

Patient Information Gary D. Hittle, Ph.D.

Date: _____ who referred you? _____

Patient Name: _____ **Age:** _____ **Sex:** _____ **B. Date:** _____

Marital Status: _____ **Previous marriages:** _____ **Soc. Security:** _____

Address: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-mail address: _____ **Can a message be left? Yes/ No** _____

Employer: _____ **Occupation:** _____ **Church Affiliation:** _____

Name of Spouse (Significant Other/Parent): _____ **Age:** _____ **B. Date:** _____

Address if different from above: _____

Employer: _____ **Bus. Phone:** _____ **Cell Phone** _____

Social Security: _____ **Briefly describe your reason for seeking counseling below:**

Who is your doctor? _____ **Last seen:** _____ **Phone:** _____

Doctor's Address: _____

List all medications you are currently taking:

Please list names, ages, and relationship of all individuals in your household:

Name	age	relationship	/	Name	age	relationship
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I understand that payment is required at the time of service unless specific arrangements have been previously made. I authorize any holder of medical or other information about me to release to my insurance company, my attorney, or their agents any information needed to determine my insurance benefits or medical necessity for services rendered. I agree to pay in full for any missed appointments that are not cancelled at least 24 hours in advance.

Signature of patient and/or responsible party

Signature

Date

Dx. _____

PAGE TWO: Client Name _____

Fee Information....The following are the charges for counseling with Dr. Hittle:

Individual, Conjoint, or Family Psychotherapy: \$200.00

In cases of financial hardship, adjustments may be made.

Psychotherapy sessions are 50 minutes in length with 10 minutes for case preparation, case management, co-ordination of care, and documentation (total 60 minutes).

Financial Agreement:

Total Fee per session: _____

Specific Agreement: _____

I understand that I am 100% responsible for all charges not covered by my insurance. I have read and understand the above and agree to these terms. If you wish to utilize insurance, we will make a copy of your insurance card at our initial meeting and assist you with billing for services.

Regarding ConfidentialityIf you are an adult, anything you do or say in the context of psychotherapy is privileged and confidential, with the following exceptions (in the event these exceptions are used, all actions will be fully discussed with you in advance):

- 1. If you are using confidentiality as a means of avoiding legal punishment, privilege is waived. That is, a psychotherapist may not aid or abet the perpetration of crimes.**
- 2. In cases of child or elder abuse of a physical nature, the therapist is legally required to make a report to the proper authorities.**
- 3. If you pose an imminent life-threatening danger to yourself or others due to your intent, privilege is waived.**
- 4. We are often asked to send records to, or request records from, other health providers. On the occasions, you will be asked to sign a release of information form, without which we will not send or request records.**
- 5. We make it a practice, as a courtesy, to contact the person/organization who refers new patients to us. If, for any reason, you do not wish us to do so, or have questions regarding this, please consult with your therapist.**

In signing below, I agree to be treated by Gary D. Hittle, Ph.D., MFT. I understand that I am financially responsible to Dr. Hittle for all unpaid balances. I authorize the release of medical information necessary to process claims for such services rendered by Gary D. Hittle, Ph.D. I authorize payments of medical benefits directly to Gary D. Hittle, Ph.D. ***I understand that I may withdraw from treatment at any time.***

I have read the above carefully and declare I understand and will abide by them

Signature

Signature

Date

Page Three: Patient Name _____

Circle any of the following areas in which you are having difficulty.

Alcohol Use _____	Elevated Mood	Panic Attacks
_____	Energy	Phobias
Anger/ irritability	Family	Perfectionism
Anxiety	Fears/Worries	Relationship difficulties
Assertiveness	Finances	Relaxation
Boredom	Headaches	Self-Control
Bowel-troubles	Health	Self-esteem
Career Choices	Isolation	Sexual Problems
Children	Legal Matters	Shyness
Chronic Pain	Loneliness	Sleep
Concentration	Making Decisions	Stress
Compulsions / Obsessions	Marriage	Suicidal Thoughts
Depression	Memory	Unhappiness
Divorce	Mood-changes	Violent Behavior
Domestic Violence	My thoughts	Work
Drug Use _____	Nervousness	Other Issues:
_____	Nightmares	_____
Eating Problems	Parenting difficulties	_____
Education		

Have you previously received counseling or psychological treatment? Yes / No
List provider and dates...

Have you ever been hospitalized? _____ Describe: _____

Describe your relationship with your family: _____

Describe any significant difficulties or traumas in your lifetime....

List any current health problems:

Gary D. Hittle, Ph.D.
5480 Baltimore Drive, Suite 202
La Mesa, CA. 91942

Telephone: (619) 464-7771 Fax: (619) 464-7772 / e-mail: drhittle@gmail.com / web: drhittle.com