Lois W. Gonzalez, Ph.D.
P.M.H.N.P-BC, C.N.S., D.A.A.P.M., L.M.F.T., L.P.C.
Board Certified Adult Psychiatric and Mental Health Nurse Practitioner
Clinical Nurse Specialist with Prescriptive Authority
Diplomat American Academy of Pain Management
Licensed Marriage & Family Therapist
Licensed Professional Counselor

NEW PATIENT INFORMATION FORM

Name: _____ Age_____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____

# of years in the Austin/Central Texas area: _____

TX Driver's License #: _____ Social Security #: _____

Employer: _____ Occupation: _____

Employer's Address: _____ Phone: _____

_____

How long at present employment? _____ Income: _____

Primary Care Physician: _____ Phone: _____

Referred by: _____

Known Allergies: _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed How long? _____

Spouse's Name: _____ Date of Birth: _____

Any current legal matter pending? ☐ Yes ☐ No If yes, please explain: _____

_____

Emergency Contact: _____ Phone: _____

Relationship to you: _____

I understand and agree that I am responsible for any professional services rendered. I verify that the above information is truthful to the best of my knowledge.

Signature: _____ Date: _____

Please print your name: _____

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INFORMED CONSENT for TREATMENT

I give consent for evaluation and treatment to be provided for myself/ward by Lois W. Gonzalez, PhD.

I am aware that the practice of psychopharmacology is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

The risks, benefit, side effects and alternative of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to Dr. Gonzalez so that I will receive effective treatment. I also agree to play an active role in my treatment process.

I understand that I may terminate treatment at any time.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Printed Name

_____

Relationship to Patient (if applicable)

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PSYCHIATRIC EVALUATION SELF-REPORT

Patient Name: _____ Date:_____

Date of Birth: _____ Age_____ Height: _____ Weight: _____

Please read and answer each question carefully.

MENTAL HEALTH HISTORY:

1.For what reason are you seeking treatment? _____

_____

_____

_____

2.Have you ever been hospitalized for psychiatric concerns?

If yes, please explain:

_____

_____

_____

_____

ARE YOU EXPERIENCING? PLEASE CIRCLE

1. Changes in your sleep? .....
   Yes No
2. Loss or increase in your appetite? .....
   Yes No
3. Significant weight loss or gain in the last year? .....
   Yes No
4. Changes in your energy level? .....
   Yes No
5. Do you do any kind of formal exercise? .....
   Yes No
   If yes, please explain:
6. Concerns about physical health? .....
   Yes No
7. Problems in concentration or decision-making? .....
   Yes No
8. Memory problems?
   Yes No
9. Anxiety?
   Yes No

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If yes, please explain:

10. Panic attacks or fears?
    Yes No
    If yes, please explain:
11. Loss of interest or activities?
    Yes No
12. Feelings of worthlessness or guilt?
    Yes No
13. Thoughts of suicide or self-harm?
    Yes No
14. A period of at least four days in which you are so happy or excited that you get into trouble or others have become worried about you?
    Yes No
15. A period of at least four days of irritability or temper problems?
    Yes No
16. Racing thoughts or feel like you can't keep up with your thoughts?
    Yes No
17. Obsessive thoughts or persistent unpleasant thoughts?
    Yes No
18. A compulsion to carry out an obsessive thought?
    Yes No
19. Thoughts that others are "out to get you"?
    Yes No
20. Voices, visions or sensations that others do not have?
    Yes No

MEDICAL/SURGICAL HISTORY:

1. Please list any CURRENT medical conditions:

2. Please list any PAST significant medical history, with dates (including childhood):

3. Have you ever had a seizure? .....
   Yes No
   If yes, please explain:

4. If you are a woman, are you pregnant or planning on becoming pregnant? .....
   Yes No
   If yes, please describe number of weeks pregnant or when you anticipate on becoming pregnant:

5. Have you ever been hospitalized for major surgeries or illnesses? .....
   Yes No
   If yes, please list diagnosis, procedure and date

6. Please list all current medications, including psychiatric:
   Medication Dosage
   Frequency

7. Re psychiatric medications only, please describe reason for starting, how long you've been taking and the effectiveness of the medications:

SUBSTANCE USE HISTORY:

1. Do you consume alcohol? Yes No

2. Do you use any illegal drugs (cocaine, amphetamines or others?) Yes No

3. Have you ever abused prescription medications or over-the-counter medications, such as pain medicine, narcotics, anxiety medication, tranquilizers, sleeping medications or others not listed? Yes No

4. How many caffeine products (sodas, tea, coffee or energy drinks) do you consume each day?

5. Do you use tobacco products? .....
   Yes No
   If yes, please describe what you use and how often:
   _____
   _____

ABUSE HISTORY: PLEASE CHECK

1. Do you have any history of emotional abuse? ☐ Yes ☐ No Physical? ☐ Yes ☐ No
   Sexual? ☐ Yes ☐ No Other? ☐ Yes ☐ No

2. Do you suffer from symptoms of PTSD (Post Traumatic Stress Disorder)? .....
   Yes ☐ No

FAMILY HISTORY: PLEASE CHECK

1. Is there a family history (parent, sibling, grandparent, first-generation relative (aunt, uncle, 1st cousin), etc.) of the following:

High Blood Pressure	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Seizure Disorder	☐ Yes ☐ No
Cancer	☐ Yes ☐ No		

2. Is there a family history of mental conditions or chemical dependence, such as:

Alcoholism	☐ Yes ☐ No	Drug or Alcohol Addiction	☐ Yes ☐ No
Anxiety Disorder	☐ Yes ☐ No	Learning Problems	☐ Yes ☐ No
Attention Deficit Disorder	☐ Yes ☐ No	Suicide/Suicide Attempt	☐ Yes ☐ No
Bipolar Disorder	☐ Yes ☐ No	Depression	☐ Yes ☐ No

3. Parents: Are they living? Mother ☐ Yes ☐ No Father ☐ Yes ☐ No

4. Please list any siblings with their ages:

5. Is any significant family member deceased? .....
   Yes No
   If yes, please explain:
   _____
   Do you have any significant feelings around the death?
   _____
   _____
   _____

PERSONAL/SOCIAL HISTORY:

1. Where were you born?

2. Where were you raised?

3. Highest Education Level Achieved:_____

4. Significant Past Occupation History:_____
   _____
   _____

5. Military Service? .....☐ Yes ☐ No.....If yes, branch:

   Dates:_____ Discharge: Honorable ☐
   Dishonorable? ☐

6. Any Legal History? .....☐ Yes ☐ No.....If yes, explain:

7. Resolved:_____ If no, explain:

8. If married or in a significant other relationship, please rate (1 – 10 with 10 being the best; please circle):
   1 2 3 4 5 6 7 8 9 10

9. Do you have any problem relationships? ☐ Yes ☐ No
   If yes, please explain:

10. Please list any children and/or grandchildren with their ages:

11. Do you have any phobias? If yes, please explain_____

12. Please describe any interests you have (e.g., hobbies, sports, etc.)

13. In what religion/denomination were you raised?_____

14. Do you still practice your childhood faith?
    Yes No

15. Is there anything you really feel guilty about? Yes No If Yes, Please Explain

16. Do you have any specific request or anything else that should be known to help make your treatment more successful?

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POLICY AND TREATMENT CONTRACT

PATIENT RESPONSIBILITY: Please understand that your health is ultimately your responsibility. I am here to help diagnose and suggest treatments that are best suited for you, but this is a working relationship. In order to ensure optimal care, the following is required:

1. All visits are by appointment only. If you cannot come to your appointment, all cancellations must be made 24 hours in advance of the scheduled appointment. Please be on time.
2. Adherence to the treatment is essential. This includes not only medications but also changes that are suggested, such as sleep habits, exercise, eating program, etc.
3. Be honest and disclose truthful information.
4. Take your medications only as directed. You must make sure your medication is not lost or stolen or improperly used by you or anybody else.
5. You understand that the consumption of alcohol or illicit drugs of any amount is not recommended and that it may negatively interfere with your treatment.
6. If you are female, you must immediately notify me if you are pregnant or thinking of becoming pregnant.
7. Please notify me if your address/or phone number changes.

PROFESSIONAL FEES: Initial Psychiatric Evaluation: 60-70 minutes $250.00
Couples/Family 60-70 minutes $225.00
Individual Psychotherapy/Pharmacological Management 50-60 minutes.....$200.00
Individual Psychotherapy/Pharmacological Management 20-30 minutes.....$100.00
Telephone Consultations with another Professional (minimum).....$100.00
Professional Letter (minimum) $100.00
Form Completion: These include any disability, leave from work,.....$100.00
Return to work, or any other forms requested by you or a third party.
There is no charge for a simple Back To Work/Back to School form.

Payments for all charges are due in full at the time of service.
For your convenience we accept cash, check and Visa/Master Card.
No insurance is accepted. However, you will be provided with all the necessary information with instructions for you to file. Most insurance do not cover couple or family counseling. Please check with your insurance company on what types of counseling your policy allows. Also, insurance companies will not reimburse you for missed appointments or late cancellations, form completions or letters. Those charges will always be your responsibility.
You will be charged $35.00 for any appointment not cancelled 24 hours in advance or for a bounced check.
There are "No Show" charges. The first "no show" will be charged ½ the cost of the visit. Any second "no show" will be charged the entire fee. If you are more than 20 minutes late, your appointment will be cancelled and you will be charged the amount of the scheduled appointment.

CALLING AFTER HOURS OR ON WEEKENDS OR HOLIDAYS: This should be utilized for urgent situations only. If you call, you must leave a message with a call back phone number and reason for calling. Calls should last no more than 10 minutes. For any call or after-hour refills, you will be charged $25.00.

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ONE-TIME VISITS AND AUTOMATIC TERMINATION OF SERVICES: For a one-time consultation or if at the first visit, we decide not to pursue initiation of treatment, no patient relationship is formed and you will not be considered an established patient. You will not receive any written termination letter. If you have not been seen in 12 months or it has been at least 12 months from the date of your last prescription, your services will be automatically terminated. If you decide to come back for a visit, you will be charged the initial evaluation rate, rather than a follow up visit rate.

PRIVACY ISSUES AND REQUEST OF MEDICAL RECORDS: You have the right to ask for your medical records. You must sign a Release of Information Request. Request must be in writing. The charge for coping or faxing your medical record is $25.00 for the first 10 pages and $1.00 per page thereafter. This charge must be paid in advance. We are not responsible for records that have been released from this office. We have the legal right to refuse to release any medical records if it is not in your best interest. It takes up to 10 business days to have records ready.

LEGAL ISSUES: We strongly advise against bringing forth your mental health information in any legal case. You have the right to block your mental health records from being brought into any legal case by asking your attorney to write a letter to the judge asking that these records be barred from legal inquiry. This is your right. However, if you chose to bring your records into a legal case, please understand that once you allow mental health records to be opened in a legal case, there is no more confidentiality. Also, if I am brought into court for any reason, you will be charged $300.00/hour. You will be asked to give a retainer fee of $3,000.00 in advance.

Please note that I hold the right to deny services to anyone who I believe I am unable to give proper treatment. Office hours are 9 am to 5 pm, Monday thru Thursday. If at any time you need immediate assistance, please go to your local emergency room or call 911. Additional resources: MHMR Crisis Hotline 512-472-4357; Suicide Hotline 1-800 suicide; AA Hotline 512-444-0071.

I, the undersigned, acknowledge that I have read the above Policy and Treatment Contract and agree to its terms. I also acknowledge that I have received a copy of this Agreement.

_____

Patient's Name (Please Print) Today's Date

_____

Signature of Responsible Party

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