

**Patient Information: Adult**

*(Please fill in completely. If there is no information for a question, please put NA)*

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL \_\_\_\_\_

PHYSICAL ADDRESS \_\_\_\_\_  
*(necessary in case of emergency)*

MAILING ADDRESS \_\_\_\_\_  
*(if different than physical)*

EMAIL: \_\_\_\_\_

I prefer to be notified by:

MEDICAL/PSYCHOLOGICAL HISTORY

CALL TEXT EMAIL

KNOWN PROBLEMS (INCLUDING HOSPITALIZATIONS, SURGERIES, APPROXIMATE DATES) \_\_\_\_\_

PREVIOUS MENTAL HEALTH TREATMENT (PLEASE LIST APPROXIMATE DATES) \_\_\_\_\_

PREVIOUS AND CURRENT MEDICATIONS (PLEASE INDICATE CURRENT MEDS) \_\_\_\_\_

ALLERGIES \_\_\_\_\_

DRUGSTORE NAME \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY CARE DR. \_\_\_\_\_ PHONE \_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_

EMPLOYMENT INFORMATION

OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

INSURANCE INFORMATION

PRIMARY INSURANCE CO. \_\_\_\_\_ PHONE \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

SECONDARY INS. CO. \_\_\_\_\_ PHONE \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

SPOUSE/PARENTS' INFORMATION (EMERGENCY CONTACT #1)

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

FRIEND OR RELATIVE AT DIFFERENT ADDRESS (EMERGENCY CONTACT #2)

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY TREATING PROVIDER OR SUPPLIER OF SERVICES.
SIGNATURE _____ DATE _____	SIGNATURE _____

**I VERIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE PATIENT INFORMATION IS ACCURATE**

**Signature Of Patient Or Responsible Adult** \_\_\_\_\_ **Date** \_\_\_\_\_

# Albemarle Psychological Services

Post Office Box 303  
Elizabeth City, North Carolina 27907-0303  
(252) 338-8821

## Offices

301 East Church Street  
Elizabeth City, NC

Martin's Point Professional Center  
6365 Croatan Highway, Suite A  
Kitty Hawk, NC

**Roger D. Allen, Ph.D.**  
**Catherine A. McGrogan, Ph.D.**  
Clinical and Consulting Psychologists

## LIMITS TO CONFIDENTIALITY

The information you provide to us is considered confidential and will not be released without your permission, with a few exceptions.

If you reveal information that you are a danger to yourself or to others, we may be required to contact your family, intended victims, or the police.

North Carolina law requires that we must report child abuse and neglect to the proper authorities.

If you have been involved in serious criminal activity, we may be required to notify legal authorities.

If your attorney or an opposing attorney subpoenas us to court, we can be ordered by a judge to reveal confidential information.

If you have any questions regarding these limits of confidentiality, please talk with Dr. Allen or Dr. McGrogan before you reveal any information having to do with the above issues.

I understand the above limits to my confidentiality.

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Signature

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Date

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Witness

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## FORENSIC SERVICE POLICY

At times, clients find it necessary for a psychologist to act as an expert witness in either civil or criminal matters. The American Psychological Association and the North Carolina Psychology Licensing Board have determined that it is unethical for a psychologist to act as an expert witness for a client that they have also seen for psychotherapy. This means that if you are coming to see us for therapy you must arrange to see another psychologist for an evaluation so that they can act as an expert witness for you if you require this service. If you are coming to us for an evaluation so that we may act as an expert witness for you, then we cannot see you for therapy. If you are a therapy patient and your attorney subpoenas us as a fact witness, we may give no conclusions, opinions, or recommendations. We cannot bill healthcare insurance for forensic services. If you have questions about this policy or if you have any legal actions pending for which you might require the services of a psychologist, please discuss this with Dr. Allen or Dr. McGrogan at your first appointment so that our role can be clarified from the outset. **WE CANNOT PROVIDE BOTH SERVICES FOR YOU.**

This Forensic Policy applies most frequently to divorce/custody proceedings. For example, if we have seen a child for treatment, should the parents separate, we cannot give any legal opinions regarding custody or visitation. If a psychological opinion is needed for a situation like this, the parties involved need to obtain a separate forensic evaluation from another provider not in our practice.

### FORENSIC SERVICE FEE POLICY

There will be a \$3000.00 retainer due prior to any evaluation, testing, consultation with your attorney or court appearance. As the evaluation continues you will be required to add additional money to your retainer as the psychologist's time is billed against the retainer. Whether we are **Expert** or **Fact** Witnesses, time will be billed as follows:

\$3000.00 For court time, billed only in units of whole days.

\$300.00 Per hour for time used for evaluation, testing, report writing, obtaining information from sources, court preparation, attorney consultation, any other psychologist's time.

These fees are **NOT** billable to your health insurance. They will be deducted from the \$3000.00 retainer. If any amount of the retainer remains after your forensic work is finished, we will issue you a refund with an itemized statement.

I understand the above Forensic Service Policy and agree to the above Forensic Service Fee Policy for services as both an expert and fact witness. I understand that this document is a binding contract and I have received a copy of this document.

HAVE YOU RECENTLY, ARE YOU CURRENTLY, OR ARE YOU IN A SITUATION THAT IS LIKELY TO RESULT IN ANY KIND OF LEGAL ACTION?  
YES \_\_\_\_\_ (  CIVIL OR  CRIMINAL ? ) No \_\_\_\_\_

**IF YES, ATTORNEY'S NAME AND ADDRESS:** \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness