Kimberly J Cravotta-Purvis, MFC # 48771
23120 Alicia Parkway #200
949-306-1772 Fax: 949-242-4280

PLEASE TAKE YOUR TIME TO FILL OUT ALL INFORMATION ACCURATELY. ***

PATIENT'S INFORMATION

Patient's Name:_____Birthdate:_____
Cell Phone:_____Home Phone:_____Work Phone:_____
Home Address:_____
_____
Fax Number:_____
Email Address:_____
SSI #/ID#:_____
Company Name:_____

RESPONSIBLE PARTY AND OR SPOUSE'S INFORMATION

Responsible Party (Policy Holder)- Self___ or Spouse___
Primary Insurer's
Name:_____Birthdate:_____
Cell Phone:_____Home Phone:_____Work Phone:_____

Employer'sName:_____
SS#:_____
Address:_____
_____
Fax Number:_____
Email Address:_____

******MENTAL/BEHAVIORAL HEALTH PLAN INFORMATION-PLEASE CALL THE NUMBER ON YOUR INSURANCE CARD TO RECEIVE YOUR COVERAGE INFORMATION PRIOR TO THIS APPOINTMENT!!! IT IS YOUR RESPONSIBILITY TO KNOW WHAT KIND OF COVERAGE YOU HAVE!!! THANK YOU.***

INSURANCE PLAN INFORMATION: (MENTAL HEALTH PLAN)

Name of Insurance Company_____
ADDRESS:_____
PHONE NUMBER:_____
I.D. NUMBER:_____ Group#_____
ORIGINAL DATE OF POLICY:_____
OUPATIENT DEDUCTIBLE: OUT OF NETWORK_____I
IS YOUR DEDUCTIBLE MET?: YES_____ NO_____

PLEASE GET HELP WITH THE INSURANCE QUESTIONS FROM YOUR CUSTOMER SERVICE NUMBER ON YOUR CARD. We bill as a courtesy to you. We are not responsible for non-payment from your insurance company. All services must be paid up front unless otherwise arranged. You are responsible for any visits that go unpaid by your insurance company.

SIGNATURE OF UNDERSTANDING:_____

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IT IS YOUR RESPONSIBILITY TO READ, UNDERSTAND & SIGN FORM***

Some Facts About Insurance

For those who feel unsure about their insurance coverage. There are three (3) general kinds of policies:

A) Reimbursement Policies or PPO policies: A patient who has a reimbursement policy can choose his or her own therapist, even if the therapist is not on their insurance panel. The PPO percentage that is reimbursed varies with each policy.

B) We do not take HMO's/Managed Care policies. Some HMO's have an out of network portion which may reimburse. A patient would need to pay at the time of session. We would give you a bill to turn into your insurance, so you may be reimbursed.

C) PPO or POS-Preferred Providers: We will bill, but you will have to pay our fees up front. After we are paid by this type of policy you will be reimbursed if the payment (yours and the insurance payment) exceeds our billing rate.

ALL INSURANCE CHECKS MUST BE REMITTED TO THE PROVIDER NOT THE INSURED. IN THE EVENT THAT THE INSURED RECEIVED PAYMENT DIRECTLY BY THEIR INSURANCE COMPANY, THEY AGREE TO REMIT PAYMENT WITHIN 3 BUSINESS DAYS OR A $50.00 SERVICE CHARGE WILL INCUR MONTHLY FOR ANY OUTSTANDING BALANCE.

You are responsible for finding out which type of policy you have and what they reimburse.

We will bill policies which reimburse, but you are responsible for paying the Institute of Adv. Sciences therapist at the beginning of each session. After the therapist is paid by your insurance company you will be reimbursed, if the total payment (yours and the insurance payment) exceeds our billing rate.

Our fees are as follows:

A) Initial Assessment: $250.00 for 1 Hour 20 Minutes
B) Individual Therapy: $150.00 for 50 Minutes
C) Family Therapy: $185.00 for 50 Minutes
D) Group Therapy: $135.00 for 50 Minutes

*****The fees for Assessment Interview, Individual, Family or Group therapy are considered "moderate". However upon occasion, some of the therapists apply a sliding scale (DEPENDING ON INCOME & DEPENDENTS) for clients who may not be able to afford our regular fees. We will make every attempt to place a patient, who cannot afford our regular fees, in a fee category they will be able to afford. Your insurance company will always be billed our regular rates. You will be responsible for any percentage or co-pay that your insurance company sets for you *(unless other arrangements have been made).***

*****RULES FOR THERAPY APPOINTMENTS *** There is a FORTY EIGHT (48) Hour Cancellation Policy.**

Due to the nature of a small private practice we must have a 2 day cancellation notice. If you miss an appointment you will be responsible for the rate you have been given, whether it is our regular rates or a sliding scale rate. You can receive a receipt for the session which, if you submit it to your insurance company, you may be reimbursed. If you are sick please call to re-schedule your appointment immediately.

Please Sign Here that you understand the Institute of Advanced Sciences FEES & RULES.

X_____DateX_____

*****SOME POLICIES HAVE A SEPARATE MENTAL /BEHAVIORAL HEALTH POLICY. IT IS YOUR RESPONSIBILITY TO KNOW WHAT REIMBURSEABLE INSURANCE PROGRAM YOU HAVE FOR MENTAL/BEHAVIORAL HEALTH. ***Find out from your insurance company what they reimburse for out of network individual, family and group counseling. We are not on panels, so we are considered out of network therapists.**

CALL THE NUMBER ON YOUR INSURANCE CARD TO RECEIVE DETAILS AND HAVE THEM FAXED TO YOUR THERAPIST AT (949) 306-1772. This is very important if you want to get reimbursed.
THANK YOU FOR YOUR COOPERATION!! Fees & Rules Form 2011

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Dear New Patient:

Welcome to our Psychotherapy Office! We have a staff of therapists waiting to assist you with any issues/challenges you may be facing. We offer a Psychiatric Assessment, Accurate Diagnosis and many different therapeutic interventions to match your needs.

Everything you discuss in your sessions is confidential. The only way we may break your confidentiality is if you are Harmful to Self, Harmful to Others, Persistently & Acutely Disabled, or Gravely Disabled. The other ways confidentiality can be broken is if your referral is from an employer who has mandated the visit or some court orders. We are mandated Child Abuse/Elderly Abuse Reporters. You can also release your confidentiality if you fill out this form.
Depending on your insurance carrier, they may want diagnostic/treatment information.

PLEASE SIGN RELEASE OF INFORMATION BUT DO NOT FILL OUT AT THIS TIME. Your signature acknowledges you have been explained your patient rights.

I hereby authorize: Institute of Advanced Sciences and Consulting Staff
23120 ALICIA PARKWAY #200
MISSSION VIEJO, CA 92691

To Release to: _____Specific Person
_____Name of Facility
_____Street Address
_____City, State, Zip
_____Telephone/Fax

Psychotherapy Records obtained during the course of treatment of the patients name below:
Patient's Name:_____ Date of Birth:_____
DISCLOSURE OF RECORDS SHALL BE LIMITED TO THE FOLLOWING:
_____History _____Psychological Evaluation _____Progress Notes _____
_____Prognosis_____Treatment Plan_____Diagnosis _____Alcohol/Drug Use____
Other (Specify):_____
_____

I understand that I may revoke this authorization at any time except to the extent that action has been taken. Authorization will automatically expire in 60 (sixty) days from the date of my signature.
I understand that the specific type of information to be disclosed may include history of drug, alcohol and/or psychiatric treatment. *Federal Law (42CFR, part 2*) prohibits redisclosure of this information by the recipient. Minor patients 12-17 years of age, and the parent or legal guardian must sign the authorization. A photo copy or facsimile transmission of this authorization may be accepted in lieu of the original.

_____ ___/___/___ Date of Birth:_____
Signature of Patient ,Parent or Guardian (12-17)

_____ ___/___/___ Date of Birth:_____
Signature of Patient

_____ ___/___/___
Witness

Each of you were referred in a different way. You may have been referred by your insurance provider, Employee Assistance Program (EAP), Family member or Friend. How were you referred?_____

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Questionnaire

Name: _____Address:_____

Home Phone: _____Cell Phone:_____

1. **How old are you? _____ Year Born? _____Birth Date?_____**
2. **Where were you born? _____**
3. **Where did you grow up? List Key Places You Lived.**

_____

_____.

4. **Are your parents alive? Yes____No____. Are you in contact with them? Yes____No____.**
5. **How many siblings do you have? _____. Please list starting with the oldest and include yourself**

_____

_____. **Which siblings are you in contact with? Please circle above.**

6. **Are you Single ____Married_____ Divorced_____?**
7. **How many times have you been married/Long term relationships? _____. Please list names of previous**
8. **Spouses/Partners ? _____**
9. **How many times have you been divorced/separated? _____. From who?**

_____

_____.

10. **Who is in your life presently?**

_____

11. **What family members are you close to?**

_____

12. **What family members are you distant from?**

_____

13. **Do you have children? Yes_____No_____? How Many? _____.**

Please list names of children and ages starting with the youngest?

_____

_____

14. **What occupation are you? _____**
15. **What religion are you? _____**
16. **What are your hobbies? _____**
17. **Do you have a Large____ Medium____ Small____ support system? Please list people closet to you?**

_____

18. **Do you have any history of abuse? Yes_____No_____**
19. **What Abuses have you Experienced ? Physical____ Verbal____ Sexual____ Neglect____ Domestic____ Other_____.**
Are you presently in therapy? Yes____No____

Please list present therapist?
_____

20. **Past Therapy/psychiatric Experiences? Yes____No____.**

21. **Duration of Therapy in past? _____**

22. **(Please list names of all previous treatment practitioners/psychiatrists)_____**
_____.

23. **Are you presently under care of a psychiatrist? Yes____No____?**

24. **Are you presently on psychiatric medication(s)? Please list:**

_____

25. **Are you presently under care of a medical doctor? Yes____No_____.**

26. **Are you presently on any medical medication(s)? Please list:**

_____

27. **Have you had any psychiatric hospitalizations? Yes____No? Please list all hospitalizations and duration**

_____

28. **Please list all medical/psychiatric hospitalizations?**
_____

29. **Do you have legal problems? Yes____No____ please list any legal problems**

_____

30. **Do you have financial problems? Yes____No____ Please list any financial problems**

_____

31. **Please describe the reason you are seeking therapy?**
_____

_____

_____.

32. **What goals in therapy would you like to achieve?**
_____

_____

33. **How long do you see yourself needing to achieve these goals? 1-3 months ____ 3-6 months ____ 6-8 months _____.**
34. **Please list top 3 Goals**
_____

_____

_____

35. **Why are these goals important?**
_____

_____

36. **Please list any other comments in order to help identify problem areas?**

_____

_____

37. **Who else would you like to include in your treatment?**

_____

_____

Thank you for filling out this form thoroughly.
Institute of Advanced Sciences
Question Form 2011

Checklist must be completed.

NAME:_____

Please check which apply to you:

Criminal problems____
Hx. of Criminal problems____
Compulsive____
Annoyance____
Anger____
Difficulty Sharing____
Giving Too Much____
Anxiety____
Sweating____
Breathing Problems____
Missing Appointments____
Intense____
Commitments_____
Gambling____
Depression____
Loss____
Bad dreams____
Trauma____
Stress____
Crying____
Violence____
Mood swings____
Not caring about anything____
Infidelity ____
Fear(s) ____
Decreased interest in pleasurable activities____
Sleep disturbance____
Appetite disturbance____
Motivation problems____
Panic____
Guilt ____
Hopelessness____
Worthlessness ____
Fatigue ____
Restlessness ____
Difficulty concentrating ____
Isolation ____
Sexual problems ____
Arguing/Agitation____
Thoughts of death ____
Plans for suicide ____
Rage____
Thoughts of hurting others____
Repetitive Behaviors____
Difficulty Completing Things____
Problems Keeping Friends____
Intimacy Issues____
Learning Disorders____
Grooming & Hygiene
Frequent Law Suits____
History of Any Law Suits____
Unstable____
Dramatic____

Thoughts of hurting self____
Talkative____
Foolish spending habits ____
Visual hallucinations____
Auditory hallucinations____
Suspiciousness____
Distracted ____
Racing Thoughts ____
Paranoia ____
Voices ____
Dependency ____
Jealousy ____
Bossiness____
Disappointment____
Frustration____
Fetishes ____
Orderliness____
Pain____
Past hx. of drugs____
Memory problems____
Impulsive thoughts____
Repetitive behaviors____
Difficulty completing things____
Please list any issues or problems that were not on the check list that you would like to address?

_____