IPCI
INTEGRATED PSYCHOLOGICAL CENTER OF INDIANA

50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317-550-3221
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Maria P. Hanzlik, PsyD, HSPP-Clinical Psychologist
Jessicah D. Walker, PhD, HSPP-Counseling Psychologist
Josie Gronbach, PsyD-Post-Doctoral Resident

ACKNOWLEDGMENT: RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of HIPAA Notice of Privacy Practices from IPCI effective July 1, 2015.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

(For couples)
Name (please print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of Notice of Privacy Practices from IPCI effective July 1, 2015.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

FOR OFFICE USE ONLY:

Notice of Privacy Practices effective July 1, 2015 was given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

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Consent for Treatment-Adult Psychological Evaluation

A psychological assessment (also referred to as psychological testing or evaluation) usually takes considerable time on both the part of you and your clinician, often over the course of several days or weeks. During the first session, we will discuss your current and past family and relationship history, any problems or symptoms you are experiencing, any past treatment and its outcome, and other general background information. Over the course of several meetings, we will complete a number of different tasks together. You will probably also complete a number of forms and questionnaires on your own. When you have completed all the tasks, your clinician will review, score and interpret the results. Occasionally, your clinician will determine, after reviewing some of the material, that an additional test(s) would be helpful. If that is the case, we will call you to inform you of this determination. We schedule feedback to review test results approximately 3 weeks from the time of the last testing appointment to provide your clinician with enough time to complete scoring, interpretation, and report writing. It is important to understand that your clinician will not be engaging in psychotherapy with you when the psychological evaluation is being conducted. Nonetheless, your clinician still bound by the ethical and legal limitations and laws that any clinician must follow.

Scheduling: Scheduling presents a special problem, because once testing time is blocked out, it typically cannot be filled again on short notice. As a result, we ask that you give us at least **48-hours** notice if you need to cancel an appointment. Failure to do so (except in cases of serious illness or emergency) will result in you being billed a cancelation fee as outlined in the Office Policies form. Please be aware that fees for missed visits are not covered by insurance.

FINANCIAL AGREEMENT

General: In consideration of the psychological evaluation being rendered to _____ (Name of patient) by my clinician, I, the undersigned, hereby agree to pay for services provided in accordance with the estimated cost of the evaluation as outlined below. I understand that my clinician bills an hourly rate for psychological evaluations at the fee outlined in the office policies. This rate applies to all telephone calls to any other parties for whom I give my clinician permission to speak. I will also be billed for all time in which my clinician: meets with me to complete testing; reviews, scores and interprets the tests; writes the professional report; and meets with me to provide feedback about the results of the evaluation. The balance of the evaluation will be due at the last testing appointment (prior to scheduling feedback). My clinician cannot meet with me, nor complete the assessment, including feedback to myself or other professionals, until I have paid the full balance of our bill for the assessment.

For insurance clients: In some cases, my clinician may determine that additional testing could be useful that insurance does not cover. They will discuss this with me prior to completing more hours, and together, we will decide whether we will eliminate some of the tasks or agree to pay a higher cost. If I agree to further testing, my clinician will provide me with an amended financial agreement outlining the cost of the additional services. I understand that if the assessment takes considerably longer than usual, and I chose not to complete all the tasks rather than incur more expense, the assessment results may not be valid. My clinician will discuss what, if any conclusions, can be drawn from an abbreviated evaluation in a valid manner.

There are also times when insurance companies decide they will not pay for the cost of a completed evaluation based on certain diagnoses or if the evaluation results indicate I do not meet criteria for a mental health diagnosis. I understand that, even in these situations, I am ultimately responsible for the full cost of the evaluation.

I, _____, agree to participate in a psychological assessment conducted by my clinician. I have been informed by my clinician of the nature of this evaluation, and I understand that a report will be written based on the results of the evaluation. My clinician has informed me that this is considered a medical record document that cannot be disclosed to third parties without consent, unless under special circumstances (e.g., possibility of harm to self or others, abuse or neglect of children or vulnerable adults, court-order). I understand that this testing is voluntary, and that I can choose to not be tested or to stop testing at any time.

My signature below indicates that I have fully discussed with my clinician the various aspects of our contract for a psychological evaluation. My clinician has discussed with me scheduling, the nature of the fee and policies regarding missed appointments, and I agree to proceed with the evaluation.

Please initial after the following statements:

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered for in-network benefits. _____
Initial

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status. I understand that if collection proceedings are necessary, I will pay all fees with collecting this bill. _____
Initial

I authorize communication between my clinician and referring physician/clinician _____ to inform that I have initiated services (separate release is required for further exchange of information). _____
Initial

I would like to be contacted for appointment reminders and other correspondence via the following ways (check all that apply):

☐ Telephone (please provide preferred number): _____

☐ Voicemail Message _____

☐ Text Message (if different than above):_____

☐ Email: _____

☐ Postal Mail (include address if other than provided): _____

_____ _____
Patient Signature Date

_____ _____
Printed Name Date

_____ _____
Witness Signature Date

_____ _____
Witness Printed Name Date

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Adult Patient Information Form

Name: _____ Date of Birth: _____ Today's Date: _____

Gender: _____ Gender Pronouns: _____ Sexual Orientation: _____

Age: _____ Partner/Relationship Status:_____ Race/Ethnicity: _____

Other Important Demographic Information/Identities: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone Number (home/work/cell): _____

Referring Provider: _____

Current Medications: _____

Previous Mental Health Services: _____

Presenting Problems: _____

Contact Information in Case of Emergency

Name:_____ Relationship to Patient: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name:_____ Phone#:_____

Policy Holder's Name:_____Date of Birth:_____

Relationship to Patient:_____ Name of Policy Holder's Employer:_____

ID#:_____ Group#:_____

SECONDARY INSURANCE INFORMATION

Insurance Company Name:_____ Phone#:_____

Policy Holder's Name:_____Date of Birth:_____

Relationship to Patient:_____ Name of Policy Holder's Employer: _____

ID#:_____ Group#:_____

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CREDIT CARD AUTHORIZATION FORM

NAME OF PATIENT: _____
NAME ON CARD:_____
BILLING
ADDRESS:_____
_____

Circle one: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

ACCOUNT #: _____

EXPIRATION DATE: _____

CVC # (ON BACK OF CARD): _____

By signing this form, I authorize IPCI and my clinician to charge this card. I may choose to use other forms of payment such as cash, check or an HSA account. I understand that, should my account be **30 days overdue**, I authorize IPCI and my clinician to automatically charge this card.

I hereby grant permission to charge my credit card after every ____ session(s) _____ (initials)

or

I hereby grant permission to charge my credit card if my balance reaches $100 without further authorization.

AUTHORIZED
SIGNATURE:_____

DATE: _____

AUTHORIZED
SIGNATURE:_____

DATE: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____do hereby consent and authorize my provider and/or IPCI,

TO DISCLOSE to: _____
Name/Address/Telephone Number

The following specific information regarding (self/child's name): _____

___ Admission
___ Attendance in Treatment
___ Progress in Treatment
___ Prognosis/Diagnosis
___ Discharge Summary
___ Patient Demographic Information
___ Treatment Plans
___ Other: _____
___ Progress Notes
___ Psychological Evaluation

I understand that this information is to be used for the purpose of: _____

_____ _____
Patient/Guardian Signature Witness Signature

_____ _____
Printed Patient/Guardian Name Witness Printed Name

_____ _____
Date Date

I, _____do hereby consent and authorize my provider and/or IPCI, **TO DISCLOSE to:**

_____
Name/Address/Telephone Number

The following specific information regarding (self/child's name): _____

___ Admission
___ Attendance in Treatment
___ Progress in Treatment
___ Prognosis/Diagnosis
___ Discharge Summary
___ Patient Demographic Information
___ Treatment Plans
__ Other: _____
___ Progress Notes
___ Psychological Evaluation

I understand that this information is to be used for the purpose of: _____

_____ _____
Patient/Guardian Signature Witness Signature

_____ _____
Printed Patient/Guardian Name Witness Printed Name

_____ _____
Date Date

Patients may revoke releases at any time by informing my clinician verbally or in writing. Unless otherwise specified by this patient, this release will remain valid for **1 year** from the time of signing.

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Adult History Form

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Gender: _____ **Gender Pronouns:** _____ **Sexual Orientation:** _____

Age: _____ **Partner/Relationship Status:**_____ **Race/Ethnicity:** _____

Religious/Spiritual Affiliation (if applicable): _____

Other Important Cultural/Identity Information: _____

Presenting Problem:

Reasons for seeking services:

Please list current symptoms:

Mental Health History:

How long have you been dealing with these concerns?:

Please list past outpatient therapy you may have received:
(Name of therapist/length of time in therapy/type of work completed/past diagnoses)

Please list past inpatient mental health hospitalization you may have received:
(Name of hospital/location/length of stay/age of hospitalization/reason for hospitalization)

Please list past and current medications you have been prescribed/are using:

Medication name	Dosage	Reason for med.	Taking as prescribed? (Y/N)

Educational History:
Highest level of education/name of school:

Please list/describe any trouble you may have experienced in school (academic or behavioral)?:

Employment History:
Occupation:
Place of employment:
Have you ever been fired from a position? Y/N
If Yes, what were the circumstances?

Military Status (circle all that apply)
Branch of military served:
Currently enlisted
Reserves
Veteran-Discharge Status/Reason for discharge: Honorable/Other Than Honorable Conditions/Bad Conduct/Dishonorable/Officer/Entry-level separation/Medical/Administrative
Tours of duty completed:

Social Functioning:
Who do you rely on for support?:

What do you do for fun?:

Medical History:
Please list any medical conditions you have, and rate how well managed they are (good, fair, poor):

Please list any surgeries you may have had:

Please list any hospitalizations you may have had for a medical condition/length of stay:

Family of Origin History:
Place of birth:

By whom were you raised?:

Relationships with family members (e.g. good, fair, poor, abusive, no contact):

(QoR=Quality of Relationship)

Name	Relationship	Past QoR	Current QoR	Mental Health Symptoms/Diagnoses

Please list other family members not listed above who may have had diagnosed or undiagnosed mental health conditions:

Current Family & Living Conditions:

Please list who currently lives with you and the quality of those relationships:

Sexual History:

Please indicate the last time you were sexually active (with a partner and alone):

Age at first sexual encounter:

Attracted to males/females/both/other:

Please circle/highlight any of the following sexual concerns:

Low desire *Low arousal* *Difficulty reaching orgasm* *Premature/rapid ejaculation*

Delayed ejaculation *Pain with vaginal penetration* *Pain with anal penetration*

Discrepancies in level of sexual desire with your partner *Sexual avoidance*

Feelings of embarrassment talking about sex with a partner

Are there any other sexual concerns you might want to discuss with your clinician? Y/N

(Feel free to write those below or wait until face-to-face session to discuss

Trauma History

The purpose of this section is for me to have a better understanding if there have been past experiences of trauma on your part that may be affecting you in the present. We can discuss this section in more detail when we meet in person.

Please circle/highlight any of the following you may have experienced:

Physical abuse *Emotional/verbal abuse* *Sexual abuse*

Witnessing violence (including domestic violence) *Bullying*

Confusing experiences/boundary violations *Peer rejection*

Natural disasters *Loss of a parent or other important caregiver*

Substance Use:

Please check the following substances you have used in the past and currently:

	Past	Current
Alcohol		
Wine		
Liquor		
Beer		
Marijuana (any form)		
Cocaine		
Crack Cocaine		
Hallucinogens		
Inhalants		
"Club Drugs" (i.e. Ecstasy)		
Heroin		
Prescription Drugs (not as prescribed)		
Stimulants		
Tobacco		
Caffeine		
Other		

Has anyone ever expressed concern that you might need to cut back on your use?
(Y/N/Who/Circumstances):

If so, have you felt annoyed/irritated and has it caused conflict?:

Please list any prior treatment for drug or alcohol use:
(Inpatient/Intensive Outpatient/Educational/Detox/Date/Location):

Legal History:

Charge	Date of Arrest	Incarcerated (Y/N)	Pending Case (Y/N)

Other Important Information Your Clinician Should Know About:

Goals for therapy (*if applicable*):

Short Term	Long Term
1.	1.
2.	2.
3.	3.