WAYNE PSYCHOLOGICAL GROUP LLC

Patient's Last Name_____**First**_____**M.I.**___ Mr./Mrs./Miss/Ms./Dr.
Date of Birth_____ Preferred Gender Identification:_____ Occupation/Grade _____
Address_____ City_____State_____Zip_____
Home Phone (___)_____ Work Phone (___)_____ Ext. _____
Patient's Cell Phone(___)_____ **Patient's Email Address**:_____
If patient is a child, Mother's Cell Phone (____)_____ Father's Cell Phone (____)_____
Parent's Email _____

Today's Date_____Who referred you or how did you hear of us?__
Marital Status (please circle) single/married/separated/divorced/widow/other
Employment Status (please circle) employed full time/employed part-time/part-time student/full-time student/homemaker/unemployed/other

Date Symptom First Occurred_____
Has Patient ever had similar condition? yes/no If yes, when?_____

Was Condition Related to (please circle)
Employment? yes/no
Auto Accident? yes/no State Auto Accident Occurred _____
Auto Insurance Company_____ Claim #_____
Other Type of Accident? yes/no

Have you or the patient ever been to another psychotherapist (or psychiatrist) or been a patient in a psychiatric hospital? If so, please list:

Name or Hospital	Address	Reason	Dates

Please list all psychoactive medications that have been prescribed:

Medication	Dosage	Dates	Physician

Primary Care Physician_____
Address_____
Phone Number_____

Who is in your Household?

Name of Household Member	Age	Relation to patient	Grade or Occupation

Briefly describe why patient is coming here: _____

_____

Any suicidal thoughts? _____ Plans? _____ Attempts? _____

List any physical or medical problems:

Education:

Religion or Spiritual Beliefs:

Have you served in the Armed Forces? Yes____ No_____ If so, what branch and when? _____

History of Legal Issues? Yes_____ No_____ If yes, please explain _____

_____

Alcohol/Chemical/Abuse or Dependency History:

Past Use: Yes____ No____ Current Use: Yes____ No____
Substance(s)_____
If Current Use, Describe: _____
Frequency:_____ Amount:_____
Length of Use:_____ Longest Period of Sobriety _____
Prior Treatment (Include 12 Step involvement):_____
Comments:_____

Substance Use: Please check all that apply:

	Past Use	**Present Use**
Caffeine		
Tobacco or vaping		
Alcohol		
Marijuana or THC vaping		
Opiates/ Narcotics		
Amphetamines		
Cocaine		
Hallucinogens		
Prescription Pain Killers		

Preferred Gender Pronouns (Optional): _____

Please fill out only if person responsible for payment is *not* the patient.

Last Name_____ First_____M.I.___ Mr. Mrs. Miss Ms. Dr. Gender _____
Date of Birth_____ Email Address _____
Street Address_____
City_____ State_____ Zip_____ Home Phone (___)_____
Work Phone (___)_____Ext._____ Cell Phone (___)_____

THE FOLLOWING MUST BE COMPLETED BY EVERYONE. Please read carefully.

INFORMED CONSENT: I agree and consent to participate in behavioral health care services offered and provided by Drs. Emile Gurstelle or Eileen Stahl, a behavioral healthcare provider. I understand that I am consenting and agreeing only to those services that the above-named providers are qualified to provide within the scope of the provider's license, training, and experience. For example, we don't prescribe medicine. You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that I provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this Agreement, you agree that we can provide requested information to your carrier. I also agree to participate in HIPPA compliant telehealth if I or the provider request it. If the patient is under the age of 18 or is unable to consent to treatment, I attest that I am legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____**Date**_____**Relationship to Patient** (if applicable)
_____ _____

I have received a copy of OFFICE INFORMATION and our HIPAA Notice and Patient Agreement Forms. Please initial:_____

ARE YOU PAYING PRIVATELY OR WILL YOU USE YOUR HEALTH INSURANCE?

I will pay for these visits privately and I am responsible to pay all charges in full at the time of the appointment. **Please initial: _____**

OR

I will use my insurance. I authorize the release of any information to my insurance and/or managed care company that is necessary to process my claims. Although most insurance companies maintain confidentiality of medical records, I understand that Wayne Psychological Group LLC cannot be responsible for the confidentiality of any information and/or records once they leave this office. I authorize my insurance and/or managed care company to pay medical benefits to Wayne Psychological Group LLC for services rendered. I agree that I am responsible to pay any copayment, deductible, or for any services not covered by my insurance. Should my insurance or managed care company determine that any services received here are not medically necessary, I understand and agree that I will be responsible to pay for these services in full.
Please initial: _____

I understand that deductibles, copayments and/or coinsurance are due at time of service. I understand, except in case of emergency, I will be charged $75.00 for any missed appointment or appointment not cancelled with at least 24 hours notice.

Signed_____Date_____