Dr. Stephen Scott
Licensed Psychologist

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NEW PATIENT FORM

Welcome to Dr. Scott's office. I look forward to working together with you to reach your goals and improve your quality of life.

This form is meant to help me to start planning your treatment, and give you valuable information about what to expect during our time together. If the person seeking care is a minor, the parent or guardian should fill out and sign this form. Feel free to ask me questions at any time.

Name _____ **DOB** _____

Address _____ **Gender** _____

_____ **SS#** _____

Phone: (____)____-_____ (____)____-_____
Home – OK to call/leave message?_____ **Work –** OK to call/leave message?____

(____)____-_____ _____
Cell – OK to call/leave message?_____ **e-mail**

Emergency Contact: _____ (____)____-_____ _____
Name **Phone** **Relationship**

Please list the others living in your household and their relationship to you: _____

_____

How much are the following areas being affected by the issues you are experiencing?

	Not much		**Somewhat**		**A lot**
Relationships	1	3	5	7	9
Job / School	1	3	5	7	9
Finances	1	3	5	7	9
Physical Health	1	3	5	7	9
Depression	1	3	5	7	9
Worry / Nerves	1	3	5	7	9
Anger	1	3	5	7	9
Sleep	1	3	5	7	9
Eating	1	3	5	7	9
Sexual Functioning	1	3	5	7	9
Alcohol / Drug Usage	1	3	5	7	9
Concentration	1	3	5	7	9

Have you been thinking about harming or killing yourself? _____

Have you ever seen someone for counseling before?_____ Please describe your experience: _____

_____

What made you decide to see a psychologist now?_____

_____

_____

Please list any medications you are currently taking: _____

_____

If the person seeking treatment is a minor, please write the name, phone, and address of each person who has legal custody:

_____

_____

Treatment Philosophy

I believe in providing solution-oriented therapy. This means that I will work with you to identify treatment goals within the first or second session and then I will focus on helping you to reach those goals. After the first session I will recommend a number of sessions that you should plan to attend in order to reach your goals. At the end of those sessions we will evaluate progress and then you can decide if you have accomplished your goals or if there are others that you would like to pursue.

Confidentiality

Everything that we talk about will be held strictly confidential unless:

1. The client signs a release of information
2. The client presents a danger to self
3. The client presents a serious danger to others
4. Child/elder abuse/neglect are suspected

Financial Terms

You are responsible to pay the full fee at the time service is given. Payment is accepted in check or cash. If you would like to request reimbursement from your insurance company I will be glad to help you, but you should be aware that many insurance companies only pay for a portion of the fee, or only pay for therapy with those with whom they have contracted.

Cancelled / Missed Appointments
A scheduled appointment means that time is reserved only for you. If an appointment is missed or is cancelled with less than twenty-four-hours notice you will be responsible for the full session fee.

Emergency Procedures
If you need to contact me, leave a message at my phone number and I will return your call. If you are experiencing a true emergency, please call 911 or have someone take you to the hospital emergency room.

Forensic Psychology
If you are interested in having a report, assessment, or evaluation directed to an attorney, court, or legal interest, you need to tell me before we begin the first session.

Consent for Treatment
I authorize and request that my treatment provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while therapy is designed to be helpful, it may at times bring up uncomfortable feelings, memories, and experiences. I understand that this is a normal response to working through unresolved life experiences and is something that I can address with my psychologist. I also authorized my treatment provider to bill me for any outstanding balances and/or to disclose identifying information necessary for a third-party collection. If I am signing consent for a minor, I certify that I am the legal guardian.

I understand and agree to all of the policies on this form.

_____	_____
Client (or parent/guardian) Name (printed)	Date
_____	_____
Client (or parent/guardian) Name (signed)	Date