Stacy E. LaMorgese, Psy.D.
4115 East Valley Auto Drive, Suite 208, Mesa, Arizona 85206
480-507-7880 dr.l@divorcedoctors.org

INFORMED CONSENT FOR TREATMENT

I _____DOB_____SSN_____

1. I have been informed of my rights and responsibilities as a patient of Dr. Stacy LaMorgese, Psy.D.

2. I have been informed about the limits of confidentiality of my records.

3. I have been informed of the cost of services from Dr. LaMorgese. I understand that I am responsible to pay the agreed rate for service and that it is payable each time I come for treatment.

4. I have been informed of Dr. LaMorgese's qualifications. I am aware that Dr. LaMorgese a fully licensed independent Psychologist working as an independent practitioner and not as part of a group practice.

5. I understand that I may address any concerns or grievances with my doctor at any time.

6. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time. However, I agree to let Dr. LaMorgese know before stopping treatment.

7. I agree that if at any time I feel that I may be a threat to myself or others, I will call Dr. LaMorgese, EMPACT Crisis Hotline 480-784-1500, or Banner Helpline (602) 254-4357 before calling 9-1-1. No matter what, I will call for help until I reach someone.

8. I give my authorization and consent to receive outpatient diagnostic and treatment services from Dr. LaMorgese. I understand that my therapist/doctor believes that this treatment will help me and there is no guarantee as to the result. I also understand that on occasion there are negative consequences to treatment and I agree to inform Dr. LaMorgese if there are unexpected changes in my condition.

_____ _____
Signature of patient or legal consenter Date

I give my permission for Dr. LaMorgese to speak to _____

who is my _____with regard to my continued treatment.

_____ _____
Signature of patient or legal consenter Date

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PATIENT/RESPONSIBLE PARTY LETTER OF AGREEMENT
NON-INSURANCE BILLING AND PAYMENT POLICY
PLEASE INITIAL EACH ITEM BELOW

_____ I request Dr. LaMorgese to submit billing on my behalf directly to my insurance carrier.

_____ I acknowledge that payment for services will be paid by me: _____.

_____ Payment liability for Non-insured patients and for charges of DENIED services rests with the patient, or responsible party, who is the beneficiary of those services.

_____ I agree to be personally responsible for payment of those services, as well as, any legal fees, court costs, collection fees, and late fees connected with collection of payment.

_____ I agree to pay a $25.00 fee for any personal checks returned for insufficient funds.

_____ I agree that the person who brought the child in to see the doctor is responsible for all the fees associated with the visit.

APPOINTMENT POLICY

_____ The cooperation of each patient is necessary to assure that everyone's needs are met. Frequently, patients are placed on a "waiting list" for appointment cancellations. It is therefore necessary that every consideration be given to avoid missed appointments that could be used by someone else.

_____ Each patient is responsible for keeping appointments with his or her provider. If it becomes necessary to break an appointment, it is EXPECTED that a patient contact this office 24 hours in ADVANCE of scheduled appointment.

_____ If a patient misses his or her scheduled appointment or fails to provide 24 hours' notice, there will be a charge of $50.00. This charge will not and cannot be billed to your insurance company. You are personally responsible for this charge. In the event my account is turned over for collection. I understand that I will be responsible for all collection costs.

Responsible Party Name and Relationship: _____

Responsible Party Signature: _____ Date: _____

Witness to Signature: _____ Date: _____

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Personal Identification Information

Date: _____ Name: _____ Birth Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ email: _____

Referred by: _____ Primary Physician: _____

Current Medication(s): _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

I UNDERSTAND THAT DR. LaMORGESE DOES NOT ACCEPT INSURANCE FOR **COURT ORDERED OR FORENSIC PSYCHOLOGICAL SERVICES** AND THOSE SERVICES ARE PRIVATE PAY ONLY

Please list each professional, program, or hospital that has provided behavioral health services to you or your family. If you don't have their current addresses, please bring this information to the next appointment. Professional/Program or Hospital Address/Location Dates Close Family Members (Parents, Siblings, Spouse, Children, etc.)

Name Relationship Age Any Mental Health, Drug/Alcohol Problems:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Patient Printed Name: _____

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Personal Status/Ideation Information

Name: _____ Date: _____

Reason for seeking help and/or Current problems experienced.
Please circle any relevant problems.

Sadness Anxiety Drug Abuse Parenting Spouse Stress Limited Communications Behavior problems

Sexual behavior Anger control Work conflicts Lonely Nightmares Lack of energy Confused thinking

Sexual dysfunction Marriage problems Family conflicts Stealing Sibling conflicts Physical abuse

Criminal/delinquent behavior Assertiveness Co-dependency Panic attacks Fears Compulsive behavior

Underachievement Hyperactivity Short Attention Eating disorder Stuttering Apathy Job Stress

Learning disability Financial problems Physical disability Death/loss Spirituality Weight/appearance Legal problems

Are you currently in a crisis state, if so, please briefly explain? _____

_____

Are you currently having thoughts of hurting yourself or others, if so, please briefly explain? _____

_____

In a few words, what do you think therapy is all about? _____

_____

_____

How long do you think your therapy should last? _____

_____

My Goals for Treatment: _____

_____

_____

What personal qualities do you think the ideal therapist should possess? _____

_____

_____

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ADULT HISTORY FORM (Confidential)

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and accurately as you can, you will facilitate your therapeutic program. You benefit by completing these routine questions in your own time instead of using your actual consulting time. Case records are strictly confidential. No outsider is permitted to see your case record without your written permission. If you do not desire to answer any question, merely write: "Do not care to answer."

Referral: _____

Date: _____

GENERAL

Name Address _____

Home Phone _____ Work Phone _____Email_____

Age _____ Date of Birth and Place _____

Occupation_____ Employer_____

Do you live in a house, hotel room, apartment, etc.? _____

MARITAL HISTORY

Marital Status (Circle): Single Married Separated Widowed Divorced

How many times have you been married, including marriage above? _____Length of present marriage_____

How long did you know your marriage partner before engagement? _____

For how long were you engaged? _____ Husband's/Wife's age_____

Husband's/Wife's occupation? _____ Employed now?_____

How many hours per week? _____

Describe his or her personality in your own words: _____

_____

_____

In what areas is there compatibility? _____

In what areas is there incompatibility? _____

How do you get along with your in-laws? (This includes brothers and sisters-in-law)

_____

_____

How many children do you have? (List names, ages, sex, and personality). Note any from previous marriage. _____

_____

_____

Give any details of any previous marriage(s): _____

_____

_____

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INDIVIDUAL PAST HISTORY

Are you adopted? _____ If yes: When _____ Where_____

What age _____ By Whom _____

What age did you find out _____ What was your reaction: _____

When you were born, were there any medical or emotional complications for you or your mother? _____

If yes, explain: _____

List all serious diseases or illnesses you had as a child or teenager. (Include age) _____

_____

_____

_____

List all serious operations or accidents that you had as a child and what age you were _____

_____

_____

Please describe any fearful or distressing experiences you've had which have not been previously mentioned.

_____

_____

_____

Underline any of the following that applied during your childhood. Problems with: Sleep-walking, thumb-sucking, nail-biting, stammering, fears, night terrors, shyness, tantrums, tics, day-dreaming, overweight, imaginary playmates, repeated fighting, dreams, slow development, special classes, excessive masturbation, bowel problems, nightmares, bed-wetting.

Do you remember your childhood as being happy or unhappy? _____

Games and interest during childhood (including make-believe) _____

Interests and hobbies during adolescence (teens) _____

Athletic or other accomplishments _____

Have you ever bullied or given a nickname which hurt your feelings? _____

Present interests, hobbies, activities _____

Relationship with brothers and sisters: _____

Past:_____

Present:_____

Give a description of your father's personality and his attitudes towards you. (Past and present)_____

_____

Give a description of your mother's personality and her attitudes towards you. (Past and present) _____

_____

In what ways did your parents punish you as a child? _____

Describe the home atmosphere in which you grew up, any family problems, and the status of compatibility between parents and between parents and children: _____

_____

_____

At what age were parents divorced? _____ How did you react to divorce? _____

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If you were not reared by your parents, who reared you and between what years? _____

Who are the most important people in your life? _____

Are there any other members of the family about whom information regarding illness, etc. is relevant? _____

MEDICAL HISTORY

Who is your current medical provider or primary care physician? _____

Are you being treated for any issues? If so what and how: _____

Are you taking any prescription or OTC medication? If so what and dosages: _____

Have you had any medical issues in adulthood? If so, what: _____

Is there any other current or historical medical information that have not noted? _____

SCHOOL HISTORY

Age Started _____ Last grade and age completed _____ Number of grammar schools attended _____

Were you often truant _____ Were you ever in special classes? Yes/No Which classes? _____

Problems in going to school because of fears or of repeated illnesses _____

Did you have difficulties or problems in school not listed? If yes, explain: _____

Have you had any trade/technical training in addition to formal schooling? If yes, describe: _____

OCCUPATIONAL HISTORY

Current Job? _____ Previous jobs? _____

Ever fired? _____ If yes, why? _____

Are you satisfied with your current job? _____

What ambitions do you have for your future? _____

Do you have any financial problems? _____

Any problems relating to your supervisors or co-workers? _____

RELIGION

Your religion _____

Have you or your spouse changed religion? Yes/No If yes, why? _____

Your church? _____

HOBBIES

List your interests and hobbies _____

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Have there been any changes in your interest or involvement in these activities? _____

LEGAL ISSUES/LAW VIOLATIONS

Have you ever been arrested, imprisoned, or appeared before a Youth Service Board? _____

If yes, explain: _____

MILITARY/SERVICE HISTORY

Were you in the services? _____Years _____ Branch _____

Date and type of discharge: _____

Rank at discharge: _____

ALCOHOL/DRUG HISTORY

What is your current & past alcohol consumption? _____

What is your current & past drug use (if any)? _____

How have alcohol and drugs affected your life? (e.g, legal issues, relationship problems, employment, health):

Have you experienced any physical or emotional reactions to your discontinuing use of drug or alcohol? _____

CURRENT PROBLEMS

Underline any of the following that apply to you: Delay in falling asleep, intermittent awakening, early morning awakening, oversleeping, mood swings, low energy level, changes in appetite, recent weight loss or gain, agitation, wishing to be dead, strange or fearful thoughts, excessive guilt, crying, decreased effectiveness at work or inability to concentrate headaches, dizziness, fainting spells, palpitations, stomach trouble, bowel disturbances, nightmares, take sedatives, alcoholism, feel tense, feel panicky, tremors, depressed, suicidal ideas, drugs, unable to relax, sexual problems, unable to have a good time, don't like weekends and vacations, over-ambitious, shy with people, can't make friends, feel lonely, can't make decisions, can't keep a job, inferiority feelings, home conditions bad, financial problems, hearing problems, vision problems, guilty, hearing voices

Explain the most important items underlined _____

My main reason for seeking help is:_____

Since they started, my problems have: Stayed the same _____ Improved _____Worsened _____

I feel the cause of my problems is: _____

My problems would be improved if: _____

How strongly do you want treatment for your problem? Circle your answer

Very much Much Moderately Could do without if necessary

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Have you had suicidal ideas? Yes/No Ever attempted suicide? Yes/No Do you think you would? Yes/No

List suicide attempts you have made: _____

_____

_____

Date or Age Method of Attempt Hospitalized? How Long?

_____

PREVIOUS MENTAL HEALTH COUNSELING OR TREATMENT

(List type of counseling/therapy, when it occurred, frequency, duration, name and location of therapist, results.)

_____

_____

_____

_____

Prior Psychiatric Hospitalizations (List Date, Hospital name and address, length of stay, voluntary or involuntary)

_____

_____

Please list family members' names, relations, and ages: _____

_____

_____

Please list family members who have had mental health issues and/or substance abuse issues: _____

_____

With whom do you live at present? (List name, age, sex, relationship to you) _____

_____

SOCIAL CONTACTS

Other important persons: Please list those persons with whom you have a strong current and continuing relationship.

_____

_____

Have you or do you take medications for medical problems and/or psychiatric problems? Yes/No

If yes, please list below Name Daily Dose Reason/Results

_____

_____

_____

Please summarize below the most important aspect of your life and would help our therapist understand you better.

_____

_____

_____

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Are you currently experiencing thoughts of hurting yourself or others? Yes No

If others, who are you planning to harm? _____

Are you currently wishing you were dead? Yes No Are you currently planning to suicide? Yes No

Is there anything else you want your therapist to know about you or your life?