East Texas Psychological Services, PLLC
(903) 675-9570 FAX (903) 675-9577

PSYCHOLOGICAL HISTORY-CONFIDENTIAL

Date: _____ Pt Name: _____ DOB: _____

Address: _____ City: _____ ST:_____ Zip:_____

Phone: _____ E-mail:_____

DL#:_____ ST:_____ SS#:_____

Marital Status: ☐Single ☐Divorced ☐Widowed ☐Separated ☐Married

Family Physician: _____ Phone#:_____

Employer: _____ How Long: _____

Job Title: _____ Work Phone:_____

Name of Spouse: _____ DOB:_____ Years Married:_____

Spouse Employer: _____ How Long: _____

Referred By: _____

Emergency Contact: _____

Reason for your visit: _____

_____

_____

Have you had previous psychological testing or psychiatric/psychological treatment for you or your spouse? If so, please list the type of treatment, date, and location?

_____

_____

_____

_____

_____

PRIMARY INSURANCE

Insurance Company:_____

Policy#:_____ Group#:_____

Policyholder:_____ DOB:_____ Relationship:_____

I hereby authorize ETPS to contact my insurance company regarding my treatment and to provide said company with any information necessary in the processing of my claim. I realize that I am responsible for all charges incurred and that I will be asked to tender my co-payment and/or deductible at the time of service.

_____ _____
Signature Date

MEDICAL HISTORY

Height _____ Weight _____ Any Recent Weight Change? _____

Date of last Physical Exam:_____ Doctor:_____

List any medications (prescription and OTC) that you take regularly:

_____

_____

List any tranquilizers, antidepressants, or nerve medications you have taken on a regular basis in the past, and did they work?

_____

_____

Allergic to Any Medications? _____

List any current medical problems: _____

_____

_____

List all hospitalizations or major surgeries/illnesses within the last 10 years:

Where When Why

_____

_____

_____

FAMILY HISTORY

	Name	Age Now	Health	Lives Where	If Deceased Age/Cause
Father					
Mother					

How did your parents get along when you were growing up? _____

Briefly describe your Father's personality during your childhood: _____

_____

Briefly describe your Mother's personality during your childhood: _____

_____

If you had a stepmother or father give his/her/their name(s) and describe their personality during your childhood: _____

_____

Were you aware of any physical or sexual abuse in your family during your childhood? If Yes, who abused who, and was the abuse physical, sexual, emotional, etc.

_____

_____

PAST HISTORY

Place of Birth: _____ Age of parents: Father ____ Mother ____

Where did you go to High School? _____ Year of Graduation? _____

What school activities did you take part in during High School? _____

_____

College attendance (where, when & what degree)? _____

_____

Do you attend church regularly? _____ Which church? _____

MILITARY HISTORY

Which branch of service? _____ Date Entered? _____

Date of Discharge: _____ Highest Rank Held: _____

Type of Discharge: _____

MARRIAGE

Marriage #1: Dates: _____Your age then: _____Spouse's age then: _____

Spouses Name: _____ Number of Children from this marriage: ____

If marriage ended, when? _____ Why?_____

Marriage #2: Dates: _____Your age then: _____Spouse's age then: _____

Spouses Name: _____ Number of Children from this marriage: ____

If marriage ended, when? _____ Why?_____

Marriage #3: Dates: _____Your age then: _____Spouse's age then: _____

Spouses Name: _____ Number of Children from this marriage: ____

If marriage ended, when? _____ Why?_____

Marriage #4: Dates: _____Your age then: _____Spouse's age then: _____

Spouses Name: _____ Number of Children from this marriage: ____

If marriage ended, when? _____ Why?_____

Marriage #5: Dates: _____Your age then: _____Spouse's age then: _____

Spouses Name: _____ Number of Children from this marriage: ____

If marriage ended, when? _____ Why?_____

INFORMATION AND CONSENT

We are pleased that you have selected East Texas Psychological Services as your mental health provider. This document is to inform you about our background and to ensure that you understand our professional relationship and the services we offer.

We accept only clients that we believe have the capacity to resolve their own problems with our assistance. We believe that as people become more accepting of themselves and more knowledgeable, they are more capable of finding happiness and contentment in their own lives. However, self-awareness and self-acceptance are goals that take time to achieve, and some clients only need a few counseling sessions to achieve their goals. AS a client, you are in complete control and may end our professional relationship at any point. We will be supportive of that decision. If counseling is successful, you should feel that you are able to face life's challenges in the future without our ongoing support and/or intervention. You are always welcome to return for a "tune-up" should you feel the need.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to the sessions you arrange with your counselor. Please do not invite your counselor to social gatherings, offer him/her gifts, or ask him/her to relate to you in any other way outside of the professional context of your counseling/treatment. You can expect to learn a great deal about your counselor as you work together during the counseling/treatment experience. However, it is important for you to remember that you are experiencing your therapist in his/her professional role.

We will keep anything you say to us strictly confidential, with the following exceptions: (a) you direct us to share information with someone else; (b) I determine that you are a danger to yourself or others; or (c) I am ordered by a court to disclose information.

If at any time, for any reason, you are dissatisfied with our services, please let us know. If we are not able to resolve your concerns, you may report your complaint to the appropriate licensing agency. Also, please be advised that excessive "no-shows," failure to comply with treatment recommendations, inappropriate or "rude" behavior with office staff and other extenuating circumstances may ethically require us to withdraw as your mental health provider.

Our services will be rendered in a professional manner consistent with accepted ethical standards. Sessions are typically 45-50 minutes in duration. You will be billed for scheduled appointments, not canceled 24 hours in advance except in the case of emergency or at the discretion of your counselor. Phone calls after hours will be charged after 15 minutes at the usual hourly rate. Payment is expected that the time of service. We will be happy to bill all accepted insurances, and you will be responsible for your co-pay. Please feel free to discuss sliding scale payment options with our office staff as we are not interested in financially burdening you. We do have a licensed psychologist on staff at UT Health Athens Emergency Room in the event of crisis or emergency.

Psychological testing is a service provided by our office. Testing can take approximately 4-5 hours for a full evaluation. These services must be authorized by your insurance company prior to services being rendered. Our policy for testing requires three appointments at a minimum. Your first appointment will be to meet with the psychologist and get background information as well as the reason for the testing. Once your testing is approved by the insurance, you will be scheduled to come in and complete the testing, and the scoring process can take up to 2 weeks. After the scoring is complete, we will schedule an appointment to come back and review your results with you and answer any questions you may have.

If you have any questions, please feel free to ask our office staff or your counselor.

Have you ever been involved in a lawsuit against a physician or other healthcare provider? Yes_____ No_____

I authorize East Texas Psychological Services to provide services to myself and/or to my minor child _____.

I authorize East Texas Psychological Services to file for insurance or other benefits on my behalf, and I assign all such benefits to East Texas Psychological and Neurobehavioral Services.

I authorize East Texas Psychological Services to disclose information obtained from me for the purpose of filing for insurance or other benefits.

I understand that I am responsible for any part of the fee which is not covered by insurance or other benefits.

_____ _____

Signature (Insured Individual) Date

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ DOB:_____

Name and address of person/ agency/ institution releasing and/or receiving information:

_____

_____

_____

_____

_____

Name and Address of Primary Therapist:

_____

East Texas Psychological Services
700 S Palestine St/ PO Box 2536
Athens, TX 75751
Phone: 903-675-9570
Fax: 903-675-9577

I hereby authorize the physician, psychologist, therapist, hospital, agency, or institution mentioned above to have medical, psychiatric, psychological, or other records and information to the person has shown above is authorized to receive such information. I further authorized Dr. McBride and associates to release their findings to the party named above and to discuss the case as it will benefit my care.

I hereby authorize the physician, psychologist, therapist, psychiatrist, hospital, institution, agency, or keeper of records of the above institution/agency supplying medical, psychological, psychiatric, and/or other information/records from all legal responsibility and liability for release of all such information and/or records.

This Authorization to Release Information is valid for the duration of active treatment of the above-named patient/client.

_____

Signature of Client/Guardian Date

Agreement to Receive Electronic Communication

Patient Name:_____ DOB:_____

(Initial Below)

_____ I DO Agree

_____ I DO NOT Agree

That East Texas Psychological Service may communicate with me electronically at the email address/ mobile phone number listed on the new patient forms.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing East Texas Psychological Services any updates to my email address and/or mobile phone number.

My preferred method of electronic communication:

_____ Text Messaging

_____ Email

_____ Voice Call

I can withdraw my consent to electronic communications at any time by calling 903-675-9570.

Signature:_____ Date:_____