

Patient Registration Information
(PLEASE PRINT CLEARLY AND COMPLETE ALL (PAGES))

PATIENT: (if responsible patient is not the responsible party; fill out information below)

LAST NAME _____ FIRST NAME _____ M. I. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME (_____) _____ WORK (_____) _____ CELL (_____) _____

PAGER (_____) _____ EMAIL _____

AGE _____ DATE OF BIRTH _____ SEX _____ SOCIAL SECURITY NO. _____ - _____ - _____

MARITAL STATUS: (circle) SINGLE Married DIVORCED WIDOWED

STUDENT STATUS: (circle): FULL-TIME PART-TIME NONSTUDENT

EMPLOYMENT STATUS: (circle) : FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME _____

EMPLOYERS ADDRESS _____ CITY, STATE, ZIP _____

In Case of an emergency notify _____

Relationship: _____ Telephone: _____

PRIMARY INSURANCE COMPANY: _____

PATIENT'S INSURANCE ID#: _____

INSURANCE PLAN NAME: _____ INSURANCE GROUP NUMBER: _____

PEAUTHORIZATION NUMBER (If applicable): _____

RESPONSIBLE PARTY INFORMATION (Only fill out if responsible party different than above):

LAST NAME _____ FIRST NAME _____ M. I. _____

RELATIONSHIP TO PATIENT: • Parent; • Legal Guardian; • • Other _____

AGE _____ DATE OF BIRTH _____ SEX _____ SOCIAL SECURITY NO. _____ - _____ - _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME (_____) _____ WORK (_____) _____ CELL (_____) _____

POLICYHOLDER'S INSURANCE ID#: _____

INSURANCE PLAN NAME: _____ INSURANCE GROUP NUMBER: _____

MARITAL STATUS: (circle): MARRIED SINGLE DIVORCED WIDOWED

STUDENT STATUS: (circle): FULL-TIME PART-TIME NONSTUDENT

EMPLOYMENT STATUS: (circle) FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME _____

PROBLEM INVENTORY

Please check problems any that apply

- Problems with my memory
- Knowing where or whom I am
- Getting lost or confused

- People following me, out to hurt me, or talking about me
- People reading my thoughts
- Hearing voices
- Thoughts being put into my head, controlling me, making me do things
- Special messages to me from the TV or radio

- Feelings of worthlessness
- Feeling irritable, grouchy, or touchy
- Low energy or fatigue
- Difficulty getting to sleep, frequent wakening, or unrefreshing sleep
- Appetite (circle) increase or decrease
- Lack of interest in things I used to enjoy
- Poor concentration and/or forgetfulness
- Social withdrawal
- Feelings of guilt
- Feelings of sadness

- Preoccupied with sexual thoughts or urges
- Needing less sleep than usual
- Spending sprees
- Trouble making myself slow down or talk less

- Urges to do something harmful to myself or others
- Urges to set fires
- Difficulty controlling my temper

- Taking Laxatives to control my weight
- Vomiting to control my calorie intake
- Exercising frequently or vigorously
- Fasting to control my weight
- Feeling helpless about my eating habits
- Extreme changes in my weight
- Other (explain Below):

Do You drink Alcohol or take Drugs: Yes No
If yes list how what, how much, and frequency.

Please go to next page

NAME: _____

DATE: _____

- Fear of crowds or public places
- Specific fear of a thing or place (list) _____
- Attacks of fearfulness where I feel I need to run
- Heart palpitations
- Chest pains
- Feeling dizzy or unsteady
- Feelings of unreality
- Tingling in hands or feet
- Hot or cold flashes
- Feelings of smothering or can't get my breath
- Feeling trebly or shaky
- Fears of dying or going crazy

- Feeling the need to do things a certain number of times of for a certain length of time
- Feeling troubled by repetitive thoughts
- Feeling the urge to do something unnecessary
- Checking or counting things

- Feeling emotionally numb
- Recurring nightmares
- Frequently being startled
- Being troubled by painful memories

- Parts of my body not working well
- Feeling aches and pains all over my body
- Often feeling sickly
- Fear of getting or having a disease

- Marital Relationship Problems
- Physical/verbal Abuse
- Problems on the job
- Losing someone or something close to me (person, job, pet, moving, etc.)
- Problems with my children
- Sexual abuse
- Current problems from past sexual abuse
- Alcohol abuse
- Drug abuse

For Children:

- Problems with grades in school
- Problems with peers
- Problems paying attention
- Problems following through on tasks
- Problems sitting still
- Problems following instructions

THE UNDERSIGNED UNDERSTANDS AND AGREES:

- Your insurance is billed as a courtesy. If payment is refused, for any reason, you are responsible for payment of charges in full.
- **Payment is due at the time of the session by cash or check** (credit and/or debit cards are not accepted). A \$35.00 fee will be charged for all checks returned by the bank for NSF or any other reason (payment is due before any further sessions).
- Sessions not canceled or rescheduled thirty (30) hours in advance will result in a charge to the patient of \$150.00.
- I understand if I am more than 20 minutes late for your scheduled appointment, I may not be seen that day.
Please attempt to call if you will be more than 10 minutes late.
- I understand that my insurance company may be charge for missed appointments or appointment not rescheduled in time. I understand that it is my responsibility to reimburse the insurance company in this event.
- I understand it is my responsibility to obtain information about whether my insurance carrier covers the services rendered.
- I am also responsible for obtaining initial authorizations for treatment and information about my copayment and deductible.
- Any costs (i.e. collection/legal fees) incurred in the collection of delinquent payments will be added to the original charges, in addition to a \$25.00 administration fee.
- I will inform Dr. Drydyk in writing of any changes in address, telephone numbers, and/ or Insurance Coverage.
- Additional Fee's are: \$150.00/ hour for report writing forms to be filled out, consultation with others, etc. (There is a minimum charge of \$35.00)
- The therapeutic session is 40-45 minutes long from the scheduled time of start of the appointment.
- The patient or guardian, if the patient is a minor, consents to counseling, psychological and psychiatric treatment, understanding that such treatment may or may not be of benefit.
- I understand that Dr. Drydyk is a treating psychologist and will not perform in a forensic capacity.
- I understand that if I miss two appointment without informing the office, all future appointment may be cancelled.
- I have read or will read the "**HIPPA PRIVACY INFORMATION**" on Dr. Drydyk's Webpage: www.drydyk.com

Please Print Patient's/Responsible Parties Name: _____

Signature of Patient/Guardian/ Responsible Party:

Date: _____

(Please Sign Name and date)

(Please Circle Relationship to patient (must be 18 years of age or older)):

Patient; Parent; Legal Custodial
Parent; Guardian