PATIENT INFORMATION

Name:_____Birth Date:_____ Age:_____

Pronoun: ◯ He/Him ◯ She/Her ◯ They/Them ◯ Prefer not to answer, Preferred Name:_____

Street:_____City:_____State:_____ZIP:_____

Phone-Cell:_____MAY WE LEAVE A MESSAGE? ◯ YES ◯ NO

E-Mail:_____MAY WE SEND MESSAGES ABOUT APPOINTMENTS? ◯YES ◯NO

SS Number:_____Employer/School:_____Position/Grade:_____

Relationship Status: ◯ single ◯ married ◯ widowed ◯ significant other ◯divorced ◯legally separated

Who referred you to our office?_____

Emergency Contact Name:_____Relationship:_____

Phone-Cell:_____Home:_____

Family Doctor/PCP Name:_____Phone:_____

Address, City, State:_____

FINANCIAL RESPONSIBLE PARTY INFORMATION

◯ Same as above OR

Name:_____Relationship:_____

Full Address: ◯ Same as above, or:_____

Birth Date:_____SS Number:_____

Employer:_____Position: _____

INSURANCE INFORMATION *Please provide a copy of your insurance card(s).*

I. Insurance Company:_____

Subscriber/Policy Holder: _____DOB:_____SSN:_____

Ins ID#:_____Group#:_____ Employer:_____

Copay amount:_____ Deductible amount:_____**Call your insurance to avoid surprises**

II. Insurance Company:_____

Subscriber/Policy Holder: _____DOB:_____SSN:_____

Ins ID#:_____Group#:_____ Employer:_____

Copay amount:_____ Deductible amount:_____**Call your insurance to avoid surprises**

I certify that the insurance coverage or Employee Assistance Program coverage described above is valid for the above-named patient and I assign all insurance & EAP benefits directly to Brithany H. Pawloski, Psy.D., if any, for services rendered. I accept financially responsible for all charges whether, or not, covered or paid by insurance.

I authorize Brithany H. Pawloski, Psy.D. to release information necessary to any party to secure payment for services provided. I authorize 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 co-payments are due at the time of service; unpaid balances greater than 60 days is subject to a $10.00 per month rebilling charge; charges for collections efforts, if any, shall be paid by the responsible party above; and, there is a $50.00 charge for appointments missed or cancelled with less than 24 hours' notice.

_____ _____

Signature of Adult Patient or Guardian Date Signed

Patient Name: _____

CONSENT FOR PSYCHOLOGICAL SERVICES

Psychologists provide services relating to mental health and mental and emotional disorders, including evaluation, assessment, diagnosis, psychotherapy, and testing. Psychologists 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 in an effort 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-today functioning and resolution of specific problems.

As part of treatment, the patient may be referred for other related services. For example, medication prescribed by a psychiatrist or primary care physician, a support group or inpatient care may be suggested. All findings and recommendations made as a result of an evaluation will be based on the evaluation alone. The outcome of an evaluation cannot be determined in advance and is not guaranteed. In no case will the psychologist 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 either, but the likelihood of a positive outcome is greatly enhanced by the patient's active participation.

All services provided by Brithany H. Pawloski, Psy.D. are voluntary. The patient may end treatment at any time. However, planned transitions (such as discontinuing therapy) are generally thought to be in the patient's best interest. The patient has the right to refuse any suggestion made by the psychologist at any time without being penalized in any way.

◯ Please initial to verify you understand & agree to the above: _____

OFFICE POLICY

I.**Confidentiality**: Information revealed by a patient to a psychologist in the course of a professional relationship is confidential and privileged. The privilege is intended to protect the interests of the patient by encouraging free disclosure to the psychologist and by preventing disclosure (by the psychologist) to others. The patient, rather than the psychologist, holds and may assert the privilege. Psychologists 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, the disclosure shall be made only to appropriate authorities, a potential victim, professional/healthcare workers, and/or your family.

II. Fees, Billing and Payments: evaluation: **$200.00**; 38–52 min therapy: **$175.00**, ≥ 53 min therapy: **$200.00**; family/marital therapy: **$175.00**; testing, per hour: **$200.00**; and **$175.00** 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 $**150.00** 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 copayments, and ALL charges not covered by insurance or EAP, unless prohibited. The co-pay is due at the time of service. Any balance unpaid after 6 days is subject to a **$10.00** per month rebilling charge. If financial problems make it difficult for you to keep current with your bill, please discuss them to work out alternative arrangements for billing. 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. If such action is necessary, 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 often based on a percentage of the balance and may equal 50% of the unpaid balance or more.

If you use insurance to cover the costs of psychological services that means you give permission for the insurance company, or their designee, to access clinical information about you. Insurance is billed monthly. Statements are mailed monthly and include all outstanding charges, including those billed to but not yet paid by insurance. Please inform us immediately of any change in insurance coverage or eligibility. You must provide all documentation necessary to ensure payment by insurance and if you do not, you will be responsible for all fees.

◯ Please initial to verify you understand & agree to the above: _____

III.Cancellations and Timeliness: Twenty-four hours notice is required for all appointment cancellations. You (not the insurance company) will be charged **$50.00** for missed or skipped appointments and for appointments cancelled with less than 24 hours notice.

If you need to reschedule an appointment, you may do so by telephone (419-537-0900) or email (office@nwopsych.com) but please do not rely on email for confidential information. DO NOT SEND EMAIL IF YOU DO NOT WANT AN EMAIL REPLY.

The answering service accepts calls 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, the no show/late cancellation fee may be waived, at the discretion of the psychologist.

IV. Business Arrangements: Brithany H. Pawloski, Psy.D. is in no way in business with Karen Robie, Ph.D. or any other professional that uses space within the office. These entities are separate businesses and in no way legally obligated to each other for day-to-day practices.

Please ask and resolve any questions you may have about the consent for treatment and the office policy before you sign. Your signature below signifies that you 1) consent to psychological treatment and 2) understand and agree to the office policies as outlined above. It also serves as 3) an acknowledgement that you have received the "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information."

_____ _____
Patient's Signature Today's Date

_____ _____
Guardian/Authorized Representative's Signature Today's Date

PERSONAL HISTORY

Patient Name:_____ Age:_____

Highest educational level **finished**: ☐ 1, 2 or 3 ☐ 4, 5 or 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ HS Grad ☐ GED ☐ College

Height:_____ Weight:_____

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 & 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 applies to you – now or in the past. **N=NOW P=PAST**

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

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

_____

_____

_____

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 _____

Current doctors or clinics OTHER than PCP, and the city of his or her office: ☐ None, or _____

Date of lastPCP visit: _____ # of physician visits in last 18 months _____

Drug Allergies: ☐ No known drug allergies, or _____

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

Caffeine use (present): ☐ None, or: _____

Alcohol & drug use (over last two years): ☐ None, or _____

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

Legal history (pending and past): ☐ None, or _____

History of traumas (as you define "trauma"), abuse or domestic violence: ☐ None, or _____

_____

Mental Health, Counseling, Psychological or Psychiatric Treatment History - list ALL prior treatment & support groups: ☐ None

Treatment Provider	Start & End Dates	Reason for Treatment	Treatment Outcome

Alcohol or Drug Abuse Treatment History - list ALL prior treatment & support group (AA, NA, etc.) involvement: ☐ None

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:			

_____ _____

Signature of Patient or Guardian Date