R. Scott Rhodes, Psy.D.

Clinical Psychologist
License # Psy9902

PATIENT INFORMATION

(Please Print)

The Patient is…

Name: _____ Today's Date: _____

Age: _____ Date of Birth: ____/____/____ Marital Status: _____

Address: _____City/State: _____Zip: _____

Cell Phone: _____ Home Phone? _____

email address? _____How should I contact you?_____

Social Security #: _____ Education Level? _____

Employed? By? _____ Work Phone: (___) _____

Spouse or Partner is…

Name of Spouse: _____ Spouse's Date of Birth: _____

Spouse's SSN: _____ Occupation: _____

Employer: _____ Phone: _____

Health Insurance is…

Insurance Plan: 1. _____Patient ID#:_____

2. _____Patient ID#:_____

Referred by: _____

Medications you take: _____ ____

_____

Nearest relative: _____Address_____

Their phone at home: _(____)_____Work Phone: _(_____) _____

Have you received psychiatric treatment before? Yes: ____ No: _____

How long ago? _____ How long was treatment_____

Who last treated you? _____

Why are you seeking treatment at this time? _____

How are you doing in these areas of your life currently?

	No Problem		*Mild Problems*		*Moderate Problems*		*Serious Problems*		*Can't function*
JOB	0	1	2	3	4	5	6	7	8
MARITAL	0	1	2	3	4	5	6	7	8
FAMILY	0	1	2	3	4	5	6	7	8
Interpersonal	0	1	2	3	4	5	6	7	8
Chemical Dependency	0	1	2	3	4	5	6	7	8
Mood problem	0	1	2	3	4	5	6	7	8
Other?	0	1	2	3	4	5	6	7	8

Please make (x) by each item below that pertain to you:

Nervousness __	Depression __	Panic attacks __	Shyness __
Sexual issues __	Suicidal Thoughts __	Separated __	Divorced __
Spend too much __	Sadness __	Drug use (specify) _____	Alcohol use __
Social problems __	Disorganized __	Few/ no friends __	Anxiety __
Impulsive __	Sleep problem __	Appetite problem __	Can't finish tasks __
Headaches __	Low motivation __	Family problems __	Difficulty keeping job __
Tiredness __	Legal trouble __	Forget things __	Don't trust people __
Hear or see things __	Can't make decisions __	Loneliness __	Low self-esteem __
Can't concentrate __	Flashbacks __	Can't relax __	Temper __
Nightmares __	Relationship Problems __	Crying spells __	Often feel dazed __
Stomach Trouble __	Medical Problems __	Compulsive habits __	Can't pay attention __
Too much energy __	Poor job habits __	Pacing, tapping fingers __	Migraines __
Chronic Pain __	Poor Social Skills __	Feel Emotionally Numb __	Poor Memory __
Hours of sleep PM? _____	Phobias ____	Learning Problems ____	Bizarre Thoughts __
Poor Judgment ___	Argumentative __	frequent failures ___	Spiritually Lost ___
Fearful ___	Stuck In Life __	Muscle tension ___	Feel inadequate ___
Feel isolated ___	Want to hurt myself ___	Difficulty w/ math ___	Don't like to read ___
Accident prone ___	Trouble w/ Violence ___	Scattered thoughts ___	Rape Survivor ___
Death in Family ___	Feel Unlovable ___	Parent / child problems ___	Other: _____

PATIENT AGREEMENT FORM

Date: _____

1. I, _____, agree to join with Dr. Rhodes at a regularly scheduled appointment time for psychotherapy sessions of fifty-minutes each. During these sessions, we will direct our mutual efforts toward therapeutic issues and goals we have identified. I have been informed and am aware that I have the right to refuse treatment at any time.

2. I agree to pay $_____per session for treatment given by Dr. Rhodes, for him resources, training, and experience as a psychotherapist. This amount is payable at the time of each session unless otherwise negotiated. This fee may be changed with a thirty day written notification to me by the doctor.

3. CANCELLATION OF SESSIONS: (**Please note carefully!)** I agree that if ever I need to cancel my session, I will do so at the earliest possible time. **If I cancel my session less than 24 hours in advance, Dr. Rhodes can bill me in full for that session if he cannot fill the session time with another client. This will be done regardless of the reason for canceling.** I am also aware that if I am seeing Dr. Rhodes using health insurance, this bill will be mine since insurance carriers will not reimburse for cancelled appointments.

4. **INSURANCE:** Therapeutic services provided by Dr. Rhodes may be paid for by insurance. However, I understand that Dr. Rhodes does not render services under the assumption that they will be paid for by my insurance. **I understand that I am fully responsible for any and all unpaid fees not reimbursed by my insurance company.** I further understand that some confidentiality will be lost as a result of the billing procedure when using my insurance. I understand that Dr. Rhodes is not responsible to bill my insurance company unless he agrees to do so. I am encouraged to ask him about this and all insurance policies he may have.

5. **COLLECTION OF DELINQUENT FEES:** I agree to assume responsibility for all unpaid fees that I incur in the process of therapy. I further understand and give consent to Dr. Rhodes to use any reasonable means necessary to collect unpaid fees (should I fail to pay my bill in a manner that we have arranged). "Reasonable or necessary means" may include collection agencies or Small Claims Court. Should these procedures become necessary, I am aware and consent to loss of confidentiality.

6. **TELEPHONE CONSULTATIONS AND TELEPHONE CRISIS INTERVENTION:** I understand that if I am in crisis or require a consultation, I may call Dr. Rhodes at any time through his cell phone VOICEMAIL or text him at 619-885-0941 or his automated answering service at 858-202-0010. If Dr. is not available to answer his phone immediately I will dial 911 for an emergency. When He calls back, Dr. Rhodes will schedule an appointment at the earliest possible time. If this is not acceptable to me, I understand that Dr. Rhodes reserves the right to bill me for sessions or parts of sessions held over the telephone. Such fees will be at the above-agreed hourly rate.

(Continued)

7. **CONFIDENTIALITY:** One of my most important rights involves confidentiality. All written or spoken material from any and all sessions, including psychological testing will be considered confidential unless I give written permission to release all or part of the information to a specific person, persons, or agency. **By law, exceptions to my confidentiality involve situations when there is evidence or suspicion of child abuse and/or when there is imminent danger to others or myself.**

8. I further stipulate that this agreement become part of my patient record and will be accessible to both parties upon request, but to no other person or party without my written consent. Such consent as has been waived above are the only exceptions.

9. I am aware that I may end treatment at any time.

MY SIGNATURE INDICATES THAT I HAVE READ, UNDERSTAND AND AGREE WITH THE NINE ABOVE CONDITIONS AND RIGHTS FOR MYSELF AS A PATIENT AND FOR DR. RHODES AS A THERAPIST.

_____ _____

Patient's or Parent's Signature **Date**

‘