Thomas H. White, Ph.D.

Child, Adolescent, Adult and Family Psychology
Licensed Psychologist

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WELCOME TO THE OFFICE

Enclosed you will find a questionnaire. This questionnaire is to assist us in better understanding your situation/problem. We recognize that there are a lot of questions, so if you do not understand a particular question or feel uncomfortable answering a question, feel free to leave it blank. We will review this questionnaire and discuss it thoroughly with you in our first appointment. We ask that you bring this packet with you to your first appointment along with your insurance card.

Please arrive 10 minutes early to check in with our reception staff. If you are unable to keep this appointment, we ask that you please call our staff so that they can assist you with re-scheduling or canceling the appointment.

Treatment with our office is voluntary and can be terminated at any time without penalty. Our goal is to be as helpful to you as possible and to assist you in most effectively dealing with your current problems. If at any time you have questions, concerns or ways we might improve our services, we would appreciate your input.

I understand that, in all cases, strict standards of confidentiality and professional ethics will be maintained. I give my permission to be treated by this office.

_______________________________________ Client

____________________ Date

(Parent/Guardian if client is a minor)

Dr. Thomas H. White, Ph.D., is a licensed psychologist who has been in private practice since 1984. Prior to entering private practice, Dr. White was the school psychologist and special education coordinator for the Franklin County School System, and later the Buford City School System. He was a member of the committee that re-wrote the Georgia Department of Education Guidelines for the Learning Disabilities program. He received his Masters and Doctoral degrees from the University of Georgia in Educational Psychology, and then continued his training in Clinical Psychology through internships at Georgia Baptist Medical Center and Atlanta Area Psychological Services.

Client Information

Date: ______________________________ SS#: ____

Client's Name: ____
First Middle Last

Address: ________________________________ City:______ _______________ Zip: _____________

________________________________ State: ______________________ Ph#: _____________

DOB: _____________ Age: _______ Male ________ Female ________Marital Status: ____________

Employer: _______________________________ Address: _____________________________________

Employer's Phone: _________________________

Who referred you to this office: ____

Who can we call in case of an emergency:_____________________________________

Phone: ____________________________________

INSURANCE INFORMATION

<u>Primary Insurance</u>

Ins. Co.: __________________________________ Policy #: __________________________________

Address: __________________________________ Group #: __________________________________

__________________________________ Policy Holder: _____________________________

Employer: _________________________________ Phone #: __________________________________

Ins. Verification Phone #: _____________________

<u>Secondary Insurance</u>

Ins. Co.: __________________________________ Policy #: __________________________________

Address: __________________________________ Group #: __________________________________

__________________________________ Policy Holder: _____________________________

Employer: _________________________________ Phone #: __________________________________

Ins. Verification Phone #: _____________________

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<u>Authorization</u> – Valid for Third Party Payer Only

I authorize this office to release any and all information regarding my treatment to the forenamed insurance company(s) or its legal representative. Any such disclosure shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the insurance company.

____ ____________________________
Client (Parent/Guardian if the client is a minor) Date

Who will be responsible for any billed amount not paid by insurance?

_____________________ ___________________________________ ______________
Name Signature Date

FINANCIAL POLICY

It is the policy of this office to request payment for services at the time the service is rendered. If it would be more helpful for you to pay the deductible and co-payment, we will be glad as a service to file your insurance for you. However, we cannot guarantee payment in part or in full by any insurance company or other party, and therefore, you are ultimately responsible for any charges you incurred. Co-payments are requested at the time of service. We also accept payments by Visa/MasterCard.

We want to be sensitive to financial hardships that you may have and we will be glad to develop alternative methods of payment. Please discuss this with us and we will be glad to work with you in any way possible. However, if you fail to follow the mutually agreed to method of payment, we will consider the charges to be delinquent and will take appropriate action to receive payment for the charges incurred.

MISSED APPOINTMENTS AND CANCELLATIONS:

We require a 24-hour notice of cancellation if you are unable to keep your scheduled appointment. There will be a charge for any appointment, which is not canceled with a 24-hour notice. Please be aware that your insurance company will not reimburse for missed appointments. If you have two consecutive missed appointments without 24-hour notification, you will not be rescheduled.

FORMS AND LETTERS:

A fee will be incurred for the completion of forms and letters. Your doctor and/or therapist can inform your of the specific charge.

NOTE: In cases of divorce and/or separation, the parent who originally brought the child in for services is responsible for paying this office, regardless of which parent is legally responsible for insurance coverage and medical bills, as established by a divorce or any other agreement. Assignment from the non-custodial parents insurance carrier will be accepted only after this office has his/her signature on file.

I HAVE READ AND UNDERSTAND THE ABOVE BILLING POLICY. I AGREE TO PAY FOR SERVICES UNDER THE CONDITIONS AND SPECIFICATIONS SET FORTH IN THIS BILLING POLICY AND ACKNOWLEDGE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES PROVIDED, REGARDLESS OF INSURANCE COVERAGE.

______________________________	______________________________
Signature of Client	Witness
______________________________	______________________________
Date	Date
______________________________	______________________________
Signature of person responsible for bill after insurance	Date

Name: ______________________________ Date: ______________

DOB: ______________________________ Age: ______________

Address: ____

Phone # (home): ____________________ (work) ____________________

Who referred you to our office: ______________________________

Primary Care Doctor: ______________________________

School (if child): ______________________________ Grade: ______________

I. Describe in one sentence what prompted you to schedule this appointment: ______________

____

____

What problems are you currently experiencing?	How long has this been present?	Is this worsening, improving or unchanged?
1.		
2.		
3.		
4.		
5.		

Please circle all that apply:

Decreased appetite
Increased appetite
Low energy
High energy
Withdrawal from others
Decreased ability to enjoy things
Excessive worrying
Explosive temper
Self-criticism
Tearfulness

Frequent crying
Impulsivity
Distractibility
Decreased concentration
Sleeping too much
Decreased sleep
Trouble waking too early
Violence
Aggression
Nightmares

Visual hallucinations
Auditory hallucinations
Intrusive thoughts
Bothersome thoughts
Inability to hold a job
Relationship problems
Sexual problems
Alcohol or drug problems
Legal problems

If the patient is a child, please circle symptoms that apply:

History of ADHD
Decline in grades
Stealing
Avoidance of school
Cruelty to animals
Drug use
Bedwetting
Lack of respect for authority

Learning disabilities
Fire setting
Lying
Runaway
Skipping school
Alcohol use
Developmental disabilities
Problems getting along with friends

School failure
Explosive behavior
Unusual fears
Sexual activity
Tics
Tobacco use
Problems with the law

Significant stressors experienced in the past year:

___Major losses:	
___Moves:	
___Work:	
___Family:	
___Other:	

II. Past Psychiatric History:

Previous Outpatient Treatment	Treatment Dates	Treatment Provider	Reason for Treatment	Results
Psychiatric Hospitalizations				

Prior medication for depression, anxiety, etc…

Date	Name	Dosage	Response

III. Past Substance Abuse History:

Substance Used Alcohol/Drugs	Age Started	Time Period of Use	Amount Used	Date of Last Use	Effect/Consequences	Treatment

IV. Medical History Problems:

Medical problems: (if you have or have ever had a problem, please circle)

Diabetes
Thyroid problems
High blood pressure
Heart problems
Rapid heart rate
Breathing problems
Asthma
Seizures
Stroke
Back problems
Head injury
Anemia
Kidney problems
Migraine headaches
Meningitis
Dizziness

Other______________________

Other ______________________

Surgeries/Major Illnesses	Time Period	Physician

Current Primary Care Physician: ____

Permission to communicate with Primary Care Doctor? _______Yes _______No

Are you seeing any other physicians (family doctor or specialist) or therapist? If so please list current medications:

Medication	Dosage	When Started	Reason	Prescribing Physician

Medication allergies: yes ____ no ____

If yes – medication allergy ____

____

V. Family History

In your immediate or extended family, has anyone experienced problems with:

	Relation
___ Depression	
___ Excessive Anxiety	
___ Manic/Depression	
___ Schizophrenia	
___ Suicide	
___ Drug/Alcohol Problems	
___ Abuse	

VI. Psychosocial History;

Who currently lives in your household?

Name	Age	Relation

Marital status of self or for child (parents): ____

Number of marriages: _________ Length of present marriage: _____________________________

Dates of previous marriages: ____

Work History:

___ Employed ___Unemployed ___Disabled ___Retired

Current job: _________________________________ Length of employment: __________________

Work related concerns: ____

Educational Background:

Adult – Last completed grade: ________________________

Child – Current grade: ________________ School: _____________________________________

School changes: ____

School concerns: ____

Legal Background:

Adult – Past or present legal problems: ____

____

Child – Legal problems: ____

Custody information: ____

Support System:

Number of close friends/family members: _______________________

Changes with relationship to friends: ____

Hobbies/interests: ____

Religious preference/beliefs: ____