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 ___________________

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? ____

____

____

==

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 (______)___________________

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 Date

Please provide the following information about your general health and your health history.

Please Circle P for personal health history. Circle F for areas of family history.

P F Alcohol use/Drug use
P F Allergies: pollen, dust, animals
P F Allergies: medications
P F Asthma, Bronchitis
P F Arthritis, Gout
P F anxiety
P F Eating disorder: anorexia, bulimia
P F Bone/joint condition
P F Back, neck, spine, disc problem or injury
P F Birth defects/ Deformity
P F Blood disease: anemia, leukemia
P F Blood vessel, circulation disorder
P F HIV/Aids
P F Breast disease
P F Breast implants (L/R)
P F Broken bones/ bone disease
P F Intestinal disorders
P F Cancer of any type
P F Concussion/head injury
P F Diabetes
P F Ear/Nose/Throat disease or infection
P F Epilepsy/seizure disorder, convulsions
P F Hysterectomy
P F Female organ irregularity, abnormal Pap, menstrual
P F Gallbladder
P F Heart problem or condition
P F Hepatitis/liver disorder
P F Hernia
P F Hypertension, blood pressure disorder
P F Hormonal/Thyroid /Pituitary disorder
P F Immune system disorder, Lupus
P F Stomach/ colon/ Crohn's disease
P F Kidney/Urinary tract condition or infection
P F Lung condition or infection
P F Male organ irregularity or condition: prostate, impotence
P F Nervous system conditions
P F Mental: nervous, depression
P F Migraines/Headaches
P F Muscle/Tendon disorders
P F Prosthetic implant/ artificial limbs
P F Reconstructive/Cosmetic surgery
P F Sexually transmitted diseases
P F Skin disorders/lesions/cancer
P F Steroid use: Prednisone, anabolic
P F Stroke
P F Tumors, cysts, polyps, growths
P F Ulcers, digestive disorders
P F Weight problems
P F 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? ______________________________________

____
____
____

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

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:____________

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: ____________________________

Date: ____________________________