PATRICIA BLAKE, PH.D. AMY COREY, PH.D.
Licensed Psychologists / Independent Practitioners
440 Regency Parkway Dr. Suite 230 Omaha, NE 68114
Tel: 402-769-2121 Fax: 402-991-2500
www.OmahaPsychology.net

Date _____

Referred by: □ Healthcare Provider: □ Phone Book □ Insurance □ Internet □ Other:

PERSONAL INFORMATION

Name □ Male □ Female
Address
City/State/Zip
Date of Birth Age Place of Birth
With whom does client live? (i.e., alone, spouse, parents, significant other, etc.)
Home Phone Okay to leave detailed message? □ Yes □ No
Cell Phone Okay to leave detailed message? □ Yes □ No
Email Address Okay to leave detailed message? □ Yes □ No
How do you prefer to be contacted by our office? □ Home phone □ Cell Phone □ Email

EMPLOYMENT

Occupation Employer How Long?
Address City/State/Zip Phone

MILITARY

Branch Years Served Rank
Where did you serve? Duties

MARITAL STATUS

□ Single □ Married year: □ Separated year: □ Divorced year: □ Widowed year:
Spouse Name Date of Birth Age
Occupation Employer

Names of Children/Stepchildren Male/Female Age

FAMILY HISTORY

Father's Name Age Occupation
If deceased, year of death Cause of death

Mother's Name Age Occupation
If deceased, year of death Cause of death

Names of Brothers/Sisters Male/Female Age

Is there a family history of mental illness or substance abuse? □ Yes □ No
If yes, please explain:

EDUCATION

High School Year Graduated
College Year Graduated
Degree(s)
Vocational, technical, or other training

LEGAL ISSUES
Please list any past or current court or legal issues.

MEDICAL

Primary Care Physician How long?
Address
City/State/Zip Phone
Is it okay if I notify your physician about your visit? □ Yes □ No

Medications	**Condition**	**Dose/Frequency**	**Name of Prescriber**

Physical Health Treatment History: (please list physical conditions, serious illnesses, injuries, and treating physicians. If hospitalized, name of hospital, dates, and duration of hospital stay.)

Is there a family history of serious medical conditions? □ Yes □ No
If yes, please explain:

Substance Use/Gambling

Tobacco □ Yes □ No Type: How much and how often?
Alcohol □ Yes □ No Type: How much and how often?
Other drugs □ Yes □ No Type: How much and how often?
(marijuana, cocaine, methamphetamines, painkillers, etc.)
Caffeine □ Yes □ No Type: How much and how often?
Over-the-counter □ Yes □ No Type: How much and how often?
Gambling □ Yes □ No Has it caused financial and/or relationship problems? □ Yes □ No

MENTAL HEALTH TREATMENT HISTORY

Please list conditions, treating providers, dates of treatment, inpatient or outpatient. If hospitalized, name of hospital, dates and duration of hospital stay.

CURRENT PROBLEMS

Please describe the reason for today's appointment.

RESPONSIBLE PARTY – Who is responsible for payment on this account?

Name _____ Relationship to Client _____

Address _____ Phone Number _____

City/State/Zip _____

FINANCIAL ARRANGEMENTS – Select One ***Signature Required***

□ I will be utilizing my insurance coverage and **I will make my co-payment at each appointment.** I understand that submitting a claim to my insurance carrier is not a guarantee of payment. Contract provisions may apply (such as deductible, coinsurance, eligibility, pre-existing conditions, exclusions, limitations, etc.) as well as non-covered charges for services that are not deemed medically necessary by my insurance carrier. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize and request my insurance company to pay directly to the psychologist.

_____

Signature of client, guardian, or legal representative *Date*

□ I will not be utilizing insurance coverage and **I will make payment in full at each appointment.**

□ My insurance coverage is state or federally funded and **I am not responsible for any co-payment.**

_____

Signature of client, guardian, or legal representative ***Date***

(Cash, personal check, Visa, debit cards accepted)

CONSENT – Select One ***Signature Required***

□ I agree to take part in **treatment** with the undersigned psychologist. I understand that treatment is voluntary and that I may stop treatment at any time. I understand that no promises have been made to me regarding the results of treatment or of any procedures provided by the psychologist.

□ I agree to take part in **an evaluation** with the undersigned psychologist. I understand that the evaluation is voluntary. I understand that no promises have been made to me regarding the results of the evaluation. I understand that the evaluation may include an interview, psychological testing, and other assessment techniques.

I understand that I am responsible for payment of services I have received. I understand that if I fail to make a payment, the psychologist may take appropriate steps to collect payment.

I am aware that my insurance company (or other third-party payor) may require information about the type, cost, date, and provider of any services or treatment I receive. My signature below shows that I have read and understand these statements.

_____

Signature of client, guardian, or legal representative *Date*

_____

Signature of Psychologist *Date*

We are independent providers who share certain expenses and administrative functions. While we share office space, each provider is completely independent in administering clinical services. Each provider alone is fully responsible for these services. The professional records of each provider are separately maintained and only your psychologist can access them unless you provide written, specific permission.

I acknowledge that a complete copy of the Privacy Notices as required by the federal governments' HIPAA legislation is available upon request.

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Signature of client, guardian, or legal representative *Date*