Psychologist

Addiction Counselor

Patrick A. Quigley, Ph.D., LSAC

Thank you for considering my services. The material on this site will take you through the intake paperwork that you will need to bring to the first session. I look forward to meeting you and the work ahead.

(480) 759-6191 • Fax (480) 339-6096 • 4350 E. Ray Road, Suite 101B • Phoenix, Arizona 85044

Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager# _____

eMail Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Gender ( ) Male ( ) Female

Employer or School _____ Employment Status _____

Referred By _____ Field 1 _____

Field 2 _____ Field 3 _____

Is the patient covered by insurance? ( ) Yes- Go to section 2

( ) No - Go to section V on back page of this form

Section II - **Insured Information**

Patient Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

If "Patient Relationship to insured" is other than "Self" please complete the following. If patient is the insured go directly to section III.

Insured's Name _____

Address _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____

Date of Birth / / Social Security Number _____

Marital Status _____ Gender ( ) Male ( ) Female

Employer or School _____ Employment Status _____

Section III - **Insurance Policy Information**

( ) Medicare ( ) Medicaid ( ) ChampUS ( ) ChampVA ( ) Group Health Plan

Other Insurance Company _____

Address _____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number Group Number _____

Is the patient covered by more than one insurance ? ( ) Yes - Please complete Section 4 - Page 2

( ) No - Please return this form to the Receptionist

(Over)

Section IV- Secondary Insurance Policy Information

( ) Medicare ( ) Medicaid ( ) ChampUS ( ) ChampVA ( ) Group Health Plan

Other Insurance Company _____

Address _____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number _____ Group Number _ _ _ _ _ _ _ _ _ _ _ _ _ _

Section V - Billing Information

(Complete only if there is no insurance coverage.)

Who is responsible for charges for this patient. ( ) Patient - Please return this form to the Receptionist.
( ) Other- Please Complete the following information.

Name _____

Address _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _ _ _ _ _ _ _ _ _ _ _ _ _

Date of Birth / / _____ Social Security Number _____

Marital Status _ _ _ _ _ _ _ _ _ Gender ( ) Male ( ) Female

Employer or School _____ Employment Status _____

Section VI- Mental Health Authorization and Billing: If you intend to use insurance for mental health or substance abuse treatment, call the customer service number on your card and find out the specifics of your coverage. In some cases, this will involve a behavioral health provider network and a utilization management company providing any required authorization and benefit payments that is different from your insurance company. In addition, if provider services are limited to a restricted panel, you must verify that Patrick A. Quigley, Ph.D. is recognized as a member of that provider group.

The following information must be completed in order to access insurance benefits. If this section is not filled out, it is assumed insurance does not apply.

Behavioral health management company:
Name _____
Phone Number (including area code)_____

Your mental health ID # (if different from your insurance plan ID #)_____

Patient Co-pay (per Session) $_ or % of fee patient pays $_____

Plan Deductible (if any) $_____Deductible already paid $_____

Sessions available yearly_____

Treatment authorization number (if applicable)_____

Number of sessions authorized __ __ __

Claims are mailed to: _____

_____

NOTE: Fee Payments: Cash, checks, credit cards, and PayPal are accepted.

HAVE YOU HAD AN PRIOR PSYCHIATRIC CONSULTATIONS?

( ) No ( ) Yes When: WHERE Therapist:

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS?

( ) No ( ) Yes When: Where: Therapist:

FAMILY MEMBERS AND OTHERS NOW IN HOUSEHOLD

Name	Relationship	Birthdate		OCCUpation	

ORIGINAL FAMILY (Mother. Father. Brother&. Sister)

Name	Relationship	Birthdate.	Birthplace	OCCUPATION	M.ARITAL STATUS

CHILDREN LIVING AWAY FROMHOME

HEALTH HISTORY QUESTIONNAIRE

Name:_____ Date:_____

D.O.B.:_____ Age:_____ Sex:_____ Hgt:_____ Wt:_____

Therapist:_____ Primary Care Physician:_____

Date last seen by Medical Doctor:_____ Date last Physical Exam:_____

Laboratory Used:_____

Allergies:

_____:_____

Other:_____

Current Medication:

Name of Medication		Frequency

FAMILY HISTORY

			Relationship
Emotional Problems	Yes []	No[]	
Substance Abuse	Yes []	No[]	
Cardiovascular Disease	Yes ()	No[]	
Hypertension	Yes [ ]	No()	
Kidney Disease	Yes []	No[]	
Respiratory Disease	Yes []	No[]	
Cancer	Yes []	No[]	
Diabetes Mellitus	Yes []		

PERSONAL IDSTORY

Emotional Problems	Yes []	No[]	Substance Abuse	Yes [ ]	No[]
Cardiovascular Disease	Yes []	No{}	Hypertension	Yes [ ]	No[ ]
Kidney Disease	Yes []	No[]	Liver Disease	Yes ( ]	No[]
Respiratory Disease	Yes []	No[ ]	TuBerculosis	Yes ( ]	No[].
Diabetes Mellitus	Yes[]	No{}	Cancer	Yes ( ]	No[ ]
Thyroid Abnormalities	Yes()	No[]	Neurological Abnormalities	Yes ( ]	No{}
Head Injuries	Yes []	No[ ]			

Past Surgeries (Date and Types):_____

Hospitalizations (Date and Types):

Medical:_____

Psychiatric:_____

Do you Smoke? Yes [ ] No ( ] How much per day? _____ How many years?_____

Do you use alcohol or drugs? Yes [ ] No [ ] Type:_____

How much per day?_____ If yes, have you felt the need to cut down?_____

Do you have access to a gun or other weapon? _Yes _NO

Psychologist

Addiction Counselor

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AN AGREEMENT FOR PSYCHOLOGICAL SERVICES

A psychologist is a licensed health care professional. Psychologists, who practice in a community or neighborhood setting, usually offer psychological counseling and sometimes psychological testing to their clientele. These services are offered to people of all ages and in .individual, family, or group settings. My psychological practice is a general, clinical practice. I work with children, adolescents, and adults. I see people individually, in couples, or as a family. Most of my work involves psychotherapy. This is the use of verbal communications to help individuals resolve personal behavioral, emotional, mental, or relational problems.

Psychotherapy comes in different varieties. I will make the best match between your goals, the resources you make available for these services, and the commitment you are willing to make to achieve your personal goals. Where your goals are unclear, I will strive to help you define them. If your goals or resources change in the course of treatment, please let me know so that I can make adjustments. Honesty, candor, and trust are obviously essential for this process to work. The work of personal change can be quite anxiety provoking and at times you may feel that you are not making progress when, in fact, you are. I will make every effort to provide a safe, nurturing, and informative environment. Anything less than total candor will undermine the goals for treatment. You will need to let me know about any feelings of discomfort so that I can make appropriate adjustments or help you understand why we should not. I will not knowingly ask or suggest that you do anything harmful.

Your treatment is confidential and privileged. I will not disclose your presence here or the content of our sessions without your explicit consent. Imminent danger to yourself or another is a legally and ethically limiting condition to this confidentiality. Also I am a mandated reporter of child abuse and neglect. Should you decide to use insurance to pay for part or all of your treatment, I may have to disclose some information to help you access your benefits.

My practice, whether doing psychotherapy or assessment, is clinical and not forensic. My work with people is for the resolution of personal issues and difficulties and not for legal documentation or assessment. If you would like your records for this purpose, I will provide you with a copy and not more than this. I do not work as an *expert witness*. I do not do custody evaluations. Custodial and forensic psychology services are best handled by specialists and I will be glad to make the appropriate referral.

My fees are $175 for the initial consultation and $160 for subsequent sessions. The sessions are usually 45 minutes. Full fees or insurance plan co-pays are due at the end of each session. Time spent scoring tests or preparing reports are billed the same as individual, face-to-face sessions. Many people use their insurance to pay for part or all of their treatment. Your insurance plan will have its own requirements and limitations, which may or may not coincide with the goals and purposes of your treatment. I will make the clinical differences known to you, as I am aware of them. However, it is *your responsibility* to know the parameters of your insurance coverage and *you are ultimately responsible for the payment of services received.* Insurance is accepted only as an accommodation to you. Professional time spent obtaining insurance benefits authorizations, completing insurance-related reports or coordinating with insurance care managers is billed directly to you at the session rate in quarter-hour increments. Delinquent accounts overdue at 90 days may be sent to collections.

Return appointments are scheduled in advance, at the end of each session. This is the best time to change the schedule if necessary. An appointment must be cancelled at least 24 hours in advance to avoid a $100 late cancellation fee.

If we decide that your treatment should involve an additional health care provider, at your discretion, I will endeavor to establish coordination of care with the other provider.

Your participation in psychotherapy is voluntary. You may stop at any time. I feel that this decision is best discussed face to face. Likewise, if i feel that our work together should suspended or terminated, I will share this with you.

Accepted by: _____ _____

Signature of responsible party Date

form date 11/14/2012