Russel Thompson, PhD
7400 Blanco Rd, Suite 126
San Antonio, TX 78216
Office: 210-699-8700
Fax: 210-587-2454

Patient Registration Information

Patient Name: _____ (*Last*), _____ (*First* *Middle*) Sex: M [ ] F [ ]

Date of Birth: _____ Home Phone: (___)_____ Cell/Work Phone: (___)_____

Address: _____ City: _____ State _____ Zip _____

Please check if we may leave a message on your ☐ Home Phone? ☐ Cell Phone?

If Patient is a Minor below the age of 18:

Guardian's Name: _____ Cell/Work Phone: (__)_____

In Case of Emergency, Please Notify: Name: _____ Relationship _____Phone Number (___)_____

Chose Clinic Because/Referred to Clinic by (Please check one box)

☐ Dr. _____ ☐ Insurance Plan ☐ Hospital ☐ Family/Friend ☐ Convenient location ☐ Yellow Pages

☐ Other: _____

Payment (check one)

☐ I will pay for these services directly and do not wish to have you my bill insurance.

☐ Please bill my insurance using the following information

INSURANCE INFORMATION

Patient's SS#: _____

Primary Insurance Name: _____ Name of Insured: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID or Policy Number: _____ Group Number: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: ( ) _____

Secondary Insurance Name: _____ Name of Insured: _____

Id or Policy Number: _____ Group Number: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

___ (initials) I authorize Russel Thompson, PhD & the above insurance provider(s) to release any information required to process my claims.

Cancellation Policy

___ (initial) Failure to cancel an appointment within 24 hours of the scheduled time is considered a "No-show" and is billed at the full rate. I understand that insurance usually does not pay for no-shows, and I will be responsible for the fee myself.

Authorization of treatment and payment

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Russel Thompson, PhD. I understand that I am financially responsible for any balance.

Signature: _____ Date: _____

Print Name: _____

Russel Thompson, PhD

NOTICE OF RECEIPT OF POLICY REGARDING PROTECTED HEALTH INFORMATION

Please sign below to indicate that you have been given the opportunity to review Russel Thompson, PhD's policies regarding protected health information. If you request it, we will provide you with a paper copy of the policy

_____

Printed Name

_____ _____

Signature **Date**

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Informed Consent Document for Psychotherapy

This document contains important information about my practice policies. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy can have benefits and risks. It often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have benefits. But there are no guarantees of improvement.

MEETINGS

I usually schedule one 50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you must pay for it unless you provide 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control.

PROFESSIONAL FEES

My hourly fee is $150. I charge this fee for therapy sessions and for other professional services, such as report-writing or telephone conversations lasting longer than 10 minutes. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS

You must pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If necessary, I will negotiate a fee adjustment or payment installment plan. If your account 60 days overdue, I may hire a collection agency or go through small claims court. If such legal action is necessary, its costs will be included in the claim.

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INSURANCE REIMBURSEMENT

If you choose to use your behavioral health insurance to pay for my services, you (not your insurance company) are responsible for full payment of my fees. You are responsible find out exactly what mental health services your insurance policy covers. Your insurance company may ask me for clinical information. This information will probably be stored in a computer. I have no control over what they do with it once it is in their hands. I will provide you with a copy of any report I submit, if you request it. You always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

CONTACTING ME

I cannot answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail that is only available to me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you can't wait for me to return your call, contact your family physician or the nearest emergency room. If I will be unavailable for an extended time, a colleague will take my calls.

PROFESSIONAL RECORDS

I will keep records of my work with you. You are entitled to receive a copy of your records. If I believe that it would be emotionally damaging for you to see them, I will arrange with you to send them to a mental health professional of your choice. I recommend that you review them in my presence so that we can discuss the contents. I charge a reasonable fee for copies of records.

MINORS

If you are under eighteen years of age, Texas law allows your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our

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work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections.

CONFIDENTIALITY

Most communications between a patient and a psychologist are private. I can only release information about our work to others with your written permission. There are a few exceptions. In some proceedings legal involving child custody or when your mental health is related to the issue in the court, a judge may order my testimony. If I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that you are a danger to yourself or others, I will act to prevent harm. I may occasionally consult with other professionals. If I do, I will not mention your name and will try to keep your identity secret. The professionals I consult with are legally bound to keep the information confidential.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____	_____	_____
Signature of client	**Printed name**	**Date**

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New Therapy Patient Questionnaire

Please fill out the following pages with as much detail as you can.
You may wish to ask family or friends to help you remember details before your appointment.

Name: _____ DOB: _____ Date: _____

Who is filling out this questionnaire? ❑ Self ❑ Other _____

Who do you live with? ❑ parent ❑ child ❑ spouse ❑ friend ❑ relative ❑ alone

How long have you lived in the current place?

History

Who raised you? Biological / adoptive / foster / step parents /other_____, until what age? ____,

Describe your caretakers (type of work, personality, etc):

Where did you grow up?
When growing up, how many brothers: _____ and sisters: _____
List their names and current ages:

What type of relationship did you have with your parents?

What type of relationship did you have with your brothers/sisters?

How was your social adjustment growing up:
❑ Very good ❑ Good ❑ Average ❑ Marginal ❑ Poor.

Extracurricular Activities (sports, band, ROTC, etc) :

Social Activities (friends, dating, hobbies):
Education:

Years of school ____ ❑ HS diploma ❑ Years of College____ ❑ Degrees:

Grades: ❑ very good ❑ good ❑ average ❑ marginal ❑ poor
Grades Repeated: _____

Describe any discipline problems in school (suspensions, police intervention, etc):

Describe any special educational services, classes, accommodations, or other help you were given in class or testing

Current and Past Substance use (e.g., alcohol, marijuana, prescription drugs, etc)

Substance	*Age Started*	*Last Used*	*Frequency of Use*	*Problems Caused?*	*Treatment?*

Past criminal charges (i.e., reckless driving, DWI, theft, assault, etc.)

Legal Charge	*Date*	*Result (incarceration, parole, etc)*

History of fights/assaults:

Work History
Are you currently employed? ❑ Yes ❑ No
What is your occupation? _____ Length of time at this job:

Describe any times in the past 12 months that your mental/emotional complaints caused you to miss work:

Previous Work History (start from most recent job)

Position	*Start Date*	*Duration*	*Fired?*	*Reason for Leaving*

Use Back of Page if Necessary

Military History
Please list branch of service, start and stop dates:

Marital/Relationship History:
Current Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Live with partner but not married
Describe your current relationship:

Past Marital History

Start Date	*Duration*	*# of Children*	*Reason for end of marriage*

Describe your current relationship with your children:

Who do you spend the most time with? (e.g., spouse, family, friends, etc):

Describe your current social interaction and your level of satisfaction with it:

How do you feel others in your life view you?

Hobbies / Pastimes:
Pain History

Do you have chronic pain?

If so, where does it hurt?

When did your current pain begin?

What happened?

Medical History

List any serious medical problems, surgeries, etc. (start with most recent):

Illness	*Date treated*	*Current Meds*	*Length of Hospitalization*

History of Psychiatric care (inpatient, outpatient, etc., start with most recent):

Problem	*Start Date*	*Current Meds*	*Counseling*

History of suicide attempts (list dates, what was going on, how you tried to harm yourself, and what happened):

Family history of psychiatric problems:

Other Information

What else would you like for me to know?

What have you tried so far that has helped or not helped?

What do you think is needed to help now?

What are your goals for treatment?

Preparing for Change

Please rate the following:

Your readiness for change	**Not Ready** 1 2 3 4 5 6 7 8 9 10 **Very Ready**
Challenge of changes needed	**Very Easy** 1 2 3 4 5 6 7 8 9 10 **Very Difficult**
Your capability to meet those challenges	**Not Capable** 1 2 3 4 5 6 7 8 9 10 **Very Capable**

MISSION PSYCHOLOGY

PSYCHOLOGICAL ASSESSMENT & TREATMENT

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T: 210-699-8700 F: 210-587-2454 missionpsychology.com

CREDIT CARD AUTHORIZATION

We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable, including, but not limited to, copayments, coinsurance, any amount applied to your deductible, no show appointment fees, and other billing charges. If you have any questions or concerns about this policy, please discuss with your psychologist before signing.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account. We will not charge your card until sending you at least two invoices by mail and doing our best to notify you by phone.

I authorize Russel Thompson, PhD and Associates **to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

□ Visa □ Mastercard

Credit Card Number _____

Expiration Date _____ / _____ / _____ **3digit Security Code**__ ___ ___

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request Russel Thompson, PhD and Associates to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Russel Thompson, PhD and Associates. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Russel Thompson, PhD and Associates in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____