



Psychological ARTS

4131 Spicewood Springs Rd. #E-2
Austin, TX 78759
Phone: (512) 343-8307
E-mail: spice@psycharts.com

Fax: (512) 452-7282
<http://www.psycharts.com>

7801 N. Lamar Blvd. F-8
Austin, TX 78752
Phone: (512) 452-6383
E-mail: lamar@psycharts.com

Please PRINT CLEARLY and fill out the form COMPLETELY

Patient's Full Name _____ Date of Birth _____

Sex: F M Age: _____ Social Security # _____ Marital Status: _____

Home phone _____ Work phone _____ Cell phone _____

I authorize any representative of Psychological ARTS to leave a message regarding pending appointments:
 on my home answering machine w/ family member _____ at work on my cell phone

INSURANCE: Please provide copies of all Insurance Cards (front and back)

What type(s) of insurance do you have? Private/Commercial Medicare Medicaid
 Workman's Comp None

PRIMARY INSURANCE If you have additional insurance, please request the "Additional Insurance Form"

Name of Insurance _____ Insurance phone # _____

Policy ID # _____ Insurance Address _____

Group # _____ City/State/Zip _____

POLICY
HOLDER
INFO.

Name: _____

Employer Name _____

Birthdate: _____

Employer Address _____

Social Security # _____

City, State, Zip: _____

PHYSICIAN: Name of Primary Care Physician _____ Phone # _____

Address _____ City/State/Zip _____ fax _____

May we share information with your Physician? YES NO _____
Your signature

REFERRAL SOURCE

How did you learn of our practice? _____

Authorizations to pay benefits to Psychological ARTS PC

I hereby authorize payment of medical/behavior health benefits to Psychological ARTS PC for services rendered to me (my dependent). I authorize the release of any medical or other information necessary to process this claim.

I also request payment of government benefits either to myself or to the party who accepts assignment.

I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in any attempt to collect said balance.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

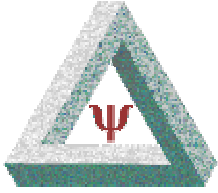
The person signing this agreement will be the recipient of the billing and must provide their address and printed name. Please write the relationship to the client. Write "self" if you are the client.

Signed _____ Date _____

Printed Full Name _____ Relationship to client _____

Address: _____

City: _____ State _____ Zip _____



Psychological ARTS Additional Insurance

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Please PRINT CLEARLY and fill out the form COMPLETELY.

Patient

Patient's Full Name: _____ Date of Birth: _____

Insurance

Please provide copies of all Insurance Cards (front and back)

What type(s) of insurance do you have?
(Check all that apply.)
 Private/Commercial Medicare Medicaid
 Workman's Comp None

Secondary Insurance

Name of Insurance: _____ Insurance Phone #: (____) _____
Policy ID #: _____ Insurance Address: _____
Group #: _____ City, State, Zip: _____

Policy
Holder
Information

Name: _____ Employer Name: _____
Date of Birth: _____ Employer Address: _____
Social Security #: _____

Any Additional Insurance

Name of Insurance: _____ Insurance Phone #: (____) _____
Policy ID #: _____ Insurance Address: _____
Group #: _____ City, State, Zip: _____

Policy
Holder
Information

Name: _____ Employer Name: _____
Date of Birth: _____ Employer Address: _____
Social Security #: _____

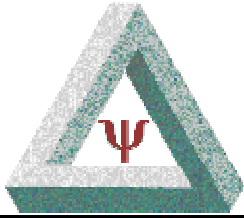
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Insured's Or Authorized Person's Signature

Signed: _____

Date: _____



Psychological ARTS Treatment Consent

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Informed Consent for Psychological Treatment

I hereby give my consent for psychological treatment for myself (or dependent) by Psychological ARTS PC. Treatment may include talk psychotherapy, relaxation training, or evaluation services rendered to me/my dependent.

Receipt of Texas Notice Form

I hereby acknowledge that I have been provided the [Texas Notice Form](#). I understand that my Protected Health Information (PHI) can be used for treatment, payment and health care operations. I understand that my PHI may be disclosed as mandated and without my authorization in the following instances: Child abuse and neglect, threats to health and safety, social security administrative functions, and judicial procedures.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Signed _____ Date: _____

Authorization to Release Clinical Records

I authorize Psychological ARTS PC to obtain/release copies of my clinical records to any physician or institution, which in the judgment of my clinician will enhance the continuity of care – treatment or evaluation – for me or my dependent. **Note: You may choose not to sign this section, please discuss this with our staff.**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Signed _____ Date: _____

Insurance and other Third Party Payers

Even if you have health care insurance, you are ultimately responsible for payment for the services which you contract to receive from our office.

Make sure you understand your policy requirements and benefits for mental health services. Most insurance companies will have a disclaimer that authorization for services does not guarantee payment of services. Also, the actual co-pay may differ from the stated amount after the insurance company processes the claim. In addition, you might have a deductible to meet before your insurance covers any charges. Furthermore, your insurance might only cover a percentage of the charge, which can change according to your policy after a certain number of sessions.

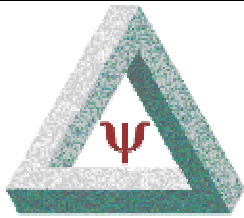
Fee for No Show

I understand that I am contracting for units of clinician time which cannot be scheduled for anyone else unless PARTS receives sufficient advance notice to reschedule the time. I agree to pay \$50 per scheduled hour unless I give 24 hours notice – in which case the “no show” fee is waived.

Your signature below indicates that you agree to the “no show” fee and agree to abide by the terms described in the [Client-Clinician Collaboration Agreement](#). If you would like to question or modify any aspect of this agreement, please bring it up with your therapist.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Signed _____ Date: _____



Psychological ARTS

Depression Screen

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[HTTP://WWW.PSYCHARTS.COM](http://www.PSYCHARTS.COM)
[HTTP://SOULDIRECTED.COM](http://SOULDIRECTED.COM)
[HTTP://ALCOHOL-DRUG.COM](http://ALCOHOL-DRUG.COM)

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Name: _____ Date: _____ Total Score: _____

How often have you experienced the following signs over the past 14 days?

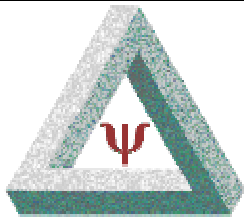
Sign and Symptoms	Score 0	Score 1	Score 2	Score 3
Depression	Rarely: 0 or 1 day	Minority of the time: 2-6 days	Majority of the time: 7-12 days	Nearly all the time: 13 or 14 days
Thoughts that you would be better off dead; or suicidal thoughts				
Diminished interests, enthusiasm, and experience of pleasure				
Feeling depressed or hopeless				
Trouble falling or staying asleep, or can't get out of bed				
Loss of appetite; or excessive appetite				
View self as worthless, a failure, or shameful				
Difficulty concentrating				
Slow movements or speech; or agitated movements or speech				
Believe that you let yourself or others down				

Total Depression Score: _____

Sign and Symptoms	Score 0	Score 1	Score 2	Score 3
Anxiety	Rarely: 0 or 1 day	Minority of the time: 2-6 days	Majority of the time: 7-12 days	Nearly all the time: 13 or 14 days
Worrying – thinking about threatening things				
Nausea, headaches, other symptoms of tension				
Shortness of breath, rapid heart rate				
Avoiding places or situations				
Seeing self as unable to cope				
Quick to startle, or enhance startle response				
Panic or anxiety attacks				
Restlessness or subjective feelings of anxiety				
Thinking, "What if. . . [some negative event]"				

Total Anxiety Score: _____

Interpretation:
 Less than 4 = insignificant symptoms
 5-9 = mild symptoms
 10-14 = moderate symptoms
 15-19 = moderate/severe symptoms
 more than 20 = severe symptoms



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Intake Form

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Name: _____

Date: _____

1. What is the problem?

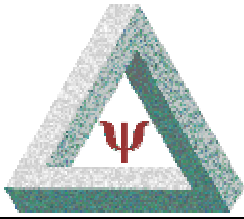
2. What caused you to seek my services at this time?

3. May I discuss your case with your physician? If so, please provide name and phone number below.

Name: _____ Phone Number: (_____) _____

4. Please list medications you take:

5. What outcome are you seeking?



Psychological A R T S Intake Form

Name: _____ Date: _____

Please choose the phrase that best describes your motivation for today's visit:

- 1. I don't have a problem; someone else thinks I do.
- 2. I do have a problem; I do want to change, but at the same time I don't want to change.
- 3. I am getting ready to change and am about to make the commitment.
- 4. I have already begun taking action to resolve this problem.
- 5. I have achieved my goal and am focused on preventing relapse.
- 6. I have relapsed and I am seeking to regain control.

I am seeking:

- Advice on solving my problems
- Hypnotherapy
- Cognitive-Behavior Therapy
- Support/Listening Ear

Please use the following code to rate how descriptive each description is of you.

0 = Never descriptive of me
1 = Rarely descriptive of me
2 = Occasionally descriptive of me
3 = Frequently descriptive of me
4 = Always descriptive of me

- _____ 1. Depressed
- _____ 2. Stressed
- _____ 3. Use alcohol or drugs
- _____ 4. Fatigued
- _____ 5. Physical pain
- _____ 6. Anxious, worried
- _____ 7. Feel shame or guilt
- _____ 8. Happy with relationships
- _____ 9. Self directed
- _____ 10. Absorbed in what I'm doing
- _____ 11. In trouble [with law, lover, family member, boss]