (names and ages) _____

_____

Chief Complaint _____

_____

_____

Previous Evaluation/Treatment (where, when, who) _____

_____

Past Medications (List any adverse reactions/dates/dosages) _____

_____

_____

_____

Current Medications _____

_____

_____

Referred by _____

ADULT SYMPTOM CHECKLIST

In order to assist your clinician in the assessment process, please check any of the following symptoms that you have experienced within the *last month*.

_____ Irritability
_____ Sleep problems
_____ Worry a lot
_____ Tense
_____ Nightmares
_____ Poor appetite
_____ Excessive appetite
_____ Binge eating
_____ Weight loss
_____ Crying
_____ Poor concentration
_____ Low energy
_____ Energy loss
_____ Hopelessness
_____ Fearfulness
_____ Lying
_____ Shyness
_____ Vomiting after eating
_____ Laxative use to control weight
_____ Trouble expressing feelings
_____ Trouble managing anger
_____ Physical Violence
_____ Chronic Pain

_____ Frequent sadness
_____ Recent loss
_____Parenting problems
_____ Marital problems
_____ Sexual problems
_____ Family problems
_____ Work or school problems
_____ Hearing voices
_____ Do things over and over
_____ Trouble making decisions
_____ Drug usage
_____ Drink too much
_____ Family members drink
_____ Overspending
_____ Gambling
_____ Jealousy
_____ Hurts self
_____ Trouble with law
_____ Memory problems
_____ Feel someone is out to get you
_____ Feel taken advantage of
_____ Fears of _____

Name: _____ Date: _____

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MEDICAL HISTORY REVIEW

NAME _____ DATE _____

DATE OF BIRTH _____ PRIMARY CARE PHYSICIAN _____

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

1. Weight changes more than 6 pounds in last 3 months	YES or NO
2. Recent chills or fever	YES or NO
3. Weakness or fatigue	YES or NO
4. Major surgical operations	YES or NO
5. Serious injuries	YES or NO
6. Allergic reaction to a medicine	YES or NO
7. Cancer or malignant disease	YES or NO
8. Amount of alcohol intake, _____ day	YES or NO
9. Smoking, packs/day _____ duration _____ yrs.	YES or NO
10. Vision problems	YES or NO
11. Glaucoma or cataracts	YES or NO
12. Inflamed eyes	YES or NO
13. Difficulty in hearing	YES or NO
14. Ear infections	YES or NO
15. Noises in ears	YES or NO
16. Severe dizziness	YES or NO
17. Sinus or allergy problems	YES or NO
18. Persistent hoarseness	YES or NO
19. Frequent colds or sore throats	YES or NO
20. Bleeding or sore gums	YES or NO
21. Soreness in mouth or tongue	YES or NO
22. Nosebleeds	YES or NO
23. Lumps or swelling in neck	YES or NO
24. Persistent cough	YES or NO
25. Coughed up blood	YES or NO
26. Shortness of breath	YES or NO
27. Pneumonia or lung infections	YES or NO
28. Tuberculosis	YES or NO

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

29. Abnormal chest x-ray/spot on lungs	YES or NO
30. Asthma or wheezing	YES or NO
31. A known heart disease	YES or NO
32. Heart attack or failure	YES or NO
33. High blood pressure	YES or NO
34. Irregular or fast heartbeat	YES or NO
35. Chest pain or tightness when active	YES or NO
36. Need to sleep on several pillows	YES or NO
37. Heart murmurs	YES or NO
38. Swelling of legs or ankles	YES or NO
39. Leg pain with or after walking	YES or NO
40. Varicose veins	YES or NO
41. Poor appetite	YES or NO
42. Difficulty swallowing	YES or NO
43. Heartburn or indigestion	YES or NO
44. Recent changes in bowel movements/habits	YES or NO
45. Vomiting blood	YES or NO
46. Passing black stools or rectal bleeding	YES or NO
47. Stomach abdominal pain	YES or NO
48. Stomach or duodenal ulcers	YES or NO
49. Hepatitis or liver diseases	YES or NO
50. Frequent nausea or vomiting	YES or NO
51. Gallstones or gallbladder problems	YES or NO
52. Chronic constipation	YES or NO
53. Chronic diarrhea or loose stools	YES or NO
54. Hemorrhoids or rectal problems	YES or NO
55. Excessive gas or bloating	YES or NO
56. Passing blood in urine	YES or NO

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

57. Frequent or painful urination (3 or more times) YES or NO
58. Frequent urination at night YES or NO
59. Difficult to start urination YES or NO
60. Difficult to control bladder YES or NO
61. Changes in urine color YES or NO
62. Sugar or albumin in urine YES or NO
63. Kidney or bladder stones YES or NO
64. Known kidney disease YES or NO
65. Frequent bladder or kidney infections YES or NO
66. Venereal diseases (syphilis or gonorrhea, etc.) YES or NO
67. Lumps in groins or genitals YES or NO
68. Hemias YES or NO
69. Impotence or sexual dysfunction YES or NO
70. Menstrual problems or irregularity YES or NO
71. Unusual vaginal bleeding YES or NO
72. Frequent vaginal infections YES or NO
73. Lumps in breast YES or NO
74. Nipple discharge YES or NO
75. Frequent or chronic joint pain YES or NO
76. Joints swollen for weeks YES or NO
77. Bursitis or tendonitis YES or NO
78. Injections in the joints YES or NO
79. Gout YES or NO
80. Bone diseases or osteoporosis YES or NO
81. Back or neck injuries YES or NO
82. Frequent back or neck pain or stiffness YES or NO
83. Numbness or tingling in hands or feet YES or NO

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

84. Rash or itching YES or NO
85. Psoriasis YES or NO
86. Skin ulcers YES or NO
87. Hives or eczema YES or NO
88. Frequent headaches or migraine YES or NO
89. Head injuries or loss of consciousness YES or NO
90. Convulsions or fits YES or NO
91. Fainting or blackout spells YES or NO
92. Numbness or paralysis (temporary or permanent) YES or NO
93. Nervous breakdown YES or NO
94. Consulted a psychiatrist/psychologist YES or NO
95. Taken medicine for nervousness YES or NO
96. Difficulty sleeping YES or NO
97. Crying or blue spells YES or NO
98. Anemia YES or NO
99. Bruise easily YES or NO
100. Frequent bleeding YES or NO
101. Blood transfusion(s) in the past YES or NO
102. Diabetes YES or NO
103. Goiter YES or NO
104. Taken thyroid medications YES or NO
105. Heat or cold intolerance YES or NO
106. Hormone medication YES or NO
107. Cortisone medications YES or NO
108. Excessive water drinking YES or NO
109. Excessive sweating YES or NO
110. Chronic Pain YES or NO

FAMILY HISTORY (SIBLINGS, CHILDREN, PARENTS, RELATIVES)

High blood pressure YES or NO
Heart disease YES or NO
Stroke YES or NO
Cancer type YES or NO
Kidney diseases YES or NO
Lung Diseases YES or NO

Blood diseases YES or NO
Tuberculosis YES or NO
Diabetes YES or NO
Epilepsy YES or NO
Asthma YES or NO
Psychoemotional Disturbances (i.e. Bipolar, Depression, Anxiety, Schizophrenia, etc.) YES or NO

List medications you are allergic to

_____

_____

_____

Other diseases (specify) _____ YES or NO

Any other information pertinent to your physical and psychological health problems?

_____

_____

_____

_____

Prior hospitalizations and why

_____

_____

_____

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Authorization for Release of Confidential Information
Part I

I, _____, give my consent for the

release of confidential information concerning:

_____myself_____

Information to be released is limited to:

_____all findings_____

Disclosure of this information is for the purpose of:

_____evaluation or treatment_____

Information shall be exchanged between:

_____Thomas C. Fain, Ph.D., M.P.A.P._____

And the following person(s): (Ex: parent/guardian, spouse, primary care physician, etc.)

_____

_____

This consent may be revoked in writing at any time, but such revocation

shall not be retroactive.

This consent shall expire not later than one year after treatment ends.

_____ _____
Date Signature

_____
Witness

Thomas C. Fain, Ph.D., M.P.
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Baton Rouge, LA 70810
(225) 387-3325

Authorization for Release of Confidential Information
Part II

I, _____, give my consent for the

release of confidential information concerning:

myself

Information to be released is limited to:

my findings

Disclosure of this information is for the purpose of:

evaluation or treatment

Information shall be interchanged between:

Thomas C. Fain, Ph.D., M.P.

and:

YOUR INSURANCE PROVIDER

This consent may be revoked in writing at any time, but such revocation shall not be retroactive.

This consent shall expire not later than one year after treatment ends.

_____ _____
Date Signature

_____
Witness

Thomas C. Fain, Ph.D., M.P.A.P.
10641-1 Hillary Court
Baton Rouge, LA 70810
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Insurance Filing Requirements

Our current office policy requires payment at the time of service. We will file with all in-network managed care companies if indicated below. If you do not wish for us to file with your in-network insurance company, we will not backdate services if you later decide you want us to file. However, we will start filing your claims starting on the date you sign a new 'Insurance Filing Requirements' form allowing us to do so. If you have out-of-network insurance, we will not file for you but you are allowed to file on your own. Please note that insurance companies have limitations on which diagnoses and services are covered, and this information may be used in determining future insurance eligibility. **This means you are responsible for any payments not covered under your insurance policy.** Refer to your policy for these details.

- ☐ I do want this office to file with my in-network insurance company at this time
- ☐ I do not want this office to file with my in-network insurance company at this time
- ☐ I do not have health insurance at this time
- ☐ I have out-of-network insurance and will handle this on my own

_____
Signature of Authorized Party

_____
Date

_____
Witness

Please sign, date, and sign.

Do not fill out the rest.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $
29. AMOUNT PAID $	30. Rsvd for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.