PARK CITIES PSYCHIATRY

Sandra Lotan, M.D.
Board Certified Adult, Child &
Adolescent Psychiatry

Regina McFarland, M.D.
Board Certified Adult, Child &
Adolescent Psychiatry

Patient Name: _____ DOB: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Employer: _____

Preferred Pharmacy Name: _____ Phone #: _____

Address: _____ City: _____ Zip: _____

	May I Contact you here?	**Check ONE preferred method of contact.**
Phone Number:		
Home:		
Cell:		
Work:		
Email:		

Education Level: _____ Religion: _____

Spouse: _____

Previous Marriage: _____ Ended by Divorce: _____ Death: _____

Children in Order of their Birth:

1) _____ DOB: _____

2) _____ DOB: _____

3) _____ DOB: _____

4) _____ DOB: _____

Names and Contact Information of Previous Therapists:

1) _____

2) _____

Identified Problem: _____

_____

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Referred by: _____

Signature: _____ Date: _____

Major reason for seeking help at this time? _____

_____

_____

_____

How long have you had these problems, symptoms? _____

What have you already tried to resolve the problems, symptoms or issues? _____

_____

_____

_____

Have you had counseling in the past? { } Yes { } No

Name of counselor:	Dates of counseling:	Reason for counseling:

Have you ever been hospitalized for psychiatric reasons? { } Yes { } No

Dates?	Where?	Reason for hospitalization?

What do you think needs to change to resolve the problems, symptoms or issues? _____

_____

_____

_____

Do you have any family members who have been hospitalized for psychiatric reasons? { } Yes { } No

Who?	When?	Reason for hospitalization?

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Are you currently under the care of a physician? { } Yes { } No

Name of physician: _____Phone #: _____

Are you currently under the care of a psychiatrist? { } Yes { } No

Name of psychiatrist: _____ Phone #: _____

Are you currently taking any medications? { } Yes { } No

Name of Medication:	Dosage:	Prescribed by:

Have you ever attempted suicide? { } Yes { } No

Date:	Method:	Reason for attempt:

Do you have any family members who have attempted suicide? { } Yes { } No

Who:	When:	Reason for attempt:

Do you have any serious medical conditions? { } Yes { } No

Please list: _____

_____

_____

Do you use alcohol? { } Yes { } No

What kind:	How often:	How much:	When:

Is it difficult for you to stop or control the amount? { } Yes { } No

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Do you use illegal substances? { } Yes { } No

(This is confidential information and will not be disclosed/reported to anyone.)

What kind:	How often:	How much:	When:

Is it difficult for you to stop or control the amount? { } Yes { } No

Have you ever had a DUI? { } Yes { } No If yes, when? _____

Has your drinking or drug use caused problems in the family? { } Yes { } No

Has it caused problems in your job? { } Yes { } No

Have you or anyone in your family been in a treatment program for substance use or abuse?{ } Yes { } N o

Who:	When:	Outcome:

Do you use any of the following?

Substance:	How much:	How often:	When:	Age started:
Caffeine				
Cigarettes				
Chewing tobacco				

Have you or anyone in your family had problems with criminal offenses/been in jail/prison? { } Yes { } No

Who:	Why:	When:	Current status:

Current Marital Status: { } Single { } Married { } Partnered { } Divorced { } Widowed

Name:	Length of long term relationship/ marriage:	Date:

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FAMILY DATA:

Name	Relationship	City of residence	Check if living with you	Age	How do you get along?
	spouse/partner				
	child				
	child				
	child				
	mother				
	father				
	sibling				
	sibling				
	sibling				

Check all that apply for present or past:

Symptom:	Now	Past	Symptom:	Now	Past
Headaches			Dizziness		
Stomach problems			Sleep issues		
Memory problems			Confusion		
Racing thoughts			Paranoia		
Euphoria			Mood swings		
Excessive energy			Unusual thoughts		
Weird feelings			Suspicion		
Depression			Bingeing		
Weight loss			Weight gain		
Worthlessness			Hopelessness		
Feeling helpless			Low energy		
Crying a lot			Irritable mood		
Worrying a lot			Phobias		
Fears			Panic attacks		
Suicidal thoughts			Homicidal thoughts		
Gambling problems			Legal problems		
Financial problems			Poor concentration		
Recurring unwanted thoughts			Can't enjoy life		
Anger problems			Impulsive behavior		

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Who is a part of your emotional support system?

Name:	**Relationship:**

What are your weaknesses? _____

_____

_____

What are your strengths? _____

_____

_____

Is there anything else I need to know about you? _____

_____

_____

_____

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FEE POLICY

Payment for service is due at the completion of each visit. Cash, personal check, or credit card (Visa or Mastercard) is accepted.

We charge for missed appointments or appointments cancelled with less than 24 hours notice.

Initial Session	(90 minutes)	$575
Full Session	(55 minutes)	$300
Half Session	(25 minutes)	$200
School Visit		$325
Prescriptions-Controlled Substance		$25
Prescriptions-Other		no charge
School Letters for SAT, ACT, or special accommodations		$250

_____ _____

Signature of Responsible Party Date

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OFFICE POLICY LETTER

- The receipt that we provide is designed to provide information required by insurance companies. You will be responsible for filing your claims with the insurance carrier.
- We do not disclose any information with your insurance without your knowledge.
- We do not share any patient information with 3rd parties, without your consent.
- In case of an emergency, call 911 or proceed to your nearest Emergency Room. If your child is in crisis and you call after hours, cell phone numbers are provided on our answering machine.

HIPAA STATEMENT

All issues discussed in the course of treatment are strictly confidential with the following exceptions:

1. Consultation with other current healthcare providers if, pertinent to treatment.
2. Instances in which the patient maybe-an imminent threat to self or others, unable to care for his or her most basic needs, or in cases of suspected child abuse.
3. Consultation with a colleague.
4. Under certain circumstances when ordered by court.
5. Some treatment information such as name, diagnosis, date of service and charge provided to insurance companies to facilitate reimbursement. This is done at your discretion.

Should you request that specific information be released to other healthcare professionals, school staff or anyone else, you will be asked to sign a consent form for the release of this information.

Please sign below acknowledging that you have read and understand our office policies.

_____

Parent or Guardian
Patient – if age 18 or older