Patient Information .... Gary D. Hittle, Ph.D.

Date: ________________________________ **who referred you?** ____

Patient Name: ____ **Age:** _______ **Sex:** _____ **B. Date:** ________________

Marital Status: _______ **Previous marriages:** _______ **Soc. Security:** ____

Address: ____
City state zip

Home Phone: ____________________ **Work Phone:** ____________________**Cell Phone:** __________________________

E-mail address: ___________________________ **Can a message be left? Yes/ No** ______________________________

Employer: _______________________ **Occupation:** ___________________ **Church Affiliation:** ____________________

Name of Spouse (Significant Other/Parent): __________________________ **Age:** ______ **B. Date:** _______________

Address if different from above: ____
City state zip

Employer: __________________________ **Bus. Phone:** _________________________**Cell Phone**__________ __________

Social Security: ___________________________ **Briefly describe your reason for seeking counseling below:**

Who is your doctor? _________________________ **Last seen:** __________________ **Phone:** _______________________

Doctor's Address: ____

List all medications you are currently taking:

____

____

Please list names, ages, and relationship of all individuals in your household:

Name age relationship / Name age relationship

____

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***I understand that payment is required at the time of service unless specific arrangements have been previously made. I authorize any holder of medical or other information about me to release to my insurance company, my attorney, or their agents any information needed to determine my insurance benefits or medical necessity for services rendered*. I agree to pay in full for any missed appointments that are not cancelled at least 24 hours in advance.**

____

Signature of patient and/or responsible party Signature Date

Dx. ______________________________

PAGE TWO: Client Name ____

<u>Fee Information</u>….The following are the charges for counseling with Dr. Hittle:

Individual Psychotherapy	**$175.00**
Conjoint or Family Psychotherapy	**$200.00**

Extended Sessions: Individual $250.00 / Conjoint or Family $300

Psychotherapy sessions are 50 minutes in length with 10 minutes for case preparation, case management, co-ordination of care, and documentation (total 60 minutes) except for extended sessions listed above .

<u>Financial Agreement:</u>

Total Fee per session: _________________________

Specific Agreement: ____

I understand that I am 100% responsible for all charges not covered by my insurance. I have read and understand the above and agree to these terms. <u>If you wish to utilize insurance, we will make a copy of your insurance card at our initial meeting and assist you with billing for services.</u>

<u>Regarding Confidentiality</u> **….If you are an adult, anything you do or say in the context of psychotherapy is privileged and confidential, with the following exceptions (in the event these exceptions are used, all actions will be fully discussed with you in advance):**

1. If you are using confidentiality as a means of avoiding legal punishment, privilege is waived. That is, a psychotherapist may not aid or abet the perpetration of crimes.
2. In cases of child or elder abuse of a physical nature, the therapist is legally required to make a report to the proper authorities.
3. If you pose an imminent life-threatening danger to yourself or others due to your intent, privilege is waived.
4. We are often asked to send records to, or request records from, other health providers. On the occasions, you will be asked to sign a release of information form, without which we will not send or request records.
5. We make it a practice, as a courtesy, to contact the person/organization who refers new patients to us. If, for any reason, you do not wish us to do so, or have questions regarding this, please consult with your therapist.

In signing below, I agree to be treated by Gary D. Hittle, Ph.D., MFT. I understand that I am financially responsible to Dr. Hittle for all unpaid balances. I authorize the release of medical information necessary to process claims for such services rendered by Gary D. Hittle, Ph.D. I authorize payments of medical benefits directly to Gary D. Hittle, Ph.D. *<u>I understand that I may withdraw from treatment at any time.</u>*

I have read the above carefully and declare I understand and will abide by them

____

Signature	Signature	Date

Page Three: Patient Name ____

Circle any of the following areas in which you are having difficulty.

Alcohol Use ____________ ____________________	Elevated Mood	Panic Attacks
Anger/ irritability	Energy	Phobias
Anxiety	Family	Perfectionism
Assertiveness	Fears/Worries	Relationship difficulties
Boredom	Finances	Relaxation
Bowel-troubles	Headaches	Self-Control
Career Choices	Health	Self-esteem
Children	Isolation	Sexual Problems
Chronic Pain	Legal Matters	Shyness
Concentration	Loneliness	Sleep
Compulsions / Obsessions	Making Decisions	Stress
Depression	Marriage	Suicidal Thoughts
Divorce	Memory	Unhappiness
Domestic Violence	Mood-changes	Violent Behavior
Drug Use______________ ____________________	My thoughts	Work
Eating Problems	Nervousness	Other Issues: ____________________ ____________________
Education	Nightmares	
	Parenting difficulties	

Have you previously received counseling or psychological treatment? Yes / No
List provider and dates…

____

____

Have you ever been hospitalized? ______ **Describe:** ______________________________________

Describe your relationship with your family: ____________________________________

____

____

____

Describe any significant difficulties or traumas in your lifetime….

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____

____

List any current health problems:

____

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