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: ______________________ , ______________________________________ Sex: M [ ] F [ ]
Last First Middle

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: ____

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

PSYCHOLOGICAL ASSESSMENT & TREATMENT

7400 Blanco Rd., Ste 126 | San Antonio, TX 78216
T: 210-699-8700 F: 210-587-2454 missionpsychology.com

Consent and Agreement for Psychological Testing and Evaluation

I __________________ agree to allow the psychologist to perform the following services: ❑ Psychological testing, assessment, or evaluation

❑ Consultation with my physician whose name is ______________________
❑ Consultation with school personnel
❑ Consultation with lawyers
❑ Deposition (that is, written testimony given to a court, but not made in open court)
❑ Testimony in court
❑ Other (describe):

This agreement concerns ❑ myself or ❑ ________________________________

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, and any other activities to support these services. I understand that the fee for this (these) service(s) will be about $150 per hour. Although my health insurance may repay me for some of these fees, I understand that I am fully responsible for payment for these services.

I understand that this evaluation is to be done for the purpose(s) of: ____

I also understand the psychologist agrees to the following:
1. The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations.
2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a secure place to maintain their confidentiality. I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

______________________________ ______________________________ ______________
Signature of client /guardian Printed name Date

I, the psychologist, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

______________________________ ______________________________ ______________
Signature of psychologist Printed name Date

❑ Copy accepted by client ❑ Copy kept by psychologist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Pain Questionnaire
Russel Thompson, PhD

Name: ______________________ Date: ______________
Address: ______________________ DOB: ______________
SS#: ______________________

Please provide the following details about your history, including current and past medical problems, medications, health habits, and family history. For questions that ask about how you feel, please give your best answer yourself. The information about your past medical history may be gathered from both you and your family members.

Where is the pain? (for example: knees,, back, head). Does it seem to move anywhere else?

How and when did the pain begin?

Tell us all you can about the pain:
 What does it feel like (burning, tingling, shooting, sharp, aching)
 What time of day does it occur?
 What makes it start?
 What makes it better?
 What makes it worse?
 What else?

Tell us all you know about previous evaluations of your pain. Particularly, tell us about any X-Rays, MRI's, or other procedures done to find out the cause.

What have you been told is causing your pain?

Have you had any surgeries or procedures for treatment of your pain? Don't forget therapies and injections. If so, tell us what, where, and by whom. Also tell us how well the treatments worked.

What medications have you taken for the pain and how well have they worked?
What medicines didn't work out for you and why? (Include both prescription and over-the-counter medicines, creams and herbals. Start back when you first developed your pain problem.)

If you have any specific ideas of what should be done for your pain, please write them here.

Please list any other current medical problems:

Please list any past mental health treatment:

Have you ever attempted suicide? If so, please describe when and the circumstances:

Social History

Where did you grow up?

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

Describe your caretakers (type of work, personality, etc):
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 ❑ Not Good

Pain Questionnaire
Russel Thompson, PhD

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

Social Activities (friends, dating, hobbies):

Education:
Years of school ____ ❑ High school diploma ❑ Years of College____ ❑ Degrees______
Grades: ❑ very good ❑ good ❑ average ❑ below average
Did you ever repeat a year? ❑ Yes ❑ No If so, what year?._____

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

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

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

Describe any past criminal charges (i.e., reckless driving, DWI, theft, assault, etc.)

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

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

If working, describe any times in the past 12 months that your illness has caused you to miss work:

Previous Work History (start from most recent job)

Pain Questionnaire
Russel Thompson, PhD

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

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

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

Previous History (if applicable)

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?

Describe your Hobbies / Pastimes:

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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: _____ / _____ / _____