ADULT INFORMATION SHEET

Date: ___/___/____

CLIENT'S NAME:_____ Birth date:___/___/____
(First) (Initial) (Last)

Age:___

Client's
Address:_____

City/State/Zip:_____ __ __ __ __ __
Zip Code

Occupation or school:_____

Referred by:_____

Please put a " ✓ " In the boxes below if it okay for me to leave a message at this number/email

Home Ph: (____)_____ ☐ Cell Ph: (____)_____ ☐

Work Ph: (____)_____ ☐ Fax: (____)_____ ☐

E-mail: _____ ☐

Marital Status:
Single __; Married __; Partnered__; Divorced __; Remarried__; Widowed __

Spouse/Partner Name: _____

His/Her Occupation: _____

His/Her Work Ph: (____)_____ ☐

Please list all children you have had. First list those currently living with you.
Then draw a line and list others who do not live with you on a full-time basis.

Name	Relationship	Age	Grade or Occupation
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____

PERSON RESPONSIBLE FOR BILL: (or "same")

Name:_____ Hom e Ph:(____) _____-_____

Address:_____ W ork Ph: (____) _____-_____

City/State/Zip:_____

- **I authorize the release of any medical information necessary to process insurance claims.**
- I authorize payment of benefits to Dr. Schenk if full payment is not made at the time of service.
- I understand that I am responsible for missed appointment charges (50% of the full fee for the length of session scheduled) unless Dr. Schenk is notified 24 hours in advance.
- I understand that I am responsible for payment of all services rendered. In the event that payment is not made at the time service is rendered, then I agree to pay my account balance in full within 30 days of the billing date. If timely payment is not made, I agree that I am responsible for all costs of collection, including court costs and reasonable attorney's fees.
- I understand that interest may be charged on outstanding balances more than 60 days old at the rate of 1 % per month.

SIGNED_____ Date: ____/____/_____

INSURANCE INFORMATION: (if applicable) ***Please*** *check your policy to determine if preauthorization is needed.* **Please note: *Claims for services will be sent to your insurance company each month unless you specifically instruct otherwise*.**

Name and address of policy holder (or "same"):

_____

_____

Insurance Company Name:_____ Ph #: (____) ____-_____

Claims Address:_____

City/State/Zip:_____

Member (ID) #:_____ Group #:_____ D.O.B. ___/___/_____

Employer:_____

Patient's Relationship to policy holder:
[ ] Self [ ] Spouse [ ] Child [ ] Other

I have read [ ] and/or received [ ] a copy of the HIPAA notice regarding Dr. Schenk's office policies and practices to protect my health information. Available at: http://www.drpaulschenk.com/forms/HIPAA.PDF

initial initial

_____ Date: ____/____/_____
Signature

ADULT QUESTIONNAIRE

Date _____

Your answers to the three sections on this page are very important. Please use the first section to tell me your reason(s) for requesting my services. Use the second section to describe ways you want your life to have changed for the better when we *finish* working together. Then use the third section to tell me about areas in your life where you are generally pleased about how things are *already* working.

Language spoken in the home if not English: _____

Internist _____

Address _____

_____

Telephone _____

Permission to talk to internist? Yes _____ (Please initial if yes) No _____

Have you been in therapy before? Yes [ ]; No [ ]

If *yes*, please briefly summarize (when, how long, goals, results):

_____

_____

_____

_____

If *yes*, please provide the name, address and phone number of your most recent therapist. I will not contact him/her before I obtain a signed release from you.

Therapist name:_____

Address _____

_____

Telephone (____)_____-_____

Pregnancy and Birth History

To the extent known, please complete the following:

Describe any complications that occurred during your mother's pregnancy with you.

_____

_____

_____

Describe any complications that occurred during delivery (e.g., prematurity, postmaturity, length of labor, special procedures, low APGAR score, etc.).

_____

_____

_____ Birth Weight _____

How long after birth did your parents take you home? _____

Early Temperament

Describe your temperament during the first six months (i.e., sleep patterns, colic, eating patterns).

_____

_____

_____

Developmental History

To the extent known, please list any developmental milestones that occurred early or late. (Walking, talking, toilet training, etc.)

_____

_____

Medical History

List significant sicknesses, operations and injuries. Note history of frequent ear infections, ruptured eardrums, tubes. Include the age when they occurred and severity. Please pay special attention to head injuries, any loss of consciousness, convulsions, or very high fever.

_____

_____

_____

_____

Did anyone in your immediate family or their close relative have any of the following:

Nervous tics	Yes ____	No ____	Who _____
Seizures (epilepsy)	Yes ____	No ____	Who _____
Depression	Yes ____	No ____	Who _____
Bipolar Disorder	Yes ____	No ____	Who _____
Thyroid problems	Yes ____	No ____	Who _____
Other emotional problems	Yes ____	No ____	Who _____
Hyperactivity/ADHD	Yes ____	No ____	Who _____
Learning problems	Yes ____	No ____	Who _____
Language problems	Yes ____	No ____	Who _____
Mental retardation	Yes ____	No ____	Who _____
Similar problems to you	Yes ____	No ____	Who _____

Does any disease run in the family? If so, what? _____

Indicate any medications you are ***currently*** taking and the prescribing physician. (Include dosage and the reason for taking it.)

Medication Dose Physician Reason for taking

_____

_____

_____

_____

_____

_____

Indicate any medication you have taken ***in the past few years for more than a month*** and the prescribing physician. (Indicate dosage and the reason for taking it.)
Medication Dose Physician Reason for taking

_____

_____

_____

_____

Approximately when was your vision last examined? _____
Results _____

Approximately when was your hearing last examined? _____
Results _____

Other special medical tests (EEG, CAT scan, MRI)
Name of Test _____ Date _____
Results _____

Have there been any previous psychological, psychiatric or neurological evaluations? Yes [ ]; No [ ] If *yes*, please list the year and provider. Please attach any pertinent reports.

_____

Height: ___' ____" Current weight: ____ Range during last 12 months: _____

Please describe current and past tobacco use: _____

_____ _____

Caffeine use: # cups coffee/day _____; # caffeinated 12 oz. soft drinks/day _____

History of alcohol use (1 beer = 6 oz wine = 1 oz hard liquor):

Your current range per week: from ___ to ___ drinks.

Past range per week (at your highest usage): from ___ to ___ drinks.

When was this? _____

Have you ever been in an accident or had a ticket for driving under the influence?

Yes [ ]; No [ ] If *yes*, please give details. _____

_____

If you have ever had moving traffic violations, please describe:

_____

_____

Social/Emotional/Behavioral History

Please list your personality characteristics, both positive and negative:

_____

_____

_____

_____

_____

_____

School History

List previous schools, colleges/universities, technical schools attended:

Years School Degree (if any) Approx. GPA

_____

_____

_____

_____

Describe any learning/behavioral/social difficulties you had while attending school:

_____

_____

_____

Describe any special services you received in school or privately (resource room, tutors, remedial reading, speech therapy, etc.):

_____

_____

_____

Did you ever repeat a grade? _____ When? _____

What was the problem? _____

_____

_____

I very much appreciate the time and energy you spent in filling out this questionnaire. Please add any additional comments on a separate sheet of paper as needed.
When you come for your first appointment, please bring a photograph of yourself (and your family if that applies.) I will make a copy and return the originals.

Signed _____

Insurance Benefits Worksheet

This worksheet is designed to help you get the most from your insurance policy. Some insurance companies require pre-authorization for behavioral/mental health services. Those that do rarely back date an authorization, so please call your carrier before your first appointment to be sure. Some insurance companies use a "third party administrator" or "TPA" to handle mental health benefits. Note: For couples with two different policies, I believe Georgia law dictates that the insurance of the policy holder with the earlier birth date (the birth *month*, not the birth year) will be the primary policy.

Insurance companies like to have providers sign contracts. Providers ostensibly benefit by getting more referrals when they are on the provider list. The tradeoff is that the "allowed" rate contracted providers are allowed to charge has continued to decrease over the past 25 years or so to what I used to charge in 1980. Because of this, in 2012 I terminated my contracts with all insurance carriers except Medicare, Medicaid, Wellcare, Ambetter/ Cenpatico and Tricare.

Unfortunately, I find it often takes several phone calls to get to the person at the insurance company who can answer the questions that follow.
1st #: (_____) _____ - _____ x__ x__ x__ x__ Name of Person Contacted:_____
2nd #: (_____) _____ - _____ x__ x__ x__ x__ Name of Person Contacted:_____
3rd #: (_____) _____ - _____ x__ x__ x__ x__ Name of Person Contacted:_____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____/_____/_____
Policy Holder's ID#: _____
Group#: _____
Please confirm the name and address for mailing mental health claims. It is usually *not* the address on the insurance card.
Insurance Company Name: _____
Address: _____
_____
City: _____ State: ___ Zip Code:_____

To answer these questions, the insurance company will need to know:
My name: Paul W. Schenk, Psy.D. ("Dr. Schenk, a doctoral level clinical psychologist")
My zip code: 30345
My federal tax id#: 58-1477829
I am an "out of network" provider (except for Medicare, Medicaid, Wellcare, Ambetter/Cenpatico and Tricare). Some policies do not cover any out of network services; some have a different deductible.

Is pre-authorization required for mental health visits? [ ] yes; [ ] no
If "yes", ask for the authorization # for the initial visit(s): _____
Authorization # for subsequent visits (if provided): _____
The number of (additional) visits approved with this authorization: _____

Is a separate pre-authorization required for testing? [ ] yes; [ ] no
If "yes", ask for the authorization # for testing: _____, or
Ask for the web site URL where they have the form that I must submit. (I have some, but not all of these.)

Is there a separate mental health deductible for the policy? [ ] yes; [ ] no
If "yes", how much is it? $_____ How much has already been met? $_____
If "no", how much is the medical deductible? $_____ How much has already been met? $_____
Is there a separate deductible for out-of-network services?
If "yes", how much is it? $_____ How much has already been met? $_____
Is your deductible based on a calendar year [ ] or on a different 12 month period? ____to ____

Getting the insurance company to tell you its Usual and Customary Rate (UCR) is usually challenging. Be persistent is you need to know. Use this list to record how much of my standard fee the insurance company will consider for the services you want. Remember, if they tell you they will cover 80%, leaving you with a co-payment of 20%, that 80% reimbursement rate will be based on their UCR rate, which is probably less than my rate.
For example, if the UCR is $140 for CPT code 90837, and the insurance company covers 80% *(of the UCR)*, they will pay $112, leaving you a co-pay of $88 (my actual fee of $200 - $112 = $88).

CPT Code	**Type of Session**	**Fee Schedule: Amount *Allowed* the "UCR" rate**
CPT code 90832	Individual Psychotherapy (30 minutes)	$_____ out of $100
CPT code 90834	Individual Psychotherapy (45 minutes)	$_____ out of $170
CPT code 90837	Individual Psychotherapy (60 minutes)	$_____ out of $200
CPT code 90791	Diagnostic Interview (60 minutes)	$_____ out of $200
CPT code 90847	Family Psychotherapy (60 minutes) (e.g., the client and one or more other family members)	$_____ out of $200
CPT code 90846	Collateral Visit (60 minutes) (e.g., the child is the client but I am meeting with one or both parents *without* the child present.)	$_____ out of $200
CPT code 96101	Psychological Testing/Evaluation (per 55 minute hour) Can more than one hour (one "unit") of Psych Testing be billed on the same day? [ ] yes [ ] no	$_____ out of $200

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