PERSONAL & BILLING INFORMATION

PATIENT INFORMATION

Name: ______________________ Birthdate: ______________ Age: ______

Preferred Name: ______________ Personal Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: ______

Address/City/State/Zip: ______________________

Phone - Primary: ______________ ☐ Cell ☐ Landline May we leave messages for you there? ☐ yes ☐ no

Phone - Work: ______________ May we leave messages for you there? ☐ yes ☐ no

Phone - Alternate: ______________ ☐ Cell ☐ Landline May we leave messages for you there? ☐ yes ☐ no

E-mail: ______________ ☐ Private ☐ Shared May we email you about appointments? ☐ yes ☐ no

SSN: ______________ Employer or School: ______________ Position or Grade: ______________

Marital Status: ☐ single ☐ married ☐ widowed ☐ significant other ☐ divorced ☐ legally separated ☐ domestic partner

Who referred you to our office? ______________________

Emergency Contact Name: ______________ Relationship: ______________

Primary Phone: ______________ ☐ Cell ☐ Landline Alt Phone: ______________ ☐ Cell ☐ Landline ☐ Work

PCP/Primary Care Provider Name: ______________ City: ______________ Phone: ______________

FINANCIAL RESPONSIBLE PARTY INFORMATION

☐ Same as above or (name): ______________ Relationship to Patient: ______________

Resp. Party Full Address: ☐ Same as above, or: ______________________

Responsible Party Birthdate: ______________ Social Security Number: ______________

Primary Phone: ______________ ☐ Cell ☐ Landline Alt Phone: ______________ ☐ Cell ☐ Landline ☐ Work

Employer: ______________________ Position: ______________

INSURANCE INFORMATION *We will need to copy your insurance card(s). Be sure to know your insurance coverage!*

I. Insurance Company: ______________________

Subscriber/Policy Holder: ______________ Birthdate: ______________ SSN: ______________

Ins ID #: ______________ Group #: ______________ Subscriber Employer: ______________

*Co-pay: $__________ *Deductible total: $__________ *Deductible met: $__________ ***Call your insurance to avoid surprises.***

II. Insurance Company: ______________________

Subscriber/Policy Holder: ______________ Birthdate: ______________ SSN: ______________

Ins ID #: ______________ Group #: ______________ Subscriber Employer: ______________

*Co-pay: $__________ *Deductible total: $__________ *Deductible met: $__________ ***Call your insurance to avoid surprises.***

I certify that the insurance coverage (includes Employee Assistance Program) described above is valid for the above-named patient and I assign all insurance benefits directly to my provider for services rendered if applicable. I accept financial responsibility for all charges whether self-pay or payable by insurance, including those denied by insurance for lack of coverage or other ineligibility. I understand that insurance coverage decisions are made by the insurer and not the provider. I authorize the release of information necessary to any party to secure payment for services provided and the use of this authorization & signature on claims for insurance or EAP payment. I certify that I am legally authorized to make this agreement on behalf of the patient named above and the responsible party named above.

☒ **I understand my responsibility to provide timely information about insurance coverage & changes in coverage & understand the provider cannot know what I do not provide. Co-payments are due at the time of service. There is a charge for a missed appointments & one cancelled with less than 24-hours notice that is not covered by insurance. A rebilling charge is added to unpaid balances after 60 days. The cost of collections efforts (if any) will be added to the total balance due that is not payable by insurance.**

______________________ ______________

Signature of Adult Patient or Guardian Date Signed

CONTINUE…

CONSENT FOR TREATMENT AND OFFICE POLICY

Patient Name:____

Related to psychological services provided by (check only one):

☐ Brithany Pawloski, PsyD, bhp@nwopsych.com

☐ Karen Robie, PhD, kjr@robiepsych.com

☐ Clinician (name): ______________________________

CONSENT FOR PSYCHOLOGICAL SERVICES

Psychologists (clinicians) provide services relating to mental health and mental and emotional disorders, including evaluation, assessment, diagnosis, psychotherapy, and testing. They might also make referrals or consult with other service providers (with your permission). All services involve finding out about the patient's thoughts, feelings, and behaviors to help the patient resolve problems or concerns.

Evaluations help identify the nature of psychological or emotional problems or concerns. Psychotherapy is used to help the patient identify and work through past or present situations that cause concern. Many different techniques can be utilized to help the patient reach goals, including dialogue, interpretation, cognitive reframing and restructuring, journaling, self-exploration, behavioral modification, and catharsis.

Risks of psychological services may include experiencing uncomfortable feelings like guilt, anxiety, sadness, anger, and frustration. It may mean talking about painful events from your life. Potential benefits of psychological services and psychotherapy include improved self-satisfaction, improved mood, increased autonomy, empowerment, decreased stress and distress, improved relationships, improved day-to-day functioning and resolution of specific problems.

All findings and recommendations made because of an evaluation will be based on the evaluation alone. The outcome of an evaluation cannot be determined in advance and is not guaranteed. The clinician will never agree to render specific findings or make specific recommendations as a condition of the patient's participation or for any other reason. The results of psychological treatment cannot be guaranteed, but the likelihood of a positive outcome is enhanced by the patient's active participation.

All services provided are voluntary. While the patient may end treatment at any time, planned transitions when discontinuing therapy are thought to be in the patient's best interest. The patient has the right to refuse any suggestion made by the clinician at any time without being penalized in any way.

Initial to verify you understand & agree to the above: ___________

OFFICE POLICY

I. Confidentiality: Information revealed by a patient to a psychologist (clinician) during a professional relationship is confidential and privileged. The privilege is intended to protect the interests of the patient by encouraging free disclosure to the clinician and by preventing disclosure (by the clinician) to others. The patient, rather than the clinician, holds and may assert the privilege. Clinicians have a primary responsibility to protect the patient's right to confidentiality in accordance with law and professional standards of practice.

With few exceptions, confidential information may be disclosed only with informed written consent of the patient, or another person legally authorized to give consent on behalf of the patient. Confidential information may be disclosed without written consent: 1) to protect against clear, substantial risk of imminent serious harm being inflicted by the patient on him or herself or another person; 2) to comply with a court order; 3) to comply with regulatory mandates to report actual or suspected abuse/neglect of a child/vulnerable adult; and 4) to get medical care in a medical emergency while at the psychologist's office.

When it is necessary to disclose confidential information to respond to a specific situation, it will be only to appropriate authorities, a potential victim, professional/healthcare workers, and/or your family.

To protect privacy & confidentiality, the clinician will not engage in or respond to any social media with anyone who is or has been a patient.

II. Fees, Billing and Payments: Standard service charges are: evaluation: $250; therapy < 38 min: $145; therapy 38–52 min: $175; therapy ≥ 53 min: $200; family therapy per hour: $180; testing, per hour: $210; and $175 per hour for other services such as filling out disability forms, record review, report writing and consultation. Telephone calls and other communication between appointments (other than for scheduling) are charged at $175 per hour and cannot be billed to insurance. Extended evaluations, extended therapy and crisis sessions are subject to additional charge. Copies of records are charged in accordance with Ohio law.

The patient/responsible party is responsible for deductibles and co-payments, and ALL permitted charges not covered by insurance, if applicable The co-pay is due at the time of service. Any balance unpaid after 60 days is subject to a $14 per month rebilling charge. Please talk with us to work out alternative arrangements for payment if you have difficulty remaining current. If you do not pay your bill, services may be put on hold so you can catch up.

Collections and/or legal action will be used if your account is more than 60 days in arrears unless suitable arrangements for payment are made and honored. The costs of collection by the agency/attorney, filing the claim, or bringing the proceeding will be added to the balance due. Collection charges are typically based on a percentage of the balance and may equal 50% of the unpaid balance or more.

Insurance is billed monthly. Regular statements include all outstanding charges, including those billed to but not yet paid by insurance. If you use insurance to cover the costs of psychological services that means you give permission for the insurance company, or their representative, to access clinical information about you. If you self-pay, your information is private except as outline herein.

Please inform us immediately of any change in insurance coverage or eligibility. Lack of information does not change strict insurer timelines for claim submission. You must provide all documentation necessary to enable payment by insurance to avoid responsibility for all fees.

Initial to verify you understand & agree to the above: ___________

III. Cancellations and No-Shows: When you schedule an appointment, time is specifically reserved for you. Twenty-four hours notice is required for all appointment cancellations. Rescheduling in the same week is not guaranteed. ***You will be charged $85 for appointments cancelled with less than 24-hours notice and/or for failure to show for an appointment.***

If you need to reschedule or cancel an appointment, you may do so by telephone (419-537-0900) or by email to office@nwopsych.com (please do not send private healthcare information by standard email). Do not send email if you do not want an email reply.

You may leave a voice mail 24-hours per day, 7 days a week. All messages are date and time stamped to keep track of cancellations. Under rare circumstances, such as extreme weather conditions or an emergency hospitalization, a late cancellation fee may be adjusted at the discretion of the clinician. No show fees are never waived.

Please address any questions you may have about consent for treatment & office policy before you sign. Your signature signifies that you 1) consent to psychological treatment, 2) agree to the office policies as outlined above, and 3) understand that the "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information" is available online at www.nwopsych.com and is posted in the office.

Signature of Adult Patient	Date Signed
Guardian/Authorized Representative's Signature	Date Signed

CONTINUE...

PERSONAL HISTORY

Name: ______________________ Birthdate: ______________ Age: ________

Highest educational level **finished**: ☐ 1-6 ☐ 7-8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ HS Grad ☐ GED ☐ College: ______________

PROBLEM LIST - Check any that are a problem for you **NOW**

	Abuse of a child		Grief, loss, or bereavement		Low energy, tired, or fatigue		Mania or hypomania
	Abuse of an adult		Panic attacks		Sexual behavior or problem		Suicidal thoughts
	Anger or temper control		Depression		Gender identity concern		Intentional self-injury
	Criminal behavior or legal		Hopeless or helpless feelings		Eating problem		Sexual abuse/assault/rape
	Poor impulse control		Loneliness		Intentional vomiting		Domestic violence
	Negative or irritability		Social isolation		Weight gain or loss		Violence or violent behavior
	Lying, sneaking, or cheating		Self-esteem problems		Excessive exercise		Alcohol and/or drug abuse
	Anxiety and worry		ADD/ADHD		Sleep		School problem
	Extreme fears		Concentration problem		Family problem		Job or employment problem
	Stress		Memory problem		Marital/partner problem		Suspiciousness/paranoia
	Compulsive behaviors		Mood swings or moodiness		Divorce or separation		Hallucinations
	Obsessive thoughts		Too much energy or hyper		Social/relationship problem		Concerns about health

PERSONAL MEDICAL HISTORY -check all that apply to you. **N=NOW P=PAST**

	Epilepsy or seizure		Kidney problem		Joint or bone problem		Vision or hearing problem
	Head or brain injury		Thyroid problem		Arthritis or gout		Hormonal concern or PMS
	Neurological problem		Liver problem		Fibromyalgia		Reproductive problem
	Headache or migraine		Diabetes		Myalgia encephalomyelitis/CFS		STD or HIV/AIDS
	Stroke or TIA		Pancreatitis		Auto-immune disorder		Mental illness
	Lung or pulmonary disease		Stomach or bowel problem		Chronic pain		Intentional self-injury
	Asthma		Urinary problem		Cancer		Suicide attempt
	High or low blood pressure		Blood-related problem		Sleep apnea		Learning disability
	Heart trouble		Skin problem		Dental problem		Developmental disability

Serious accidents, hospital stays, operations & other health or medical problems or disabilities: ______________

____

____

If applicable to your visit, your height: ______________ Weight: ______________

MEDICATIONS (include prescription, over-the-counter, borrowed, and herbal preparations):

Medication Name	Dose & Frequency	What do you take this medication for?

Medication changes over the **past six months**? ☐ None, or: ______________

OTHER than PCP, current physicians/specialists and their city: ☐ None, or ______________

____

Date of last PCP visit: ______________ # of physician visits in last 18 months: ______________

CONTINUE…

Patient Name: ______________________________

Drug Allergies: ☐ No known drug allergies, or: ______________________________

Cigarette/tobacco use (over last year): ☐ None, or: ______________________________

Caffeine use (present): ☐ None, or ______________________________

Alcohol, cannabis, or other drug use (over last three years): ☐ None, or: ______________________________

____

Military service: ☐ None, or: ______________________________ Type of Discharge: ______________________________

Legal history (pending and past, include bankruptcy): ☐ None, or: ______________________________

____

History of traumas (as you define it), abuse, or domestic violence: ☐ None, or: ______________________________

____

____

MENTAL HEALTH, PSYCHOLOGICAL, OR PSYCHIATRIC TREATMENT HISTORY - list all prior treatment & support groups (NAMI, etc.): ☐ None, or

Treatment Provider	Start & End Dates	Reason for Treatment	Treatment Outcome

ALCOHOL OR DRUG ABUSE TREATMENT HISTORY - list all prior treatment & support groups (AA, NA, etc.) ☐ None, or

Treatment Provider	Start & End Dates	Reason for Treatment	Treatment Outcome

FAMILY HISTORY - check all that apply

	Neurological/brain problems		Cancer		Dementia/Alzheimer		Mood swings
	Heart disease		Diabetes		Learning disability		Depression
	Thyroid disease		Fibromyalgia		Developmental disability		Suicide gestures/attempts
	Liver disease		Chronic pain		Anxiety		Alcoholism/drug abuse
	Pancreatitis		Disability		Anger control problems		Mental illness
	Other:				Other:		

Anything else you would like to add:

____

____

______________________________ Signature of Patient or Guardian

______________________________ Date Signed

CONTINUE…

Patient Name:____

ALCOHOL & DRUG USE SCREENING

Over the last 3 years….	Yes	No
Could you stop drinking alcohol (beer, wine, liquor, etc.) without a struggle after 1 or 2 drinks every time?		
Have you been unable to remember what happened while you were drinking or had a blackout?		
Has alcohol or drug use caused a problem between you and a family member or friend or caused trouble at home, school, or work?		
Have you been sick, gotten sick, had shakes, or DTs (delirium tremens) when you stopped drinking, after drinking a lot, or when a drug was wearing off?		
Have you had medical problems (such as memory loss, hepatitis, seizures, bleeding) because of alcohol or drug use?		
Have you used drugs or medications that were prescribed for someone else (except those you can buy in a drug store)?		
Have you used your medicine in a way that differs from how your doctor told you to take it?		
Have you done things you would not normally do or done illegal things while using alcohol or a drug?		
Have you failed a urinary drug screen or refused to take a urinary drug screen for any reason?		
Have you had an addiction to gambling, sex, spending or anything else?		

MOOD & ANXIETY SCREENING

Over the last 2 weeks how often have you….	Not at all	Several days	More than half the days	Nearly every day
Have you been bothered by little interest or pleasure in doing things?				
Have you been bothered by feeling down, depressed, or hopeless?				
Have you been bothered by trouble falling or staying asleep, or sleeping too much?				
Have you been bothered by feeling tired or having little energy?				
Have you been bothered by poor appetite or overeating?				
Have you been bothered by feeling bad about yourself — or that you are a failure or have let yourself or your family down?				
Have you been bothered by trouble concentrating on things, such as reading the newspaper or watching television?				
Have you been bothered by moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual?				
Have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?				
Have you been bothered by feeling nervous, anxious, or on edge?				
Have you been bothered by not being able to stop or control worrying?				
Have you been bothered by worrying too much about different things?				
Have you been bothered by trouble relaxing?				
Have you been bothered by being so restless that it's hard to sit still?				
Have you been bothered by becoming easily annoyed or irritable?				
Have you been bothered by feeling afraid as if something awful might happen?				

☐ This paperwork was completed independently by the patient named.

☐ This paperwork was completed with help from: ____

____ ____________________

Signature of Patient or Guardian Date Signed

CONTINUE…

4930 N HOLLAND SYLVANIA ROAD, SUITE B
SYLVANIA, OHIO 43560

PHONE: 419-537-0900 • FAX: 419-537-1300

Complete this form to allow the exchange of clinical information for coordination of care by your clinician here and your primary care provider.

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Patient Name: ______________________________

Birthdate: ____________________ SSN (Last 4): ____________________

The above-named individual, or the legal representative for the above-named individual, gives permission to (check all that apply):

☐ Karen Robie, PhD, 4930 N Holland Sylvania Road, Suite B, Sylvania, OH 43560; kjr@robiepsych.com

☐ Brithany Pawloski, PsyD, 4930 N Holland Sylvania Road, Suite B, Sylvania, OH 43560; bhp@nwopsych.com

☐ Clinician (name): ____________________ E-mail: ____________________
4930 N Holland Sylvania, Suite B, Sylvania, OH 43560

to release and receive confidential information contained in psychological, psychotherapy, clinical, medical, hospital, educational or related records which may include information about a) medical and health status, b) protected alcohol and drug abuse treatment, c) mental health treatment, d) communicable diseases and infections such as AIDS, HIV, or ARC diagnosis and treatment, and e) physical or sexual abuse, if any, of the patient named above to/with:

Primary Care Provider/Physician: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip: ____________________

Approximate date(s) of treatment/services: **All, unless specified here**:______________________________

Specific information authorized:

1. **Diagnostic Summary/Evaluation Results**
2. **Treatment Plan, Course & Progress**
3. **Medical History/Physical Exam**
4. **Medications Prescribed & Med History**

Specific information to be EXCLUDED: **None, unless specified here**: ______________________________

Purpose and need for information release/exchange: **Coordination of Care**

This authorization will be continuous for the duration of treatment with patient's clinician at NorthWest Ohio Psychological Services, LLP unless revoked in writing to the releasing entity or the patient's clinician at NorthWest Ohio Psychological Services, LLP. Revocation may occur at any time except to the extent that action has already been taken in reliance on it. Information provided under the terms of this authorization may be discussed with the patient named above and will otherwise be held as confidential. Information disclosed will not be re-released without written authorization; we ask the same courtesy of the receiving entity but cannot assure it and released information may no longer be protected by HIPAA privacy rules. No health care provider may condition treatment, payment, enrollment, or eligibility for benefits on signing this authorization.

______________________________ ____________________
Signature of Adult Patient Date Signed

______________________________ ____________________ ____________________
Authorized Representative's Signature Basis of Authorization to Sign Date Signed

______________________________ ____________________
Witness Signature, if needed Date Signed

CONSENT FOR TREATMENT AND OFFICE POLICY

Related to psychological services provided by (check only one):
☐ Brithany Pawloski, PsyD, bhp@nwopsych.com
☐ Karen Robie, PhD, kjr@robiepsych.com
☐ Clinician (name): ______________________

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Signature of Adult Patient	Date Signed

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Guardian/Authorized Representative's Signature	Date Signed