DR. SCOTT HAMILTON

The information below is to help Dr. Hamilton understand you and your situation. Please fill out these forms completely. All information given is strictly confidential and will only be released with your written permission.

PERSONAL INFORMATION DATE_____

Name_____
Last First Middle

_____

Address City Zip Code

May we leave message

Home Phone _____ ☐Yes ☐No

Cell Phone_____ ☐Yes ☐No

Work Phone _____ ☐Yes ☐No

Male ____ Female_____ Age_____ Date of Birth _____ Social Security #_____

Marital Status (Circle one): Single (never married) Married Divorced Widowed

Race: _____ Ethnicity: _____

Employer's Name_____ Address_____

Occupation _____

Education (circle last year completed) School 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 5 6+

Other Training _____

Religion: Do you attend church now? _____Where? _____

Do you believe in God? _____

Military Service: _____ Combat Service? _____

Dates_____ Branch of Service_____

Physician_____

If referred – By Whom?_____

Have you had previous counseling or psychotherapy? _____ When_____

Are you presently seeing another therapist? _____Who_____

Are you presently on medication? _____ Name of medication and dosage_____

For what condition? _____ Doctor prescribing medication? _____

INFORMATION ON FAMILY OF ORIGIN:

Who raised you? _____

Biological Parents:

Father: Age_____ Deceased____ (Date of Death_____) Divorced___your age at the time_____

Mother: Age_____ Deceased____ (Date of Death_____) Divorced___your age at the time_____

Adoptive Parents:

Father: Age_____ Deceased____ (Date of Death_____) Divorced___your age at the time_____

Mother: Age_____ Deceased____ (Date of Death_____) Divorced___your age at the time_____

Other Parents: Stepfather married your mother at your age of _____
Stepmother married your father at your age of _____
Describe any children who joined your family at these times: _____
_____

Children of your Family of origin (Brothers and sisters - list by birth order, including self)

Name	Sex	Age Now	Deceased	Date of Birth
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____

Have any other family members died? _____

What particular problems did you have as a child? _____
_____

INFORMATION ON MARRIAGE:

Present Marriage or Latest Marriage:

Name of Spouse_____Occupation_____

Address (if different) _____Phone_____

Business Address_____Phone_____

Spouse's Age_____ Education (in years) _____ Date of Marriage_____

Ages when married: You_____Spouse_____ Time known before marriage_____

Children of this marriage:

Name	Age	Sex	Now living with you?
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

Legal Action Taken: Divorce filed by: You_____Spouse____Date filed_____

If marriage was terminated, when? _____

Living at Home? (yes/no) You_____ Spouse_____

Previous Marriage:

Name of Spouse_____Occupation_____

Age when married: You____Spouse____Date of Marriage_____Length of Marriage_____

Reason for Termination: _____

Divorce_____ Date of termination_____Legal Action Taken by: Self_____Spouse____

Children of this marriage:

Name	Age	Sex	Now living with you?
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

INFORMATION ON HOUSEHOLD:

Who lives at your address?

Name	Age	Sex	Relationship?
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

Are there members of your family or household who have had a drinking or drug use problem?_____

Describe_____

CURRENT NEEDS AND CONCERNS:

State in your own words the concerns you bring with you to counseling_____

_____

_____

_____

What are your goals for counseling? _____

_____

How do you envision your beliefs, faith, or spirituality as part of your therapy?

_____

What are your faith concerns? _____

_____

Check the items that describe or relate to the concerns listed above:

_____Bereavement (grief)
_____Depression
_____Weight gain/loss
_____Anxiety
_____Nervousness
_____Relationship with Superiors
_____Marriage Problems
_____Sexual Concerns
_____Infidelity of Self

_____Infidelity of Spouse
_____Physical Abuse
_____Sexual Abuse
_____Emotional Abuse

_____Communication Problems
_____Intense Anger
_____Insecurity
_____Guilt
_____Suicidal Feelings/Thought
_____Sleeplessness
_____Troubled Dreams
_____Relationship with Parents
_____Relationship with Children

_____Relationship with Co-Workers
_____Religious Doubts/Fears
_____Anger with God
_____Loss of Faith in God

_____Verbal Abuse
_____Illness of Self
_____Illness of Relative/Friend
_____Alcohol
_____Drugs
_____Self Doubt

_____Vocational Direction

_____Loss of Faith in Others
_____Loss of Faith in Self
_____Loss of Self-Respect
_____Loss of Meaning
_____Loss of Hope
_____Loss of Love

_____Other

COUNSELING INFORMATION AND CONSENT FORM

Thank you for selecting Dr. Scott Hamilton. This consent form explains some information about the counseling experience. The counselor will review this information with you during your first session. We think it is important that you read or hear and understand this information. You will be asked to acknowledge that you understand the Center's policies and your treatment. To assure a full understanding, you are invited to discuss any item or question with the therapist.

DUTY TO WARN:

Dr. Hamilton is committed to the confidentiality and privileged communication of all clients. There are, however, several exceptions. According to Texas Law, any evidence of child or elderly abuse must be reported. Also, if an individual intends to take harmful, dangerous or criminal action against another human being, or against himself or herself, it is the therapist's duty to report such action or intent.

Required as a Duty to Warn Acknowledgement

Signature_____

In An Emergency Please Notify:

Name_____ Relationship_____ Cell Phone_____

Address_____City_____State_____Zip Code_____

Name_____ Relationship_____ Cell Phone_____

Address_____City_____State_____Zip Code_____

FEES AND APPOINTMENTS:

FEES: Our regular fee is $299.00 for a 45 – 55 minute session and $149.00 for a 60-90 minute group session. If you do not have insurance, a sliding scale based on your family income *may* be available. Please feel free to discuss this with the business office.

Court: You my request or your attorney may issue a subpoena for a counselor to appear in court. In any case where court is involved (other than a CPS court issued subpoena), you must be aware that a cash only fee of $499.00 per clinical hour of (50 minutes) will be charged. This amount is charged for perpetration time, travel time, and actual time spent in court, whether or not actual testimony is given. This compensation, in accordance to the Texas Rules of Civil Procedure, shall be made by the party retaining the services of Dr. Scott Hamilton. Furthermore, payment for five (5) clinical hours shall be made to Dr. Hamilton on or before the date of the appearance as a reinter, and following the conclusion of the court proceedings, funds will be refunded or additional fees billed based on the actual time spent in court activates, the total fee charges is the client's responsibility to pay upon receipt of statement.

INSURANCE: Some policies may cover, please check your policy or call your insurance company to determine the exact coverage, if any. If **POLICY DEDUCTIBLE HAS NOT BEEN SATISFIED YOU ARE RESPONSIBLE FOR PAYING THE ALLOWED AMOUNT.** We will assist you with your insurance filing; meanwhile you are expected to pay the quoted fee at the time of service.

My signature confirms that I have read or heard the information above and that it was presented to me in a clear, non-technical language. This information is understood by me and enables me to make an informed voluntary consent to this treatment.

_____ _____

Client (or guardian's) Signature Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, CLIENT BILL OF RIGHTS AND CONSENT

You may refuse to sign this acknowledgement. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____ _____

Please print your name **Please sign your name** **Date**

DR. SCOTT HAMILTON

SIGNATURE ON FILE

RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

1.) I hereby authorize my insurance benefits/ Employee Assistance Program (EAP) to be paid directly to Dr. Scott Hamilton. If an error occurs with the EAP company, I hereby authorize Dr. Scott Hamilton to bill the insurance on file. I realize that I am responsible to pay non-covered services (all co-pays, co-insurances and deductibles) at the time of service. I hereby authorize the release of required information to the *insurance carriers and their representatives* for the processing of claim submission. I authorize this form to be copied and used on all my insurance submissions including electronic filing (signature on file). I authorize my therapist, Dr. Scott Hamilton, to act as my agent in helping obtain payment from my insurance carriers. Please be advised that any benefits, which your insurance carrier quotes to Dr. Scott Hamilton, are not a guarantee of payment of benefits. All insurance companies read a disclaimer before quoting benefits to any provider. Your co-pay will be dependent on your diagnostic code and can be different from the original quote given to the business office. Please read your Explanation of Benefits from your insurance company when you receive it, your responsibility will be shown. If you have a deductible, it has to be met before insurance benefits will be payable. When you terminate therapy if you have a refund due from overpayment, the business office will issue you a refund check. If you seek third party reimbursement, you may be waiving the confidentiality of your sessions and any records of those sessions with your insurance company.

2.) If an appointment is missed (NCA) or canceled with less than 24 hours' notice (LCA), I understand that I may be charged a $49.00 fee <u>not billable to insurance</u>. I understand that there is a $49.00 fee not billable to insurance for additional paperwork, forms or documentation completed by the counselor that is payable at the time of request. I understand if I am using Private Pay that I am responsible for the fee quoted at the time of service. I understand that charges can result because I have not provided current and valid insurance policy information.

3.) During any counselor incapacitation, Rob Farthing will retain your records. Contact him at 757.848.6849 (cell).

<u>SIGNATURE ON FILE</u>

For Electronic Filing

Name_____Date_____

(Please print)

Signature_____ Date_____

<u>I AUTHORIZE THE RELEASE OF VERBAL AND /OR WRITTEN INFORMATION TO:</u>

I authorize release of my Psychological Evaluation/Bariatric report to Dr. _____as part of my pre/ post operation requirements.

_____

Signature for Authorization of release

DR. SCOTT HAMILTON

INSURANCE INFORMATION

If you have insurance and want the Center to file your insurance, you must complete all of the information below. Any information, which is omitted, will delay in the filing of your insurance.

Primary Insurance:

Policyholder's Information:

Policyholder' Full Name: _____ Male ____ Female_____

DOB_____ SSN_____ Race_____ Ethnicity_____

Street Address: _____ City: _____

State: _____ Zip Code_____ Your relationship to policyholder_____

Home Phone _____ Cell Phone_____ Work Phone _____

Policyholder's Employer _____ Name of Insurance _____

Member / Sponsor ID _____ Group Number_____

Patient Information:

Patient's complete name_____

DOB_____ SSN_____ Race_____ Ethnicity_____

Have you ever had same or similar illness, if so please give date_____

What date did you first notice current symptoms? _____

<u>Secondary Insurance:</u> (Tricare and Medicaid will be secondary to other insurance)

<u>Policyholder's Information</u>:

Policyholder' Full Name: _____ Male ____ Female_____

DOB_____ SSN_____ Race_____ Ethnicity_____

Street Address: _____ City: _____

State: _____ Zip Code_____ Your relationship to policyholder_____

Home Phone _____ Cell Phone_____ Work Phone _____

Policyholder's Employer _____ Name of Insurance _____

Member / Sponsor ID _____ Group Number_____

<u>Patient Information</u>:

Patient's complete name_____

DOB_____ SSN_____ Race_____ Ethnicity_____