Leta LeRossignol, L.C.S.W., B.C.D., RPT-S
3035 Whisper Fern Street
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PATIENT INFORMATION FOR MEDICAL RECORDS

Please complete the following as completely as possible and let I know if you have questions.

Patient Name ________________________________ Date ________________

Patient's Birth date _____________________________ SS# ________________

Sex: M / F Marital Status: Married ___ Divorced ___ Single ___ Other ___

Address ____

City, State, Zip ____

Home Telephone ____________________May we leave a message? _______ Age ___

Primary Care Physician ____

Referring physician ____

Please initial the following items after reading:

___ All co-payments are due at the time of services rendered

___ **Full session fees are due for cancellations with less than 48 hours notification and by Wednesday for a Saturday appointment, and Friday morning for a Monday appointment.**

___ I have read and agree to Leta LeRossignol's Notice of Privacy Practices (Health Insurance Portability and Accountability Act) describing how medical information about you or your child may be used and disclosed and how you can get access to this information.(The entire Privacy Document can be found online at **www.letacounseling.com under 'Your Privacy '/Privacy Document**

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ADULT PSYCHOSOCIAL ASSESSMENT

NAME:______________________________ SEX: (M) (F) Date: __________

Date of birth:____________ Place of birth: ____________________ Age: _______
Referred by:________________________ Employed by: _________________
Phone Number: _________________________ Alternatel Number: _______________
Phone Number: ______________ Emergency contact in the event we may be unable to reach you:
________________________ Phone Number: ____________________
Email address: ____
Reason for seeking counseling at this time:
____
____
____
I rate this problem a _______ on a scale of 1-10.
Have you previously been seen by a mental health professional? _______If so, by whom and for what purpose? ____
- **What helped? ____**
- **What did not help: ____**

What would you like to be different for you (and your family) through this process?
____
____
____

Marriages:
____
____
____

Divorce(s)____

Children:
Name Age lives w/
____
____
____

Education:
____

Work
History:____
____

Current medications: ____
____
____

Past Psychiatric hospitalizations: __________________________________
____
____

Routines and Habits

On average, how many hours do you sleep each night? ______________________

Do you feel rested when you wake? _____

Do you participate in regular exercise? _____ Describe: ____________________

Overall, are you satisfied with your eating habits? _____

Please check any of the following that describe how you have been feeling lately:

___ sad ___anxious ___depressed ___frightened ___guilty ___angry

___ashamed ___aggressive ___resentful ___worthless ___tearful ___helpless

___ irritable ___confused ___extreme ups/downs ___jealous ___hopeless

Have you ever experienced the following?:

Death of a parent? ____ age: _______

Death of a significant other? ___________________________________ age: _______

_________________________________ age: _______

Miscarriage ___________________________year __________________ age: _______

Physical abuse?____ age: _______

Sexual abuse? ____ age: _______

Long term financial instability? ________________________________ age: _______

Hospitalization? ____ age: _______

Hospitalization or absence of parent at young age? ________________ age: _______

Divorce/separation of parents at young age? _____________________ age: _______

Alcohol/Drug abuse by parent(s) ________________________________ age: _______

Suicidal/homicidal thoughts/behavior? __________________________ age: _______

Past attempt (s) to take your own life? __________________________age: _______

How was it Resolved? ____

Other significant life changes growing up? ______________________________

____

____

HISTORY OF SUBSTANCE USE:

Personal Chemical use/dependency:	Frequency	First Used	Last Used
Alcohol:	________	________	________
Illicit Drugs:	________	________	________
Prescription Drugs:	________	________	________
Over the Counter:	________	________	________
Nicotine:	________	________	________
Other:	________	________	________

Family mental health history, to include alcoholism:

____

MEDICAL HISTORY:

HISTORY OF PHYSICAL HEALTH:

____

____**Previous Medical Hospitalizations**

____

____

____

Please list your goals for counseling:

____

____

____

____

____

Is there anything else you would like to share about yourself?

____

____

____

____

____

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CLINICAL POLICIES

LENGTH OF APPOINTMENT
A regular clinical session lasts approximately 45 minutes. Please be punctual to assure the full time allotted.

FEES
The fee for a regular clinical session is $138.00. Initial intake sessions are $180.00. Full payment is expected at the time of the appointment unless other arrangements are made.

*We ask that you provide the following information. Charges will only be made for regular sessions, and**, for missed appointment/late cancellation (see below: 'Cancellation of Appointment) or in the even that there are missed payments,** or agreed upon arrangements.*

VISA AND MASTER CARD ACCEPTED

*Credit card #: _________ __________ _________ __________

Name on credit card: ______________________________ Exp date ______________

Zip match with card __________________ 3 numbers on back of card _________

Signature on file _________________________________ Date _____________

CANCELLATION OF APPOINTMENT
The full fee is due for appointments not cancelled at least 48 hours prior to the appointment time, by Wednesday for Saturday appointments, or by Friday morning for Monday appointments. *This policy allows for securing your appointment as well as allowing time to offer your appointment time to another client. You have the choice to settle the fee using credit card on file or in person by letting me know your preference.*

CONSULTS REGARDING LEGAL MATTERS:
This office does not provide forensic (court) work. If your treatment, or your child's treatment may involve the court, please let me know immediately, I am able to provide some names of forensic psychologists who may be more suitable for your treatment. *Services for court appearance are $1,500 minimum cost. Additional hours for preparation as well as consults regarding legal matters cost $400 per hour. These fees must be paid in advance. Legal fees sustained by the legal provider on behalf of the client or legal guardian(s) are the sole fiscal responsibility of the client/guardian(s).*

INSURANCE: In and Out of Network:
Once you have established that this provider is covered in network with your insurance, your claims may be filed from this office. You are strongly encouraged to obtain comprehensive information from your insurance company as this will increase the chances that your insurance company will pay for services rendered. ***Obtaining the following, whether your insurance covers these services in or out of network, will increase the chance that your insurance will pay for your services:***

- ***Obtaining an authorization if required****; if your insurance company requires an authorization, they will not pay for sessions without one.*
- ***Determine if you have a deductible****. Deductibles are due up front as your insurance will not begin to make payment on your services here until your deductible is met.*

- ***Determine your co-payment;*** *it will be collected at the beginning of the session.*
- *Inform your therapist and your insurance company* ***prior to visits here*** *whether or not you have a secondary insurance that could be involved with your treatment here.*
- ***Ask your insurance company about any limitations*** *in use of your insurance benefits; some examples are 1) any diagnosis limitations, 2) visit limitations,*
  3) health spending card limitations, and 4) any other possible limitations.

CONFIDENTIALITY

We would like to reassure you that information presented during therapy is confidential. However, please be informed that information contained in our mental health care records will be provided to medical and legal authorities as allowed under Texas State Law for your protection and the protection of others. These may include indications of intent to commit homicide, or suicide, or indications of child abuse and any lawsuit that involves your record here. In some cases, your file may be subject to a court subpoena. In addition, if your treatment is paid for by insurance reimbursement, the insurance company has a right to review your mental health care record.

Please know that if you run into your therapist outside of the office, she will not acknowledge you so that your right to confidentiality is not compromised.

Please present questions or concerns at any time.

I UNDERSTAND AND ACCEPT THE CLINICAL POLICIES OUTLINED ABOVE:

____

Signature Date

If Patient is a Minor: I am the legal guardian of managing conservator and grant permission for treatment.

____ ______________________________

Signature Date