PATIENT INTAKE FORM

Diversified Psychotherapy, Inc.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name, First Name Initial
Address _____
City _____ State _____ Zip _____
Sex ☐ M ☐ F Age _____ Birth date _____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Domestic Partner
Patient Employed By _____ Occupation _____
Home Phone _____ Mobile phone _____
Whom may we thank for referring you? _____
In case of emergency, who should be notified? _____ Phone _____

Psychiatric/Medical/Family History

Please answer these questions as best as you can to help facilitate a more thorough evaluation.

PAST PSYCHIATRIC HISTORY

Please check the box that applies:

Seen a psychiatric practitioner	☐ Yes ☐ No	Suicide attempts ☐ Yes ☐ No
Been on psychiatric medications	☐ Yes ☐ No	Alcohol/drug treatment ☐ Yes ☐ No
Counseling	☐ Yes ☐ No	Legal problems ☐ Yes ☐ No
Hospitalization	☐ Yes ☐ No	DUI/DWI conviction ☐ Yes ☐ No

MEDICAL HISTORY

Indicate which of the following you have experienced or are currently experiencing:

☐ Heart surgery/disease/attack	☐ Liver disease (inc. jaundice)	☐ Paralysis, stroke
☐ Severe muscular/skeletal problem	☐ Sexually transmitted infection	☐ Seizure
☐ Diabetes	☐ Currently pregnant	☐ Neurological disorder
☐ Thyroid disease	☐ Currently nursing	☐ Stomach problem
☐ High blood pressure	☐ Bleeding tendencies	☐ Visual impairment
☐ Cancer	☐ Severe respiratory problem	☐ Hearing impairment
☐ Hepatitis	☐ Severe urinary tract problems	☐ Glaucoma

If you checked any of these conditions, or are experiencing others, please indicate the specific nature here:

_____
_____

If you have a family history of these conditions, **psychiatric or substance abuse**, or similar conditions, please indicate the specific nature here:

_____
_____
_____

PAST PSYCHIATRIC HISTORY

Height: _____ Weight: _____

Please indicate any prescribed and/or over-the-counter medications that you are currently taking.

MEDICATION
DOSAGE (mg)
FREQUENCY

Allergies _____

Have you seen a physician in the past two years? ☐ Yes ☐ No

Date of last physical exam: _____

Primary Care Physician _____

Telephone number _____

Problem List

CURRENT PROBLEMS

I am currently experiencing the following problems (please check all that apply)

☐ Marital relationship problems

☐ Physical abuse

☐ Problems on the job

☐ Losing someone or something close to me (person, job, pet, moving, etc.)

☐ Problems with my children

☐ Sexual abuse

☐ Current problems from past sexual abuse

☐ Alcohol abuse

☐ Drug abuse

☐ Feeling guilty about past misdeeds

☐ Feeling that I am no good

☐ Feeling the need to get more sleep

☐ Losing pleasure in my daily activities

☐ Often feeling restless or irritable

☐ Thinking about dying or killing myself

☐ Trouble keeping my mind on a task

☐ Feeling the urge to do something unnecessary

☐ Checking, hand washing, hair pulling

☐ People following me, out to hurt me, or talking about me

☐ People reading my thoughts

☐ Hearing voices

☐ Thoughts being put into my head, controlling me, making me do things

☐ Special messages to me from TV or radio

☐ Feeling emotionally "numb"

☐ Recurring nightmares

☐ Frequently feeling startled

☐ Being troubled by painful memories

☐ Parts of my body not functioning well

☐ Feeling aches and pains all over my body

☐ Often feeling sickly

☐ Fear of having or getting a disease

☐ Feeling sad or "down in the dumps"	☐ Problems with my memory
☐ Preoccupied with sexual thoughts or urges	☐ Knowing where or who I am
☐ Needing less sleep than usual	☐ Getting lost or confused
☐ Spending sprees	☐ Having trouble remembering my past
☐ Trouble making myself slow down or talk less	☐ Finding things I don't remember having
☐ Fear of crowds or public places	☐ Feeling that I've lost time
☐ Specific fear of a thing or place	☐ Urges to do something harmful to myself or others
☐ Attacks of fearfulness where I feel I need to run	☐ Urges to set fires
☐ Heart palpitations	☐ Difficulty controlling my temper
☐ Chest pains or discomfort	☐ Feeling anger or resentment
☐ Feeling dizzy or unsteady	☐ Taking laxatives to control my weight
☐ Feeling things that aren't there	☐ Vomiting to control my calorie intake
☐ Tingling in hands or feet	☐ Exercising frequently and vigorously
☐ Hot or cold flashes	☐ Fasting in order to control my weight
☐ Trouble breathing	☐ Feeling helpless about my eating habits
☐ Feeling trembly or shaking	☐ Extreme changes in my weight
☐ Fears of dying or going crazy	
☐ Feeling the urge to avoid certain places or objects	
☐ Feeling troubled by repetitive thoughts	
☐ Feeling anxious and nervous	
☐ Worrying about things over and over	

Any other problems not mentioned above

_____

ASSIGNMENT AND RELEASE

I give permission for treatment of myself/my dependent to my assigned provider.

_____ _____ _____

Responsible Party Signature / Relationship **Date**

Patient Financial and Fee Agreement

Your insurance will be billed at the following rate or contracted rate. You will be responsible for co-pays, co-insurance, or deductibles as directed by your insurer at the time of service.

TREATMENT	PSYCHOTHERAPY
Initial evaluation and diagnostic consultation	$225.00
Individual psychotherapy session	$180.00
Family/Couple psychotherapy session	$180.00
Video psychotherapy session	$180.00
Telephone psychotherapy session > 15 minutes	$180.00
Court testimony, inc. travel, wait time (per hour)	$300.00
Missed appointment	$180.00
Late cancellation (less than 24-hour notice)	$180.00
Court Progress Reports	$225.00 +

Due to insurance carriers' tardiness regarding service claims submitted by providers, please read the following information:

If your insurance company does not respond in a timely fashion, a "Statement" will be released to you. Upon receipt of the "Statement" we suggest that you contact your insurance carrier and request that they process your claim.

Should you receive any correspondence from your insurance company regarding your services in this office, **you must respond to that correspondence immediately,** in order to have the claim processed and paid.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance at the time of service. Additionally, your insurance does not pay for late cancellations or missed sessions. You are responsible for this payment as noted above.

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process my insurance claim.

Insured's or authorized person's signature: I authorize payment of medical benefits to the provider for services. I fully understand that, regardless of insurance coverage, I am legally responsible for all fees due to my provider.

Print Name _____ Date _____

Responsible Party's Signature _____ Date _____

PAYMENTS CAN BE MADE BY USING PAYPAL – THERAPY@MICHAELNAVA.COM

Returned checks will be assessed a $45.00 fee. Please note that unless your appointment is cancelled with a 24-hour notice, late cancellation fees will apply. Delinquent accounts are subject to referral to collection agencies and interest at a rate of 10% per annum will apply for balances over 60 days old.

Diversified Psychotherapy, Inc.
Michael Nava, Ph.D., LCSW
Concord, CA 94518
(562) 743-2789 License: LCS 21160

CONSENT FOR TREATMENT AND OFFICE POLICIES

I, _____, authorize and request that Dr. Michael Nava provide psychological examinations, treatment and/or diagnostic procedures, which now or during the course of my care as a client are advisable. The frequency and type of treatment will be decided between my therapist and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

The scheduling of an appointment involves the reservation of time specifically for me. To avoid being charged for a missed session, I will inform of my cancellation at least 24 hours in advance by calling (562) 743-2789.

All information disclosed within sessions, including that of minors is confidential and may not be revealed to anyone without my written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- When there is a reasonable suspicion of child abuse or abuse to a dependent or elder adult.
- When the client communicates a threat of bodily injury to others.
- When the client is suicidal.
- When disclosure is required pursuant a legal proceeding.

I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FOR TREATMENT AND OFFICE POLICIES FORM

_____ _____