Name: SS#: Date:

Home Address:

City: Zip Code:

Home Phone:

Work Phone:

Cell Phone:

Email:

Date of Birth:

Emergency Contact: Phone: ( ) - Relationship:

**Primary Care Physician:**

Phone:

Address:

City / State: Zip Code:

**Person responsible for payment:** Relationship:

Driver’s License Number:

State:

Address:

City: Zip Code:

Phone:

Number in household:

Would others be willing to come in? **YES □ NO □**

Employer: Occupation:

**Health Insurance Company:**

Insurance Address:

Insurance phone number:

ID or Policy #:

 Group #:

**The Fedora Psychological Group, LLC**

P.O. Box 49284 – St. Petersburg, FL 33743 · **Phone:** (727) 209-7792

Have you been in therapy before? **YES □ NO □**

If yes, briefly provide details:

Have you ever been hospitalized for mental disorders? **YES □ NO □**

If Yes, provide details:

Why are you seeking therapy at this time?

What are your goals for therapy:

Describe your usual diet, including beverages:

* Breakfast:
* Lunch:
* Dinner:
* Snacks:

Do you drink caffeinated beverages? **YES □ NO □**

If yes, quantity:

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# MEDICAL QUESTIONNAIRE

**Name: SS#:**

**Date:**

What medical problems, if any, are you currently having?

Are those problems being treated? **YES** □ **NO** □

By whom? Last medical examination (date): Primary care doctor: Current psychotropic medication (include dosage and schedule):

Prescribing Physician:

**PCP** □ **Psychiatrist** □

What prescription or non-prescription drugs (including alcohol and cannabis) are you currently taking or have taken in the last six months? How often? How much?

List past hospitalizations, operations, or serious illnesses:

* Year:
* Year:
* Year:
* Year:

Check any of the following diseases you have had:

**Disease At what age? Disease At what age?**

□ Thyroid Disorder

□ Chronic Bronchitis □ Emphysema □ Epilepsy (convulsion)

□ Venereal Disease

□ Asthma

□ Hay Fever

□ Nervous Disorder

□ Hormonal Issues

□ Diabetes

□ Cancer

□ Heart Disease

□ Stroke

□ Anemia

□ Kidney Disease

□ Liver Disease

□ Hepatitis

□ Other

Do you use tobacco? **YES** □ **NO** □ What f□rm?

**WOMEN ONLY:**

Are you pregnant? **YES** □ **NO** □ Perimenopausal? **YES** □ **NO** □ Menopausal? **YES** □ **NO** □

# MEDICAL QUESTIONNAIRE

Family history with alcohol and/or drugs?

Do you drink alcoholic beverages? **YES** □ **NO** □

How often do you drink? **Daily □ 3-5 times per week □ 1-2 x per week □ Less □**

Do you sometimes drink more than you had planned? **YES** □ **NO** □

Have family of friends expressed concern about your drinking before? **YES** □ **NO** □

Have you ever been arrested for alcohol-related charges? **YES** □ **NO** □

Have you ever had an episode where you were unable to remember periods when you are drinking? **YES** □ **NO** □

Have you been treated for addictive illness before? **YES** □ **NO** □

If so, when?

|  |  |  |
| --- | --- | --- |
| **Indicate which of the following you use (or have used):** | **Within 1 year** | **Used in past** |
| **Tranquilizers:** Valium □ Xanax □Ativan □ Klonopin □ Other □ |  |  |
| **Pain Pills:** Darvocet □ Oxycontin □Hydrocodone □ Vicodin □ Percocet □ Morphine □ Heroin □ Methadone □ Other □ |  |  |
| **Stimulants:** Amphetamines □“Speed” □ Dexedrine □Adderall □ Caffeine □ Other □ |  |  |
| **Sleeping Pills:** Lunesta □Restoril □ Ambien □ Other □ |  |  |
| **“Street Drugs”:** Marijuana □Crystal Meth □ “Shrooms” □ Cocaine □ Ecstasy □ Acid □ Crack □ ”Spice” □ Other □ ⁪ |  |  |
| **Volatiles:** Aerosols □ Glue □Whippets □⁪ other □ |  |  |
| **Others:** |  |  |

Describe your usual sleep pattern:

Do you snore? **YES** □ **NO** □

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### FEE SCHEDULE

Psychotherapy Fees

Regular session………………………. $150.00

Initial Assessment………………….. $200.00

Extended time………………………… $37.50 /15 min. interval

Off-site………………………..…………… $250.00 /hour (2 hour minimum)

Phone consultation………………….. $ 37.50 /15 min. interval

Parental Evaluation Fees

Retainer for initial assessment (accounting for 3 hours of face to face time)..….…….......... $1200.00 Each

Increased complexity of case…….. $ 200.00 per hour

Legal Evaluations and other assessments: Fees are based on complexity of evaluation.

Late Cancellation (within 24 hours)……………… $ 75.00

No Show for Scheduled Appointment…………… $ 75.00

Treatment update (reports, letters, etc.)…….. $ 75.00

Returned Check Charge………………………………… $ 25.00

Copy of records (faxed, mailed, etc)…………… $ 1.00 per page

Payment is due at the time of your appointment.

We do not participate in many insurance networks. As a courtesy, we will give you information to help you file a claim to your insurance company for out-of-network services. Payments for sessions are due at the time of your scheduled appointment.

Please sign below to acknowledge receipt of this statement:

Signature Date

**P.O. Box 49284 (727) 209-7792**

**St. Petersburg, FL 34743 TheFedoraGroup@gmail.com**

### PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and healthcare operations. We are not required to agree to this restriction, but if we do, we will honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

* + Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
	+ The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
	+ The Practice reserves the right to change the Notice of Privacy Policies.
	+ The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
	+ The Practice may revoke this consent in writing at any time and all future disclosures will then cease.
	+ The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by

Date:

Patient Signature or Representative

Relationship to Patient (If other then patient): \_

Witness:

Date: