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ADULT PERSONAL HISTORY FORM

Name_____ Date:_____

Gender ___M ___ F Date of Birth: _____ Age: _____ Social Security No: _____

_____
Address City State Zip Code

_____ _____ _____
Home Phone Cell Phone Work Phone

E-Mail Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Ethnicity: _____ Family Size: _____

Referral Source(s): _____

Occupation: _____ Education level: _____

Current Employment Status: _____ Unemployed _____ Part Time _____ Full Time

Current Employer: _____

Marital Status: _____ Single _____ Married (how long) _____ _____ Separated (how long) _____

_____ Unmarried, living together (how long) _____ _____ Widowed (how long) _____

_____ Divorced (how long) _____ Total Number of Marriages _____

Assessment of current relationship (if applicable): _____ good _____ fair _____ poor

Primary reason(s) for seeking services:

___ Anger management ___ Anxiety ___ Addictive behaviors ___ Alcohol/Drugs
___ Eating disorders ___Fear/phobias ___ Coping ___ Depression
___Sleeping problems ___Mental Confusion ___Sexual Concerns ___ Other (specify)
_____

Do you feel suicidal at this time: ___ Yes ___ No

If yes, explain: _____
_____

Please check behaviors and symptoms that occur to you more than you would like them to take place:

____ Aggression	____ Dizziness	____ Irritability	____ Sleeping Problems
____ Alcohol Dependence	____ Drug Dependence	____ Judgment Errors	____ Speech Problems
____ Anger	____ Eating Disorder	____ Loneliness	____ Suicidal Thoughts
____ Antisocial Behavior	____ Elevated Mood	____ Memory Impairment	____ Thoughts Disorganized
____ Anxiety	____ Fatigue	____ Mood Shifts	____ Trembling
____ Avoiding people	____ Gambling	____ Panic Attacks	____ Withdrawing
____ Chest Pain	____ Hallucinations	____ Phobias/Fears	____ Worrying
____ Computer/Internet Addiction	____ Heart Palpitations	____ Recurring Thoughts	____ Other (Specify below)
____ Depression	____ High Blood Pressure	____ Sexual Addictions	_____
____ Disorientation	____ Hopelessness	____ Sexual Difficulties	_____
____ Distractibility	____ Impulsivity	____ Sick Often	_____

What are your goals for therapy? _____

_____

_____

_____

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	No	Yes	When	Where	Reason
Counseling/Psychiatric Treatment					
Suicidal Thoughts/Attempts					
Drug/Alcohol Treatment					
Hospitalizations					
Involvement with self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)					

FAMILY INFORMATION

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Information about family/significant others (past and present):

	No	Yes	Who	When	Reason
Counseling/Psychiatric Treatment					
Suicidal Thoughts/Attempts					
Drug/Alcohol Treatment					
Hospitalizations					
Involvement with self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)					

MEDICAL /PHYSICAL HEALTH

Check all that apply:

____ AIDS/HIV	____ Constipation	____ Hepatitis	____ Sore Throat
____ Alcoholism	____ Chicken Pox	____ High Blood Pressure	____ Scarlet Fever
____ Abdominal Pain	____ Dental Problems	____ Kidney Problems	____ Sinusitis
____ Abortion	____ Diabetes	____ Measles	____ Small Pox
____ Allergies	____ Diarrhea	____ Mononucleosis	____ Stroke
____ Anemia	____ Dizziness	____ Mumps	____ Sexual Problems
____ Appendicitis	____ Drug Abuse	____ Menstrual Pain	____ Tonsillitis
____ Arthritis	____ Epilepsy	____ Miscarriages	____ Tuberculosis
____ Asthma	____ Ear Infections	____ Neurological Disorders	____ Toothache
____ Bronchitis	____ Eating Problems	____ Nausea	____ Thyroid Problems
____ Bed Wetting	____ Fainting	____ Nose Bleeds	____ Vision Problems
____ Cancer	____ Fatigue	____ Pneumonia	____ Vomiting
____ Chest Pain	____ Frequent Urination	____ Rheumatic Fever	____ Whooping Cough
____ Chronic Pain	____ Headaches	____ Sexually Transmitted Diseases	____ Other (describe)
____ Colds/Coughs	____ Hearing Problems	____ Sleeping Disorders	_____

List any current health concerns: _____

List any recent health or physical changes: _____

Medical Doctor: _____

Psychiatrist/Therapist: _____

Current Prescribed Medications	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Over-the-counter Meds	Dose	Dates	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ___ No ___ Yes (describe): _____

Please check if there have been any recent changes in the following:

____ Sleep Pattern	____ Eating Patterns	____ Behavior	____ Energy Level
____ Physical Activity Level	____ General Disposition	____ Weight	____ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

CHEMICAL USE HISTORY

Type of Drug	Quantity/Amount	Frequency of Use	Age of First Use	Used in Last 48 Hours		Used in Last 30 Days	
				Yes	No	Yes	No
Alcohol							
Barbiturates							
Valium/Librium							
Cocaine/Crack							
Heroin/Opiates							
Marijuana							
PCP/LSD/Mescaline							
Inhalants							
Caffeine							
Nicotine							
Over-The-Counter							
Prescription Drugs							
Other Drugs							

Substance of preference:
1. _____ 2. _____

Describe when and where you typically use substances _____
_____

Describe any changes in your use patterns _____
_____

Describe how your use has affected your family or friends (include their perceptions of your use) _____
_____
_____

Reason(s) for use:
____ Addicted ____ Build Confidence ____ Escape ____ Self-medication
____ Socialization ____ Taste ____ Other (specify) _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol?
____ No _____ Yes (describe) _____

Have you had any adverse reactions or overdose to drugs or alcohol? (describe) _____
_____

Have drugs or alcohol created a problem for your job? ____ No _____ Yes (describe) _____

_____

Does (has) someone in your family (present/past) have (had) a problem with drugs or alcohol?

___ No ____ Yes (describe) _____

LEGAL

Current Status

Are you involved in any active or prior cases (traffic, civil, criminal, child protective services)? ____ No ____ Yes
If yes, please describe and indicate the court and hearing/trial dates and charges _____

_____

_____

Are you presently on probation or parole ____ No ____ Yes
If yes, please describe _____
_____

Past History

Criminal involvement: ____ No ____ Yes DWI, DUI, Etc.: ____ No ____ Yes
Civil involvement: ____ No ____ Yes

If you responded Yes to any of the above, please complete the following information:

Charges	Date	Where (City)	Results

MILITARY

Military Experience: ____ No ____ Yes Combat Experience: ____ No ____ Yes Where: _____
Issues pertaining to Military experience? ___ No ___ Yes (describe)
_____
_____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ____ Not ____ Little ____ Moderate ____ Much
Are you affiliated with a spiritual or religious group? ____ No ____ Yes (describe) _____
_____
Were you raised within a spiritual or religious group? ____ No ____ Yes (describe) _____
_____
Additional Religious Issues/Experiences? ____ No ____ Yes (describe)
_____
_____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply):

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue Often ____ Follower
____ Friendly ____ Leader ____ Outgoing ____ Shy/Withdrawn ____ Submissive
____ Other (specify) _____
_____
_____

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? ____ No ____ Yes
If yes, were you a victim of child abuse? ____ Sexual ____ Physical ____ Verbal
Other childhood issues: ____ Neglect ____ Inadequate Nutrition ____ Other (specify) _____
Comments re: Childhood development: _____
_____
_____
_____
_____

Any additional information you would like to note:
_____
_____
_____
_____
_____
_____

Adult Consent for Treatment

I _____ authorize and request treatments that are advisable now or during the course of my care as a patient of Richard D. Recor, Ph.D., Licensed Psychologist.

I understand that the purpose of any treatment and/or procedure will be explained to me and be subject to my agreement.

I further agree that I have read and fully understand the attached Patient Consent and Rights Form.

_____

Patient Signature Date

Patient Consent and Rights

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of patient consent and rights, this document is required as part of your medical record. In addition, this office feels providing this information to you in advance of your receiving services will clarify our office policies and alleviate any misunderstanding regarding what you should expect from us and what we expect from you. If you have any questions, please do not hesitate to contact Anita, Office Manager, (949) 720-0167.

Confidentiality: All aspects of services provided to you are held in the strictest confidence, in accordance with legal and ethical practice. Generally, no information will be released without your signed consent (or the consent of a legal guardian regarding a minor child in treatment). ***However, there are some situations in which we are required to break confidentiality.*** These situations are: suspected abuse of a child or elderly individual, imminent threat of harm to yourself or identifiable others, or when a court of law orders disclosure of the clinical record. When mental health is raised as an issue by a patient, in a legal proceeding, all confidentiality is waived. ***A written comprehensive Notice of Psychological Policies and Practices to Protect the Privacy of Your Patient Health Information is available upon request and is posted in the office waiting room for review.*** Please discuss any concerns you have about confidentiality with Dr. Recor at the initial session.

Insurance Billing: Your insurance policy, if any, is a contract between you and the insurance company, we are not part of the contract with you and your insurance company. As a service to you***, we will only bill the insurance companies where Dr. Recor is a contracted provider***, but cannot guarantee such benefits or the amounts covered and are not ultimately responsible for the collection of such payments. ***Any person with an insurance company that Dr. Recor is not contracted with will be handled as a self-payment account, a super-bill will be provided for your submission to your insurance company for any out of network benefits to be directly reimbursed to you.*** In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Dr. Recor charges the usual customary rates for these services provided in our area***. Person Responsible for Payment of Account is responsible for payments of any insurance company's arbitrary determination of usual and customary rates or denial of payment for services. It is understood that the ultimate responsibility of obtaining any pre-authorization and/or referral required by your insurance carrier is your responsibility as well as payment for any services rendered not covered or not medically necessary.***

Psychotherapy: Psychotherapy is a unique relationship between you (or your minor child) and Dr. Recor, in which you are provided with an environment for enhanced self-understanding. ***The process of psychotherapy works best if you are as open and honest about your thoughts and feelings as possible.*** A treatment plan will be implemented by yourself and Dr. Recor to assure working toward goals in treatment. If for any reason psychotherapy is not working for you, it is important to discuss this with Dr. Recor.

Psychological/Neuropsychological Testing: Testing can be very helpful in understanding and clarifying problems and in developing effective treatment plans. ***To be useful, tests must be carefully and truthfully answered and the directions must be clearly understood.*** If you have any questions about testing, please discuss these with Dr. Recor. The billing for psychological and/or neuropsychological testing includes the additional time the doctor spends scoring tests and compiling a comprehensive report of the testing (usually expect that for every hour spent in the office there is an additional one hour spent scoring tests and compiling the report of evaluation). ***A 2 hour follow-up appointment will also be made with the parent/legal guardian/patient to assure a complete understanding of the diagnosis, test results and recommendations. The formal report is released only after this review.*** An estimate of the total cost of the testing is available upon request.

Educational Testing: This is not typically covered under health insurance. ***Anything more than a brief screening of educational concerns will your responsibility and is not billed to insurance***. An estimate of the cost and degree of warranted educational testing is available upon request.

Services Pertaining to Legal Matters: You are responsible to notify Dr. Recor in advance of any services rendered that are pertaining to legal matters. ***A separate signed Consent of Forensic Services and Policy is required before any services are received.*** A signed consent is also required to speak with your attorney.

Appointments: ***The length of an appointment for psychotherapy is typically 60 minutes in length***. Psychological/Neuropsychological testing is typically scheduled in four to six hour blocks of time, but can vary in length depending upon the particular reason for the testing and the tests to be administered. Please direct questions regarding appointments to Anita, Office Manager.

Cancellations/Missed Appointments: We understand that emergencies can arise that require you to cancel or change your appointment. However, we require a minimum of 48 hour notice for any change in appointment or cancellation of an appointment. ***If the required 48-hour notice is not received, you will be billed for the equivalent of a 60 minute therapy session and this fee will need to be paid in advance of rescheduling any additional appointments.*** Missed and/or cancelled appointments are not covered under health insurance plans.

Our Right to Terminate Services: If Dr. Recor determines the treatment is no longer beneficial or determines you would be better served by another professional, or if two appointments are missed or canceled without the required 48 hour notice our policy is to terminate services and make referral to additional providers. ***If any of these situations apply, a certified letter will be mailed to you along with at least three referral sources***. This policy is strictly adhered to and will be enforced due to the waiting list that is in place for appointments.

Payment: ***All co-payments and deductibles are to be paid at the time of service as payment plans are not currently offered. As a courtesy, we do accept major credit cards***. After 60 days all accounts in arrears will be turned over to a collection agency and assessed a 15% interest fee effective the date the account became delinquent, as well as all collection fees associated in collecting the debt. It is further understood that no additional services will be provided until the charges have been paid in full.

Telephone Calls: The office policy for telephone calls during office hours is that all pertinent information is given to the receptionist for Dr. Recor. **It is important that regular appointments are made to alleviate the need for telephone calls.** ***All non-emergency telephone calls will be returned as Dr. Recor's schedule allows. After hours emergency calls are returned as soon as possible and you are advised to call 911 immediately. Non-emergency as well as emergency telephone calls are billed in 5 minute increments and will be directly billed to you***. Telephone calls are not covered by medical insurance.

E-Mails: The office policy for accepting and responding to email is that ***it is expressly understood that confidentiality cannot be assured in electronic submission of personal data and Dr. Recor will not be liable for lack of confidentiality of medical and/or personal information expressed electronically***. It is important that regular appointments are made to alleviate the need for emails. ***All emails that require a direct response from Dr. Recor will be directly billed to you in 5 minute increments***. Emails are not covered by insurance.

Requests for Letters/Reports for Non-Medical Purposes: The time involved in preparing such requests will be directly billed to you and is payable before release of such letter/report.

Office Hours: Regular office hours are as follows: ***Monday thru Thursday 9:00 am -5:00 pm and Friday 9:00-12:00 pm.*** All services provided by Dr. Recor are by appointment only.

I hereby certify that I have read and understand the contents of this document and will abide by the contents contained herewith. The original signed document will be retained as a part of the medical record and a copy of this signed document will be provided to you upon request per HIPAA requirements.

_____ _____

Responsible Party Signature Date

ASSIGNMENT OF INSURANCE BENEFITS

Patient Name:_____ **Date of Birth:** _____

Primary Insurance Co: _____

Name & Phone Number: _____
Mailing Address: _____

Policy Holder Name, Social Security # & Employer: _____
_____

Policy & Group #'s:_____
_
Secondary Insurance(If Applicable) _____

Name & Phone Number: _____

Claims Mailing Address: _____

Policy Holder Name, Social Security # : _____

Employer, Policy & Group #'s:_____

We suggest you confirm your insurance benefits with your insurance company(s) to assure your understanding of specific policy provisions. Your insurance Company may not pay for services they consider not medically or therapeutically necessary, or ineligible. If the insurance company(s)denies payment for any provided services, the Person Responsible for Account will be responsible for the balance of account.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my health care provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I _____ hereby authorize

_____
(Insurance Co. and/or third-party payer)

to pay and hereby assign directly to Richard D. Recor, Ph.D., all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I also understand upon 60 days default, I am liable for any and all costs associated in the collection process of said debt as well as 15% interest on balance at time of default. I further acknowledge that any insurance benefits, will be credited to my account, in accordance with the above said assignment. ***In the event Dr. Recor is not a contracted provider with your specific insurance plan, this agreement is void and you will be given a superbill to submit for your direct reimbursement and assignment of benefits to our office does not apply.*** If you have any questions regarding insurance assignment please ask in advance of the service.

_____

Patient or Parent/Legal Guardian Signature **Date**

Financially Responsible Party Information

Dr. Recor is committed to providing caring and professional mental health care to all his patients.

As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers as further described in the Patient Consent and Rights Form. The financial policy is designed to clarify the payment policies as determined by the management of Richard D. Recor, Ph.D.

Your insurance policy, if any, is a contract between you and the insurance company, we are not part of the contract with you and your insurance company. As a service to you, we will only bill the insurance companies where Dr. Recor is a contracted provider, but cannot guarantee such benefits or the amounts covered and are not ultimately responsible for the collection of such payments. ***Any person with an insurance company that Dr. Recor is not contracted with will be handled as a self-payment account, a super-bill will be provided for your submission to your insurance company for any out of network benefits to be directly reimbursed to you***. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Dr. Recor charges the usual customary rates for these services provided in our area. ***Person Responsible for Payment of Account is responsible for payments of any insurance company's arbitrary determination of usual and customary rates or denial of payment for services.***

The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 45 days***. Payments not received after 60 days are subject to collections. A 15% interest fee effective the date the account became delinquent, as well as all collection fees associated in collecting the debt.***

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g. if there were previous visits to another mental health provider during the current benefit year), this amount will be collected by our office until the deductible payment is verified by the insurance company or third-party payer. ***Insurance benefits with contracted insurance companies will be assigned to Dr. Recor. All other insurance benefits will not be assigned to Dr. Recor and the Person Responsible for Payment of Account pays the entire balance each session.***

Patients or their parent/legal guardian are responsible for payment at the time of service. ***Unaccompanied minors will be denied non-emergency services unless charges have been preauthorized by the parent/legal guardian of the minor by either credit card or other payment source at the time of service.***

Missed appointments or cancellations less than 48 hours prior to the appointment are charged the equivalent of a 60 minute therapy session and will need to be paid in full before another appointment can be scheduled. Questions regarding this agreement can be directed to either the Office Manager or Dr. Recor.

- I (we) have read, understand, and agree with the provisions of the Financially Responsible Party Information.
- Patient Name:_____
- Person (s) Responsible for Account:_____
- Person Responsible Address:_____
- Person Responsible Social Security # _____ Phone Number:_____
- Preferred Payment Method: Check Cash Visa MasterCard

Credit Card:_____ Expiration Date: _____Sec Code:_____

Signature(s) of Authorized Credit Card Holder:_____

****Signature(s) of Person(s) Responsible for Account***_____

Arbitration Agreement

This agreement made on _____between Richard D. Recor, Ph.D., Licensed Psychologist, 101 Pacifica, Suite 220, Irvine, CA 92618, hereinafter referred to as the "First Party" and

Patient/Parent/Legal Guardian Names: _____

Patient Name: -_____

Address: _____

Herein after referred to as "Second Party"

WHERAS, the business relationship between parties commenced _____ as defined in the original psychotherapy contract, namely Mental Health Services, which is attached and incorporated herein;

AND WHEREAS disputes and differences have arisen between parties;

AND WHEREAS the parties recognize that litigation in court can be time consuming and expensive;

AND WHEREAS the parties have appointed American Arbitration Association as their arbitrator.

NOW IT IS AGREED BETWEEN THE PARTIES HERETO AS FOLLOWS:

The parties hereto agree to the following matters and responsibilities to the Arbitrator:
Any controversy or claim arising out of or relating to this contract, or breach thereof, shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator)s) may be entered in any court having jurisdiction thereof.

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not be a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both partied to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

In the event of any dispute, claim, question, or disagreement arising from or relating to this agreement or the breach thereof, the parties hereto shall use their best efforts to settle the dispute, claim, question or disagreement. To this effect they shall consult and negotiate with each other in good faith and, recognizing their mutual interest, attempt to reach a just and equitable solution satisfactory to both parties. If they do not reach such solution within a period of 60 days, then, upon notice by either party to the other, all disputes, claims, questions, or differences shall be finally settled by arbitration administered by the American Arbitration Association in accordance with the provisions of its Commercial Arbitration Rules.

If a dispute arises out of or relates to this contract, or breach thereof, and if the dispute cannot be settled through negotiation, the parties agree to first try in good faith to settle the dispute by mediation administered by the American Arbitration Association under its Commercial Mediation Procedures before resorting to arbitration, litigation, or some other dispute resolution.

In the event there are any disputes or controversies that arise between the parties pursuant to the term is the aforesaid Contract, then the parties are waiving their rights to litigate these issues in court and instead elect to have these disputes resolved through arbitration.

The parties agree that any disputes are to be arbitrated through the American Arbitration Association and that the parties agree to abide by the rules of the Commercial Arbitration Rules of the American Arbitration Association.

WHEREFORE, it is agreed that all claims and disputes arising or relating to the Contract are to be settled by binding arbitration in the State of California. Said arbitration is to be resolved through Commercial Arbitration Rules of the American Arbitration Association and the parties agree to abide by these rules.

Any decision or award as a result of any such arbitration shall be issued in writing and the arbitrator shall be mutually selected pursuant to the Commercial Arbitration Rules or the American Arbitration Association. Any arbitration award may be confirmed in a court of competent jurisdiction.

The Agreement shall be signed by Richard D. Recor, Ph.D., Licensed Psychologist and by

_____, Parent(s) or Legal

Guardian(s) and/ or the patient on behalf of (Patient Name)_____.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signature_____Date: _____
(Parent(s) /Legal Guardian(s) and/or Patient)

Signature:_____Date:_____
Richard D. Recor, Ph.D.