

Richard Born, Ph.D. LLC

LICENSED PSYCHOLOGIST

One Huntington Road, #205

Athens, Georgia 30606

Phone: 706.543.7605

FAX:706.543.2397

NEW CLIENT INFORMATION AND RESPONSIBILITY INFORMATION

This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner or the office manager about these or any other matters. We are here to assist you.

FOR YOUR FIRST APPOINTMENT, PLEASE ARRIVE FIFTEEN MINUTES EARLY SO THAT YOUR CHART CAN BE MADE AND WE CAN COLLECT ANY ADDITIONAL INFORMATION IF NEEDED. PLEASE HAVE THE ENCLOSED PAPERWORK COMPLETED WHEN YOU ARRIVE AND BRING YOUR INSURANCE CARD WITH YOU. THE CLINICIANS KEEP A TIGHT SCHEDULE AND WILL USUALLY START YOUR APPOINTMENT ON TIME.

OFFICE HOURS

Office hours may vary but are usually Monday - Friday, 9:00 - 6:00, and we are typically available during these times. The office manager is in the office typically from 10:00 a.m. until 4:00 p.m. Monday through Thursday, and 10:00 until 2:00 p.m. on Friday. If you need to contact us and no one is available to take your call, please either leave a message on voice mail on the office phone, or with the answering service and we will return your call as soon as possible. The first priority and our primary concern is your well being. **In an emergency or life threatening situations, please go to the nearest hospital emergency room for help.**

APPOINTMENTS:

Appointments are most commonly scheduled with the front desk person at the completion of each visit. At times however it is recommended that the patient schedule a block of appointments in advance since the schedule can become very busy. Individual, couples, and family therapy are billed on the basis of a 45-50 minute hour. Biofeedback treatment sessions typically run 45-50 minutes also. Group therapy is based on a 75-90 minute session. If an appointment runs significantly longer than initially scheduled, there may be an additional charge for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

CONFIDENTIALITY and PRIVACY OF INFORMATION:

The Confidentiality and Privacy of information regarding you and your treatment with my practice is very important. There are laws and legislation that govern this topic that we must abide by. I apologize for the lengthiness of this form, but I feel it is very important that you are aware of this information.

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

- (1) where abuse or harmful neglect of children, the elderly, or disabled or incompetent individual is known or reasonably suspected
- (2) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist
- (3) where the patient is perceived as being in danger of harming themselves by

suicidal behavior

MISSED APPOINTMENTS:

An appointment time occupies a significant portion of our professional time. An appointment that is missed or late cancelled keeps us from seeing another patient in need. Therefore, except in the case of an acute emergency, we require a 24-hour notice of any cancellation; otherwise, your account will be subject to a fee. The current charge for a late cancelled or missed session is \$50.00. You are financially responsible for this charge since any

insurance coverage will not apply. If our office is closed or we are not at the phone when you need to cancel an appointment, you can leave a message either with the answering service or on the office voice mail. Please let us know of a need to cancel or reschedule an appointment as soon as possible, since there are other patients who are on a 'call' list who are waiting to get in to see a clinician.

FEES:

Arrangements for payment of fees for professional services need to be made prior to or at the time of the first visit. We will file for payment through your insurance company whenever possible. When we file for insurance payment, it is still your responsibility to pay any deductible and co-payment amounts. It is also important that you also understand that you are ultimately responsible for payment of the fees in the event that insurance doesn't pay. Delinquent accounts over 90 days may be referred to a collection agency.

ASSESSMENT AND/OR TESTING:

Testing is billed on the basis of the type of test and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with the type of test and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. Reports are typically not included in assessment and/or testing fees and will be billed as a separate procedure. The written report summarizing testing results, if requested, is generated after payment in full for testing services is received.

COMPLETION OF FORMS AND ADDITIONAL REPORTS:

Occasionally, situations may come up in which a patient requests that the psychologist complete additional forms or develop additional reports, (ie. disability forms, reports to schools, employers, or insurance companies). The charge for completion of reports or development of reports are billed on the basis of a pro-rated charge of \$130.00 per hour, with a minimum charge of \$25.00.

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to psychological services. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand that the potential benefits of undergoing psychological services may include obtaining a professional opinion, reduction of my psychological symptoms, and an increased understanding of myself. I understand that potential risks may include predictive validity of psychological assessment (when applicable), possible disagreement with the opinions offered to me, and possible emotional distress when addressing my situation. I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with the progress of my treatment.

By signing below, I acknowledge that I have read and accept the above information regarding professional services rendered.

PRINTED NAME OF PATIENT/person responsible for payment

SIGNATURE OF PATIENT/person responsible for payment

DATE

Richard Born, Ph.D. LLC
Applied Psychological Health
•PATIENT INFORMATION•

Patient Name: _____ Gender: M F Date of Birth: _____

Address: _____
Street City State Zip Code

Billing Address if different from above: _____
Street City State Zip Code

Social Security No: _____ Telephone: Home: _____

Marital Status: Single Work: _____

Married Cell: _____

Divorced Is it OK to call and leave messages at these numbers? Yes No

Separated Responsible party (if patient is a minor): _____

Widowed Address (if different from above): _____

Employer/School: _____

Primary Care Physician: _____ Phone No.: _____

•PRIMARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: M F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Employer Address: _____

INSURANCE COMPANY: _____ MENTAL HEALTH ADMINISTRATOR: _____

Address to send claims: _____ Phone # for authorizations: _____

Phone No.: _____

Policy Holder's Social Security No.: _____ Policy #: _____ Group #: _____

Authorization #: _____ for _____ sessions. Effective dates _____ to _____.

Medicare #: _____ Part B effective date: _____ Primary Secondary

Medicaid #: _____ Effective date(s): _____ Primary Secondary

Worker's Compensation Claim #: _____ Injury date: _____

•SECONDARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: M F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Employer Address: _____

INSURANCE COMPANY: _____ MENTAL HEALTH ADMINISTRATOR: _____

Address to send claims: _____ Phone no. for authorizations: _____

Phone No.: _____

Policy Holder's Social Security No.: _____ Policy #: _____ Group #: _____

The office of Richard Born, Ph.D. LLC will bill your insurance carrier directly for all services. Your signature expresses your agreement that the dates of service, services rendered, and the diagnosis will be provided with the insurance claim as necessary to process the claim. Your signature also indicates that you understand and agree that you are liable for payment of any services not covered by your insurance company.

Signature: _____ Date: _____

OFFICE USE:

Diagnosis:

Treatment Provider:

Financial Notes:

Richard Born, Ph.D. LLC
Applied Psychological Health Services
One Huntington Rd. #205 Athens, GA 30606
EVALUATION ONLY

Patient Name: _____ Gender: M F Date of Birth: _____
Address: _____
Street City State Zip Code
Phone: (H): _____ (W): _____ (Cell): _____
Social Security #: _____
Who Referred You? _____

PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING YOURSELF:

Who is your primary physician? _____
Address: _____
Telephone: _____

What other physicians do you see on a regular basis and for what problem?

Physician	Problem
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What medications are you taking:

Name of Medication	Date Started	Dosage	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any over-the-counter medications, herbs, or other supplements you take:

Do you have any allergies to medications? Yes No

Please list any allergies you have:

What is your occupation? _____

What level of formal education have you reached? _____

Do you have children?

Yes No. If "Yes", please list their names and ages:

Do you smoke cigarettes? ___Yes __No use other tobacco products? ___Yes __No
Do you use alcohol? ___Yes __No Do you use other psychoactive drugs? ___Yes __No
What is you estimate of your average caffeine intake per day? _____

Have you ever been in trouble with the law? ___Yes __No
Are you presently involved in any litigation? ___Yes __No

Do you have health problems? ___Yes __No

If 'Yes', please describe what they are

Have you ever been to a counselor, psychologist, or psychiatrist, or been admitted to a psychiatric hospital? ___
Yes __ No. If "Yes", please list who you saw, when, and for what purpose.

Have any of your family members (parents, grandparents, aunts, uncles, siblings, etc.) experienced emotional problems or been in psychiatric treatment? ___Yes __No

If 'Yes', please list who and what type of problem: _____

Please add any additional information that you think is important for us to know about your history:

Thank You,

Richard Born, Ph.D.

DSM-IV PROBLEM CHECKLIST

Richard Born, Ph.D. LLC
One Huntington Road #205
Athens, Georgia 30606
Applied Psychological Health Services

Phone: (706) 543-7605
Fax: (706) 543-2397

Name: _____ SS#: _____ - _____ - _____ Date: _____

The following questions are meant to help your therapist determine the types of difficulties you are experiencing. Answering these questions save time in your therapy sessions which enables your therapist to work more efficiently. Please check the boxes to the right of each "problem" which you have experienced in the last month. If you have not experienced a problem listed, check the "None" box. Underline any problems that seem to be particularly important to you.

Thanks!

296.300.4	None	Minimal	Moderate	Severe
Depressed mood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of self-esteem.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest or pleasure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling slowed down.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest in sex.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling guilty or worthless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent thoughts of death or dying.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of harming oneself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide plans.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

296.4x	None	Minimal	Moderate	Severe
Feeling on top of the world with no reason.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased need for sleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being more talkative than usual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having racing thoughts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being distracted by unimportant things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling speeded up.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being impulsive: overspending, sexually overactive, driving too fast etc.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

300.01	None	Minimal	Moderate	Severe
Brief "attacks" in which any of the following occur (circle which do) – shortness of breath, choking feeling, dizziness, rapid heart beat, trembling, sweating, nausea, or abdominal distress, feelings of unreality, chest pains, overwhelming feelings of doom or imminent death, fear of going crazy or losing control.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Minimal	Moderate	Severe
300.02				
Unrealistic or excessive anxiety and worry about things in your life.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension, restless and fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling keyed up and on edge.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mind going blank because of anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
300.031	None	Minimal	Moderate	Severe
Persistent thoughts that are intrusive and/or senseless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having to do things (e.g. counting or checking) over and over until they are "just right".....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preoccupation with what you consider to be "silly worries".....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having to check, repeat, wash or count to a degree that is upsetting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
303.x – 305.x	None	Minimal	Moderate	Severe
Using a larger amount of a drug or alcohol than intended.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsuccessfully trying to cut down or control use of a drug or alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spending time using drugs and/or alcohol recovering from such use.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giving up social or recreational activities because of alcohol or drug use.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using drugs or alcohol despite arguments from spouse, family and/or friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using larger amounts of alcohol or a drug to get the same effect.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinking more than 2 caffeinated drinks per day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
307.10/307.50/307.51/316	None	Minimal	Moderate	Severe
Loss of more than 5 pounds in the past year.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intense fear of gaining weight / becoming fat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling "fat" regardless of your weight.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Missing 3 or more consecutive periods (females).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using food to comfort oneself when sad, angry, anxious.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overeating, vomiting or abusing laxatives.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
314.01	None	Minimal	Moderate	Severe
Difficulty in sitting still, not fidgeting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being easily distracted.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty having sustained attention.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acting without thinking, being impulsive.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty getting work or studies done.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current being physically abused.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing a voice when no one else is around.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowing special secrets known by no one else.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Minimal	Moderate	Severe
Having someone else read my mind or tamper with my thoughts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having an outside force control my thoughts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being able to control the thoughts of others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling detached from my mind or body.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling like in a trance or dream state.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory lapses or altered states of consciousness unrelated to drugs or alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having trouble controlling anger.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of harming other people or their property.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty relating to boy or girlfriend, spouse or romantic partner.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty relating to friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty relating to family, parents.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

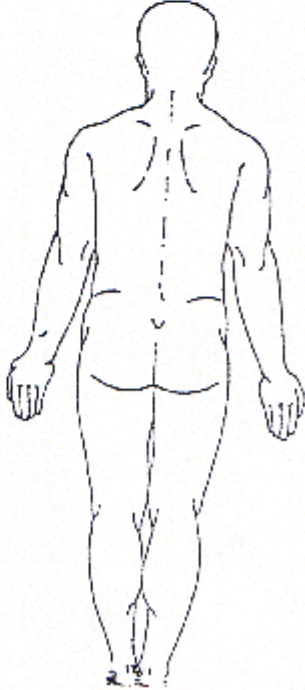
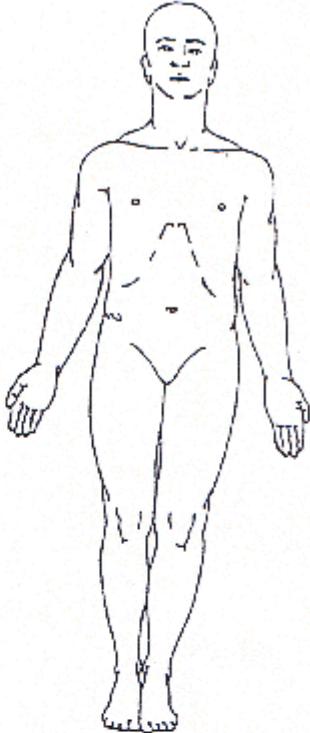
	Yes	No
Has there been some event or experience in the past 3 months from which most of your problems date?.....	<input type="checkbox"/>	<input type="checkbox"/>

Are there any problems you are having that are not on this list? If so, please write down what they are on the back of this page.

Thanks for taking the time to fill out this form!

YOUR PAIN

SHOW WHERE YOUR PAIN IS.



PAIN INVENTORY

Applied Psychological Health
Richard Born, Ph.D. LLC
One Huntington Rd. #205
Athens, Georgia 30606
tel 706.543.7605 Fax 706.543.2397

Date: _____

Name: _____

Pain Location: _____

1. Please rate your pain by circling the one number that best describes your pain at its **worst** during the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Ever/
Unbearable

2. Please rate your pain by circling the one number that best describes your pain at its **least** during the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Ever/
Unbearable

3. Please rate your pain by circling the one number that best describes your pain **on average**.

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Ever/
Unbearable

4. Please rate your pain by circling the one number that best describes your pain **right now**.

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Ever/
Unbearable

What kinds of things make your pain feel better (for example: heat, medication, rest, etc.):

What kinds of things make your pain feel worse (for example: walking, certain movements, etc.):

Of the twelve-hour period ranging from 9:00 AM to 9:00 PM on an average day, about how many hours would you estimate that you spend either sitting or lying down due to pain? _____

