Castillo Psychological, LLC

1605 S. Main St. **Phone: 575-527-0614**
Las Cruces, NM 88005 **Fax: 575-541-4062**
Email: services@castillopsychological.com

INTAKE INFORMATION

Name: _____ Social Security #_____

Date of Birth:_____ Age: _____ Guardian (if applicable) _____

Address: _____

City: _____ State:_____ Zip Code:_____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Employer: _____ School: _____

Highest Level of Education: _____

Referral Source: _____

Emergency Contact (name & number) _____

Please check if a message can **NOT** be left at the following number:

Home phone___ Cell Phone___ Work phone___

Medical Information

Primary Physician _____ PCP Phone _____

Medication _____

Medical Concerns _____

FINANCIAL INFORMATION

Primary Insurance: _____

Member ID #: _____ Group ID #: _____

Secondary Insurance:_____

Member ID #: _____ Group ID #: _____

Guardian and/or Policy Holder and relationship to client

_____

Guardian/Policy Holder's Social Security Number: _____

Guardian/Policy Holder's Date of Birth: _____

Consent to Bill Insurance:

1. I authorize use of this form to release information for all my insurance submissions.
2. I understand I am responsible for the full amount billed for services provided.
3. I understand I am expected to pay the deductible, co-pay or outstanding balance at the time of service.
4. I authorize direct payment from the insurance company to this provider.
5. I permit a copy of this authorization to be used in place of the original.
6. If I have a 30-day past-due balance, I understand that my services could be terminated.

_____ _____

Responsible Party Signature Date

MISSED APPOINTMENT POLICY

1. After 3 missed appointments without 24-hour notification, Castillo Psychological has the opportunity to discontinue treatment services.

2. If services are discontinued due to lack of attendance there will be a 3-month waiting period before returning to Castillo Psychological.

3. If you are not able to attend your appointment, notice to Castillo Psychological must occur 24 hours prior to the missed appointment.

4. If you arrive 15 minutes after your scheduled appointment, this does not allow ample time and the appointment will need to be rescheduled.

I have read and understand the above missed appointment policy and agree to follow the requirements.

_____

Print Name

_____ _____

Client Signature Date

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT VERSION

(* elements added with permission for Lifeline centers)

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

	Suicidal and Self-Injury Behavior (Past week)		
☐	Actual suicide attempt	☐ Lifetime	
☐	Interrupted attempt	☐ Lifetime	
☐	Aborted attempt	☐ Lifetime	
☐	Other preparatory acts to kill self	☐ Lifetime	
☐	Self-injury behavior w/o suicide intent	☐ Lifetime	
	Suicide Ideation (Most Severe in Past Week)		
☐	Wish to be dead		
☐	Suicidal thoughts		
☐	Suicidal thoughts with method (but without specific plan or intent to act)		
☐	Suicidal intent (without specific plan)		
☐	Suicidal intent with specific plan		
	Activating Events (Recent)		
☐	Recent loss or other significant negative event		
	Describe:		
☐	Pending incarceration or homelessness		
☐	Current or pending isolation or feeling alone		
	Treatment History		
☐	Previous psychiatric diagnoses and treatments		
☐	Hopeless or dissatisfied with treatment		
☐	Noncompliant with treatment		
☐	Not receiving treatment		
	Other Risk Factors		
☐			

	Clinical Status (Recent)
☐	Hopelessness
☐	Helplessness*
☐	Feeling Trapped*
☐	Major depressive episode
☐	Mixed affective episode
☐	Command hallucinations to hurt self
☐	Highly impulsive behavior
☐	Substance abuse or dependence
☐	Agitation or severe anxiety
☐	Perceived burden on family or others
☐	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
☐	Homicidal ideation
☐	Aggressive behavior towards others
☐	Method for suicide available (gun, pills, etc.)
☐	Refuses or feels unable to agree to safety plan
☐	Sexual abuse (lifetime)
☐	Family history of suicide (lifetime)
	Protective Factors (Recent)
☐	Identifies reasons for living
☐	Responsibility to family or others; living with family
☐	Supportive social network or family
☐	Fear of death or dying due to pain and suffering
☐	Belief that suicide is immoral, high spirituality
☐	Engaged in work or school
☐	Engaged with Phone Worker *
	Other Protective Factors
☐	

Describe any suicidal, self-injury or aggressive behavior (include dates):

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I have been provided a copy of the Information to New Clients, Mental Health Policies and Procedures, and Privacy Practices. I agree to participate in treatment with

_____ Janette E. Castillo, PH.D.

_____ Joe A. Castillo, LCSW

_____ Kandace McGee, LMSW

_____ _____
Signature of Client Date

If the client is a minor: I am the legal guardian/custodial parent of

_____ and give my permission to Janette Castillo, Ph.D. and therapists employed at Castillo Psychological, LLC to provide psychological or counseling services to my child.

_____ _____
Signature of Parent/Guardian Date