Melanie S. Rich, Ph.D., L.L.C.
8115 E Indian Bend Road, Suite 119
Scottsdale, AZ 85250
480.467.0288

Private & Confidential - Patient Information

Today's date _____
mm/dd/yyyy

Name _____

Birth date _____ Age_____ Gender: __M /__F Email _____

Address_____City_____State_____ Zip_____

Home Telephone _____ Work Telephone _____

Cell Phone _____ May We Call You At Work? _____Yes ____No

Marital Status: _____Married _____Single _____Divorced _____Widowed _____Separated _____# of Years

Name of Spouse/Significant other: _____

Number of Children : _____

Names & Ages:

_____

What Precipitated This Visit?

_____

_____

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Referred By_____

Person to Contact in Case of Emergency: _____ Relationship_____

Telephone _____

Billing /Responsible Party Address (if Different from Address Above):

Name of Responsible Party_____

Address_____City_____State_____ Zip_____

Family Physician Address, Phone & Name: _____

Address_____City_____State_____ Zip_____

Phone _____

Psychologist – Patient Agreement

All payments are due at the time of service.

There is a 24 hour cancellation policy for appointments.
The full session fee for the scheduled appointment will be charged if not cancelled within that time period.

Please initial: _____

This agreement has been prepared to help Dr. Rich's patients understand how the business office operates with respect to the psychologist-patient relationship. Please read all of the information contained in this agreement and indicate your confirmation by signing this document.

Confidentiality Policy

Please see Patient's Privacy Form available at www.DrMelanieRich.com

Office Policy

Dr. Rich reserves the right to decline patient's seeking reports for third party opinions, as well as disability and divorce cases. The practice is focused on treatment and cannot sustain the amounts of additional report writing these cases requires.

Health Insurance Plans

Dr. Rich participates in several health insurance plans or policies. Please visit www.DrMelanieRich.com for a list of current plans or check with your health insurance provider. Patients may also elect to file claims individually. A 'Super Bill'/receipt will be provided upon request at the time of visit, providing the appropriate mechanism for patients to file the claim with the appropriate insurance plan.

Health insurance policies require patients to release all encounter information for any service rendered and claimed against the health care plan. The diagnosis and treatment information required on the claim form is often forwarded by the patient's insurance plan to the *Medical Information Bureau* (MIB). The patient's health history then becomes available to other insurance companies without the patient's knowledge or consent. Therefore, Dr. Rich believes that the release of any diagnostic information through the claims filing process may present a potential risk that could be personally damaging to unknowing patients. Therefore, Dr. Rich wants each patient to be aware of any potential risk of releasing medical information should an inappropriate party have access to the MIB national database.

Payment Policy & Terms

A $25.00 fee will be charged for any returned check. Patients, who call Dr. Rich with routine problems or issues, will be charged a fee of $50.00 for every15 minutes. The patient agrees to pay all charges, in accordance with the Payment Policy outlined in this agreement. Should Dr. Rich be forced to incur collection charges or legal fees, the patient agrees to pay them in full.

Patient Responsibilities

Each patient is responsible for providing accurate contact information as well as billing information. If telephone numbers and/or addresses change, patients must inform Dr. Rich's business office.

I have read, understood, and accept the provisions of this agreement, and have no questions about the policies outlined herein. I understand that if I violate any provisions of this agreement, my treatment may be terminated. I understand that this agreement is binding in the State of Arizona and that the provisions are for my protection and for the protection of Dr. Rich. The original copy of this agreement will become a part of my private medical record.

_____ _____

Signature (typing your name is equivalent to signing) Date mm/dd/yyyy

Confidential Patient History Patient:

Please provide the following information about your general health and your health history. Please Enter P for personal health history. Enter F for areas of family history.

____Alcohol use/Drug use
____Allergies: pollen, dust, animals
____Allergies: medications
____Asthma, Bronchitis
____Arthritis, Gout
____anxiety
____Eating disorder: anorexia, bulimia
____Bone/joint condition
____Back, neck, spine, disc problem or injury
____Birth defects/ Deformity
____Blood disease: anemia, leukemia
____Blood vessel, circulation disorder
____HIV/Aids
____Breast disease
____Breast implants (L/R)
____Broken bones/ bone disease
____Intestinal disorders
____Cancer of any type
____Concussion/head injury
____Diabetes
____Ear/Nose/Throat disease or infection
____Epilepsy/seizure disorder, convulsions
____Hysterectomy
____Female organ irregularity, abnormal Pap, menstrual
____Gallbladder
____Heart problem or condition
____Hepatitis/liver disorder
____Hernia
____Hypertension, blood pressure disorder
____Hormonal/Thyroid /Pituitary disorder
____Immune system disorder, Lupus
____Stomach/ colon/ Crohn's disease
____Kidney/Urinary tract condition or infection
____Lung condition or infection
____Male organ irregularity or condition: prostate, impotence
____Nervous system conditions
____Mental: nervous, depression
____Migraines/Headaches
____Muscle/Tendon disorders
____Prosthetic implant/ artificial limbs
____Reconstructive/Cosmetic surgery
____Sexually transmitted diseases
____Skin disorders/lesions/cancer
____Steroid use: Prednisone, anabolic
____Stroke
____Tumors, cysts, polyps, growths
____Ulcers, digestive disorders
____Weight problems
____Other, explain _____

Has there been any family psychiatric history?:

_____
_____
_____

Current & Past Medications (please indicate by circling C [current] or P [past] med)

C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	

Do you have any medication allergies? __Y__ N If yes, what medications: _____

_____

Please list any other substances you have allergies to, such as foods or over-the-counter medications:

_____

_____

Have you ever been hospitalized? If yes, please state when, where, why: _____

_____

_____

Have you ever had surgery? If yes, please state type of surgery and when, where, why: _____

_____

_____

Please check any of the following areas that you have experienced:

___ Head Injury ___ Loss of consciousness ___ Seizures ____ convulsions ____ other neurological diagnosis

Have you ever smoked? ___ Yes ___ No If yes, number of years: _____ Daily Use: _____

If female, Date of last menstrual period: _____ Are you pregnant? ___ Yes ___ No

Height: _____ Weight: _____ Blood Pressure History: __ High __ Normal __ Low BP Range (if known): _____

PLEASE BRIEFLY DESCRIBE YOUR FAMILY WHEN YOU WERE GROWING UP:

_____
_____
_____
_____
_____
_____

PLEASE LIST ANY EVENTS FROM YOUR CHILDHOOD / OR ADULTHOOD THAT HAVE HAD A PROFOUND EFFECT ON YOUR LIFE:

_____
_____
_____
_____

HIGHEST GRADE/DEGREE COMPLETED? _____ WHERE? _____

HOW MANY HOURS A WEEK ARE YOU EMPLOYED? _____

HOW OFTEN DO YOU SPEND TIME WITH OTHERS?_____

HOW MANY CHILDREN DO YOU HAVE?_____ DO THEY ALL LIVE WITH YOU?_____

DESCRIBE ANY AREAS OF CONFLICT WITH YOUR CHILDREN AND/OR SPOUSE:

_____
_____
_____

PLEASE SHOW HISTORY OF SUBSTANCE ABUSE:

	CURRENT	PAST		CURRENT	PAST
ALCOHOL			HYPNOTICS		
TOBACCO			DIET PILLS		
CAFFEINE (TEA, COFFEE, SODA)			NARCOTICS / PAIN		
COCAINE			NERVE PILLS		
MARIJUANA			SLEEPING PILLS		
STIMULANTS			OTHERS (SPECIFY)		

LEGAL HISTORY (IF APPLICABLE):

HAVE YOU EVER BEEN ARRESTED? ___Y ___N

ARE YOU CURRENTLY OR HAVE YOU EVER BEEN INVOLVED IN A LAWSUIT?

_____
_____
_____

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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I, (parent/guardian if patient is a minor) _____, hereby authorize
(print name)

Dr. Melanie Rich to obtain information from and/or release information to:

_____

_____

_____

Regarding Patient:_____

Date of Birth:_____
MM/DD/YYYY

Portion of record to be released:
___ All
___ Diagnostic Evaluation
___ Summary of Contact with Client
___ Verbal Contact
___ Diagnostic Test Reports

___ other:
specify
_____
_____

I understand why this information is needed and I am satisfied that it will be held confidential.

Photocopies of this form will be considered as valid as the original.

This authorization will remain in effect until revoked by me in writing.

Signed: _____
Please sign by hand

Date: _____
MM/DD/YYYY