

Chat with Jill

Patient Information

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

Male ___ Female ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Address: _____

City, State, ZIP: _____ Referred by: _____

Employer: _____ Occupation: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Would you like to receive our email newsletter? Yes ___ No ___

What phone number/method is best for communication with you: Home ___ Work ___ Cell Phone ___ Email ___

In the event of an emergency whom should we contact:

Name: _____ Relationship: _____

Cellular # _____ Work # _____ Home # _____

Who Is Responsible for this account? Who is the insured?

Name: _____ Relationship to Patient: _____

Birthdate: _____ Soc. Sec. # _____

Address: _____

City, State, Zip: _____

Insurance Co. Name and Policy #: _____

Insurance Co. Phone # for Mental Health: _____

Employer: _____ Occupation: _____

Work # _____ Home # _____ Cell # _____

Authorization and Release:

- ❖ I authorize the release of necessary information to third party payers/insurance companies and/or other health practitioners.
- ❖ I authorize/request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me.
- ❖ I am informed of HIPAA guidelines and regulations related to confidentiality of medical records.
- ❖ I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

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❖ I agree to notify your office more than 24 business hours in advance if I need to reschedule or cancel an appointment.

X _____

Signature of Patient or Responsible Party

_____ Date

*****Please Provide Your Insurance Card & Driver's License for Verification of Benefits and Identity*****

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Credit Card Authorization

(Cash or check are the preferred method of payment; however a check or credit card retainer on file.)

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee. An additional \$25 fee will be assessed for 1.) Returned checks, and 2.) Inaccurately disputed charge-backs.

I, _____, hereby authorize Jill Robin Payne PLLC to bill my credit card or cash check at the usual fee for professional services including all of the following:

- ❖ Appointments and/or copayments that I elect to pay for by credit card
- ❖ Missed appointments
- ❖ Telephone and email consultations
- ❖ Appointments that I have cancelled with less than 24 business hours' notice
- ❖ Returned checks
- ❖ Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card/Debit Card Type (check one):

Visa MasterCard Discover American Express

Card # _____ Expiration Date: _____

Verification/Security Code (3-digit code on back of card by signature line): _____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

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By signing below I am authorizing Jill Robin Payne, PLLC to bill my credit card at the usual fee for professional services as described above.

Signature: _____ Date: _____

Print Name: _____

ALL ABOUT YOU (THE PATIENT)

About Your Education:

Where did you attend public school? _____

Did you attend college/professional school? When, where, degree earned? _____

Any plans to further your education? _____ If so, when and what? _____

About your Relationships:

Please list your marriage(s) or other important "significant-other" relationships

	Spouse's name	Year Begun	Year Ended	Married to this person?	Children from this relationship and their ages
#1					
#2					
#3					
Please list all people who currently live with you					

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About Your Family:

Relative	Name	Living?	Current age, or age at death	Occupation	Describe the Relationship
Father					
Mother					
Brother(s)					
Sister(s)					
Any other significant person?					

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ABOUT YOUR CONCERNS

Please check all of the items below that you currently experience or are having difficulty, and feel free to add any others at the bottom under "Other concerns or issues." You may add details as needed to clarify.

Abuse – emotional	Impulsive spending	Self-abuse – burning
Abuse – neglect	Impulsiveness	Self-abuse – cutting
Abuse – physical	Indecision	Self-abuse – other
Abuse – sexual	Inferiority feelings	Self-abuse – scratching
Aggression	Inhibitions	Self-centeredness
Anger	Interpersonal conflicts	Self-control
Anxiety	Irresponsibility	Self-esteem
Arguing	Irritability	Self-neglect
Attention Problems	Judgment problems	Separation
Career Concerns	Laziness	Sexual conflicts
Childhood Issues	Legal matters	Sexual desire differences
Children – care of	Loneliness	Sexual dysfunctions
Children – custody	Loss of control	Sexual – other issues
Children - management	Losses	Shyness
Choices I have made	Low energy	Sleep – insomnia
Codependence	Low frustration tolerance	Sleep – nightmares
Compulsive spending	Low income	Sleep – too little
Concentration problems	Low mood	Sleep – too much
Confusion	Marital coldness	Step-parenting
Crying	Marital conflict	Stress
Deaths	Marital distance	Stress-management
Debt	Marital infidelity/affairs	Suicidal thoughts
Decision making	Medical concerns	Suspiciousness
Delusions – false ideas	Memory problems	Temper problems
Dependence	Menopause	Tension/stress
Depression	Menstrual problems	Thought disorganization
Distractibility	Mixed feelings	Threats of violence
Divorce	Mood swings	Tiredness

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Drug abuse – over the counter	Motivation	Tobacco use
Drug abuse – prescription	Mourning	Violence
Drug abuse – street drugs	Obsessions	Violence – victim of crime
Drug abuse – alcohol	Outbursts	Work problems
Eating – poor appetite	Oversensitive to criticism	Weight and diet issues
Eating – making myself vomit	Oversensitive to rejection	Withdrawal – isolating
Eating – overeating	Panic or anxiety attacks	Employment problems
Eating – under-eating	Parenting	Employment – lack of
Emptiness	Perfectionism	Employment – overdoing
Failure	Pessimism	Employment – termination
Fatigue	Phobias	Other Concerns or Issues:
Fears	Physical problems	
Financial troubles	PMS	
Friendship problems	Poor self-care	
Gambling	Procrastination	
Goals not being met	Relationship problems	
Grieving	Relaxation	
Guilt	Re-marriage	
Headaches, pains	Risk taking	
Health	Sadness	
Hostility	School problems	

The following information is very helpful in case we need to contact your physician or psychiatrist. Please provide accurate contact information. Thank you very much for providing this so we may be of help to you.

About Your Health:

Who is your Medical Doctor? _____ Last Visit: _____

Phone/Address _____

Medical Concerns? _____

Prescribed Medications _____

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Who is your Psychiatrist? _____ Last Visit: _____

Phone/Address _____

For what reasons/issues? _____

Prescribed Medications _____

Have you previously seen a counselor/therapist? _____ Name: _____

Phone/Address (if recent) _____

Reason for visits: _____

Do you have any chronic medical or mental-health conditions or concerns? _____. If so, please list: _____

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had: _____

List **all other** medications or drugs (prescribed or street) you take or have taken in the last year: