

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

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Patient Signature: _____

Date: _____

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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 | ☐ Frequent sadness |
| ☐ Sleep problems | ☐ Recent loss |
| ☐ Worry a lot | ☐ Parenting problems |
| ☐ Tense | ☐ Marital problems |
| ☐ Nightmares | ☐ Sexual problems |
| ☐ Poor appetite | ☐ Family problems |
| ☐ Excessive appetite | ☐ Work or school problems |
| ☐ Binge eating | ☐ Hearing voices |
| ☐ Weight loss | ☐ Do things over and over |
| ☐ Crying | ☐ Trouble making decisions |
| ☐ Poor concentration | ☐ Drug usage |
| ☐ Low energy | ☐ Drink too much |
| ☐ Energy loss | ☐ Family members drink |
| ☐ Hopelessness | ☐ Overspending |
| ☐ Fearfulness | ☐ Gambling |
| ☐ Lying | ☐ Jealousy |
| ☐ Shyness | ☐ Hurts self |
| ☐ Vomiting after eating | ☐ Trouble with law |
| ☐ Laxative use to control weight | ☐ Memory problems |
| ☐ Trouble expressing feelings | ☐ Feel someone is out to get you |
| ☐ Trouble managing anger | ☐ Feel taken advantage of |
| ☐ Physical Violence | ☐ Fears of _____ |
| ☐ Chronic Pain | |

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

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

List medications you are allergic to

Prior hospitalizations and why

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

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

Other diseases (specify) _____ YES or NO

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

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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

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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

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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

