CLIENT

NAME:
_____

ADDRESS:
_____

_____

CITY/STATE/ZIP:_____
_____

HOME TELEPHONE:_____

EMPLOYER

COMPANY NAME:_____

ADDRESS:_____

_____

CITY/STATE/ZIP:_____
_____

PHONE #1: _____
PHONE #2:_____

OCCUPATION:_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME:_____

ADDRESS:_____

_____

CITY/STATE/ZIP:_____
_____

TELEPHONE #:_____

SOCIAL SECURITY #:_____

RELATIONSHIP TO CLIENT: _____

DATE: _____ DATE OF BIRTH: _____

AGE: _____ SEX: _____
_____

SOCIAL SECURITY #: _____

THERAPIST TO BE SEEN:

- ☐ **RICK ADAMS, PH.D.**
- ☐ **JOHN SIMONEAUX, PH.D.**

WHO REFERRED YOU TO C.P.C.L.?

_____

MAY WE SEND A "THANK YOU" LETTER TO REFERRAL PERSON?

- ☐ **YES**
- ☐ **NO**

PLEASE PROVIDE THE NAME OF YOUR PHYSICIAN

NAME: _____

CITY:_____

PLEASE LIST THE NAME AND ADDRESS OF A RELATIVE OR SOMEONE ELSE WHO WILL KNOW HOW TO GET IN TOUCH WITH YOU.

NAME:_____

ADDRESS:_____

_____

CITY/STATE/ZIP:_____

PHONE:_____

RELATIONSHIP:_____

PERSONAL DATA

WHERE WERE YOU BORN?:
_____

WHAT IS YOUR RELIGION?:_____

HOW ACTIVE ARE YOU IN YOUR RELIGION?:

- ☐ **VERY ACTIVE**
- ☐ **SOMEWHAT ACTIVE**
- ☐ **ROUTINE ATTENDANCE**
- ☐ **NOT VERY ACTIVE**
- ☐ **NOT AT ALL ACTIVE**

WHAT IS YOUR EDUCATIONAL LEVEL?:

- ☐ **LESS THAN HIGH SCHOOL**
- ☐ **FINISHED HIGH SCHOOL**
- ☐ **VO-TECH SCHOOL**
- ☐ **BUSINESS COLLEGE**
- ☐ **SOME COLLEGE**
- ☐ **FINISHED COLLEGE**
- ☐ **SOME PROFESSIONAL SCHOOL**
- ☐ **FINISHED PROFESSIONAL SCHOOL**

HOW WERE YOUR GRADES IN SCHOOL?:

- ☐ **VERY GOOD**
- ☐ **GOOD**
- ☐ **AVERAGE**
- ☐ **BELOW AVERAGE**
- ☐ **POOR**

PLEASE INDICATE WHICH OF THE FOLLOWING HEALTH PROBLEMS APPLY TO YOU:

- ☐ **BLACKOUTS**
- ☐ **DIZZINESS**
- ☐ **FATIGUE**
- ☐ **MUSCLE SPASMS**
- ☐ **RACING HEART**
- ☐ **SWEATING**
- ☐ **ALLERGIES**
- ☐ **WEAKNESS**
- ☐ **BLURRED EYES**
- ☐ **UNCONSCIOUSNESS**
- ☐ **BOWEL PROBLEMS**
- ☐ **DRY MOUTH**
- ☐ **HEADACHES**
- ☐ **NUMBNESS**
- ☐ **SKIN PROBLEMS**
- ☐ **TREMORS**
- ☐ **VOMITING**
- ☐ **CONSTIPATION**
- ☐ **IRREGULAR MENSES**
- ☐ **CHEST PAINS**
- ☐ **FAINTING**
- ☐ **HEARING PROBLEMS**
- ☐ **MEMORY PROBLEMS**
- ☐ **STOMACH PROBLEMS**
- ☐ **ASTHMA**
- ☐ **DIARRHEA**
- ☐ **MENSTRUAL CRAMPS**
- ☐ **WEIGHT CHANGE**
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

MARITAL STATUS

SPOUSE'S NAME: _____

SPOUSE'S AGE: _____

IS THERE ANY CHANCE THAT SERVICES WILL INVOLVE LEGAL PROCEEDINGS AT ANY POINT?

- ☐ **YES**
- ☐ **NO**

YOUR ATTORNEY:_____

ADDRESS:_____

_____

CITY/STATE/ZIP:_____

_____

PHONE #:_____

OPPOSING ATTORNEY: _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY?

- ☐ **YES**
- ☐ **NO**

IF SO, PLEASE EXPLAIN THE CHARGE:

_____

_____

_____

_____

_____

_____

WHAT WERE THE REASONS FOR SCHEDULING THIS APPOINTMENT?

- ☐ **HOSPITAL AFTERCARE**
- ☐ **BEHAVIOR PROBLEMS**
- ☐ **FAMILY PROBLEMS**
- ☐ **CHILD PROBLEMS**
- ☐ **MARITAL PROBLEMS**
- ☐ **PERSONAL PROBLEMS**
- ☐ **OCCUPATIONAL PROBLEMS**
- ☐ **SCHOOL PROBLEMS**
- ☐ **COURT ORDERED EVALUATION**
- ☐ **COURT ORDERED THERAPY**
- ☐ **COURT RELATED**
- ☐ **CUSTODY EVALUATION**
- ☐ **CHILD PROTECTION EVALUATION**
- ☐ **CHILD PROTECTION REFERRAL**
- ☐ **DISABILITY DETERMINATIONS (SOCIAL SEC.)**
- ☐ **WORKMAN'S COMPENSATION**
- ☐ **OTHER PROBLEMS**

_____
_____
_____

PLEASE INDICATE WHICH OF THE FOLLOWING WORDS WOULD DESCRIBE YOU:

- ☐ **AMBITIOUS**
- ☐ **CONFLICTED**
- ☐ **CRAZY**
- ☐ **EVIL**
- ☐ **HARDWORKING**
- ☐ **IMMORAL**
- ☐ **INDECISIVE**
- ☐ **LONELY**
- ☐ **NAIVE**
- ☐ **PROCRASTINATING**
- ☐ **TRUSTWORTHY**
- ☐ **WORTHLESS**
- ☐ **NO CONCENTRATION**
- ☐ **CONFUSED**
- ☐ **DEVIANT**
- ☐ **FUNNY**
- ☐ **HONEST**
- ☐ **INADEQUATE**
- ☐ **INTELLIGENT**
- ☐ **OUT OF CONTROL**
- ☐ **PERSEVERING**
- ☐ **SENSITIVE**
- ☐ **UGLY**
- ☐ **UNMOTIVATED**
- ☐ **WORTHWHILE**
- ☐ **ATTRACTIVE**
- ☐ **CONFIDENT**
- ☐ **CONSIDERATE**
- ☐ **ENERGETIC**
- ☐ **GUILTY**
- ☐ **HOPELESS**
- ☐ **INCOMPETENT**
- ☐ **JEALOUS**
- ☐ **LOYAL**
- ☐ **REGRETFUL**
- ☐ **STUPID**
- ☐ **UNLOVABLE**
- ☐ **USELESS**
- ☐ **OVERWEIGHT**
- ☐ **SKINNY**

INDICATE WHICH OF THE FOLLOWING HAVE BEEN PROBLEMS FOR YOU IN YOUR LIFETIME:

- ☐ **AGGRESSION**
- ☐ **ANGER**
- ☐ **ANXIETY**
- ☐ **BAD THOUGHTS**
- ☐ **COMPULSIONS**
- ☐ **CONCENTRATION**
- ☐ **DRINKING**
- ☐ **EATING PROBLEMS**
- ☐ **IMPULSIVENESS**
- ☐ **SEXUAL PROBLEMS**
- ☐ **HOMICIDAL IDEAS**
- ☐ **ALCOHOL**
- ☐ **OUTBURSTS**
- ☐ **SUICIDE**
- ☐ **CRYING**
- ☐ **DELUSIONS**
- ☐ **DEPRESSION**
- ☐ **DRUGS**
- ☐ **FEARS**
- ☐ **VISIONS**
- ☐ **SLEEP PROBLEMS**
- ☐ *_____
- ☐ *_____
- ☐ *_____

PLEASE STATE YOUR CURRENT PROBLEMS BELOW:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE LIST CURRENT MEDICATION INFORMATION BELOW:

MEDICATION NAME	HOW LONG	DOSAGE	FREQUENCY	DOCTOR

PREVIOUS TREATMENT HISTORY
OUTPATIENT THERAPY

APPROXIMATE DATES	THERAPIST	REASONS FOR STARTING AND FINISHING

INPATIENT TREATMENT - PSYCHIATRIC OR OTHERWISE

HOSPITAL NAME	APPROX. DATE	LENGTH OF STAY	DOCTOR	REASON FOR ADMISSION

PATIENT INFORMATION

STAFF

Rick Adams, Ph.D. — Clinical Psychologist
John Simoneaux, Ph.D. — Counseling Psychologist

SERVICES

Individual, marital, and family therapy.
Group psychotherapy
Parent counseling for child management problems
Psychological evaluation for school, medical, home, and legal purposes

Education and consultation for community and professional groups on psychological problems and issues

APPOINTMENTS

Our office hours are scheduled daily, Monday through Friday, 7:00 a.m. - 5:00 p.m. Each appointment lasts 50 minutes. Schedules of individual staff members vary and arrangements for late evening appointments may be made.

Failed appointments and appointment cancellations without 24-hour notice are often a sign of resistance to treatment and are viewed as a reason for case termination. Charges for canceled or failed appointments are billed at the full hourly rate. This policy will be enforced unless there are highly extenuating circumstances. If you have to cancel your appointment, please give us adequate notice so that your appointment time may be used for someone else. New patients on waiting lists and patients with emergencies are scheduled as cancellations occur. Thus, when patients fail to keep their appointments or cancel without 24-hour notice, they have deprived another person an appointment time. Please be considerate of not only your therapist's time, but also your fellow man. Our telephone number is (318) 641-0800. Messages can be left with our answering service at any time, day or night, weekends or holidays.

TELEPHONE

Consultations are for your convenience and can require as much time for us as an office consultation. A large number of phone messages are handled by us each day. We return our calls as time permits or as the situation demands. If you need to call, we ask that you give a brief description of your problem to our receptionist. In this manner, your problem may be relayed intelligently and quickly to your therapist for a more prompt response. All long-distance calls will be returned collect or gilled to the patient's account. In the case of an emergency, after hours or on weekends, please call our answering service at (318) 641-0800. We are on 24-hour call and will return your call as soon as possible.

It is not our policy to consistently treat psychological difficulties over the phone, unless you have an emergency. If you are having problems, please schedule an office appointment.

FEES

All fees for services rendered are standardized for equality and based on the amount of professional time involved in providing the service. Payment is expected at the time the service is provided. We accept personal checks, Master Card/Visa, and cash for the exact amount of the service. A $20.00 service fee is charged for all NSF checks.

Charges are also made for consultations with family members or other professionals involved in the total care of the patient (e.g., physicians, attorneys, teachers). We are happy to discuss any and all charges and fees with you. If your account becomes delinquent and a collection agency is required, the account will be turned over for collection and you will be responsible for any attorney fees involved in the collection of your account.

INSURANCE

Payments for psychological services are generally covered under health insurance policies having mental health benefits.

CONFIDENTIALITY

Your record is confidential, subject to the following exceptions: suicide, homicide, and child protection issues, etc.

If you have questions about this, please discuss them with your therapist.

CONFIDENTIALITY

Confidentiality does not apply:

1. **If you are ever involved in personal injury litigation.**
2. **When child abuse is suspected — it is mandatory that it be reported.**
3. **If you are ever involved in child custody litigation.**
4. **If you are ever charged with a crime and claim insanity as a defense, your medical records can be subpoenaed.**
5. **If you discuss any criminal activity which may ultimately be investigated by law enforcement personnel and you have signed a release statement on a health insurance form to obtain benefits. (This Louisiana District Court Ruling is currently under appeal.)**

PATIENT AGREEMENT

I have read the Patient Information and Confidentiality information sheet and understand and agree to these policies.

____ Date: ____

Patient Signature

____

Witness

****

Assignment of Insurance Benefits and Release Information:

I hereby authorize my insurance benefits to be paid directly to Consulting Psychologists of Central Louisiana, Inc. and I understand that I am financially responsible for any remaining balance. I understand that I am responsible for this bill in it's entirety, in the event that insurance reimbursement is not forthcoming. I also authorize release to the insurance carrier of any information pertaining to this claim.

Signature of Insured: ____

Date: ______________________________