Patient Information .... Gary D. Hittle, Ph.D.

Date: _____ who referred you? _____

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

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

Address: _____
City state zip
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: _____
City state zip
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

_____

_____

_____

_____

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 Confidentiality **….If 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 _____

Check 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:

_____

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