# *Atomic Shrink Psychology, Inc.*


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## PATIENT IDENTIFICATION

Patient Full Legal Name:_____
Date of Birth:_____
Last 4 of Social Security Number or full SSN if TriCare/TriWest/VA patient:_____
Primary Telephone Number:_____
Secondary Telephone Number:_____
Permission to send appointment reminders by SMS text: **CIRCLE ONE**: **Yes / No**
Home Address:_____
City / State / Zip:_____
Email Address:_____

## GUARDIAN INFORMATION — IF PATIENT IS UNDER GUARDIANSHIP

Guardian Name:_____
Telephone Number:_____
Address if different from patient:_____
City / State / Zip:_____

## MARITAL AND FAMILY STATUS

Marital status:_____
Spouse's name:_____
Spouse occupation:_____
Children: **CIRCLE ONE: Yes / No**
Number of children & Ages:_____

## EMPLOYMENT INFORMATION

Employer:_____
Employer Address:_____
Job Title:_____Length of Employment:_____
Insurance obtained through employer: **CIRCLE ONE: Yes / No**

## INSURANCE INFORMATION

Primary Insurance Carrier:_____
Primary Insured Name:_____
Primary Insured Date of Birth:_____
Relationship to Patient:_____
Insurance ID:_____
Group ID:_____

Secondary Insurance Carrier if applicable:_____
Primary Insured Name_____
Primary Insured Date of Birth:_____
Relationship to Patient:_____
Insurance ID:_____
Group ID:_____

Tertiary Insurance Carrier if applicable:_____
Primary Insured Name_____
Primary Insured Date of Birth:_____
Relationship to Patient:_____
Insurance ID:_____
Group ID:_____
Insurance card(s) must be provided prior to first appointment by secure upload, email, or in person.

## EMERGENCY CONTACT

Name:_____
Relationship:_____
Primary Telephone:_____
Secondary Telephone:
Address if different from patient:_____
City / State / Zip:_____

## MEDICAL HISTORY

Major illnesses:_____
Surgeries:_____
Hospitalizations, with dates, and reason: _____
_____
_____
Current medications, dosage, prescribing provider:_____
_____
_____
Primary care physician and city:_____

Date of last physical examination:_____
Currently under care of psychiatrist, psychologist, or other mental health provider: **Yes / No**
If yes, name and specialty:_____

## SUBSTANCE USE HISTORY

**Alcohol:** Never / Current / Recent / Past / Addiction
**Cannabis:** Never / Current / Recent / Past / Addiction
**Stimulants:** Never / Current / Recent / Past / Addiction
**Opioids:** Never / Current / Recent / Past / Addiction
Other substances:_____

## PRESENTING PROBLEM AND RISK SCREEN

Reason for seeking services:_____
_____
Current symptoms [please detail]:_____
_____
_____
_____
Onset of symptoms:_____
Duration:_____
Psychiatric medications currently prescribed:_____
_____
_____
History of psychiatric hospitalization: **Yes / No**
If yes, when:_____
History of suicidal thoughts: **Yes / No**
**If YES, fully explain:** _____
_____
_____
Current intent, plan, or means: **Yes / No**
**If YES, fully explain:** _____
_____
_____
History of thoughts of harming others: **Yes / No**
**If YES, fully explain:** _____
_____
_____
Current intent, plan, or means: **Yes / No**
**If YES, fully explain:** _____
_____
_____
History of victimization or violence exposure: **Yes / No**
**If YES, fully explain:** _____

Disability status:_____

Military service history and years served:_____

## INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES

Psychological services include evaluation, diagnosis, consultation, and treatment of behavioral and mental health conditions. Treatment methods vary by clinical need and may include structured psychological interventions, assessment procedures, and coordination with medical providers.

No guarantee of outcome is made. Participation is voluntary and may be discontinued at any time.

Mandated reporting laws require disclosure when there is risk of harm to self or others, suspected abuse or neglect, or court-ordered release.

## CRISIS AND EMERGENCY LIMITATION

This practice is not an emergency service provider.
In an emergency call 911 or 988.
Do not use email, SMS, or portal messages for urgent or crisis communication.

## NO SURPRISES ACT
## GOOD FAITH ESTIMATE NOTICE

You have the right to receive a Good Faith Estimate of expected charges for services if you are uninsured, self-pay, or elect not to utilize insurance. You may request this estimate at any time. If billed charges substantially exceed the estimate, federal dispute procedures are available.

## FEES AND PAYMENT POLICY

Payment is due at time of service unless contractual insurance arrangement exists.
Accepted payment methods: credit card or debit card.
Card-on-file authorization is required.
Charges may be processed for copayments, deductibles, coinsurance, missed appointment fees, and balances owed.
Returned payments, unpaid balances, and delinquent accounts may be referred to collections.
***NOTE: ALL VA PATIENTS ARE EXEMPT FROM ANY FORM OF PAYMENT.***

## CANCELLATION AND ATTENDANCE POLICY

**Minimum cancellation notice: 24 hours.**

Missed or late-cancelled appointments incur a fee.
Repeated late arrival, missed appointments, or repeated rescheduling may result in discharge from care.

**ELECTRONIC COMMUNICATION CONSENT**

SMS and email are not fully secure. By consenting, patient accepts privacy risk. These methods are for scheduling and administrative communication only. Clinical emergencies must not be sent electronically.

Consent to electronic communication: **CIRCLE ONE Yes / No**

**RECORDING POLICY**

Audio or video recording of sessions is prohibited without written authorization from the provider. Unauthorized recording may result in termination of services.

**TELEHEALTH INFORMED CONSENT**

Telehealth uses secure electronic communication systems. Platform may change to maintain compliance and security standards.

Risks include technical failure, data transmission limits, and privacy risks.

Patient responsibilities
Maintain private location
Maintain secure internet connection
Provide physical location at each session
Provide emergency contact information

If connection fails, provider may continue by alternate secure method or reschedule.

Services may only occur when patient is physically located in a state where the provider holds active licensure. [Dr. Story is licensed in CA, CO, and TX.]

Patient location verification required each telehealth session.

Telehealth consent granted: **CIRLE ONE Yes / No**

**DIGITAL TOOLS DISCLOSURE**

Secure digital documentation and clinical decision support tools may be utilized to assist documentation and scoring functions. Final clinical judgment is always made by the licensed psychologist.

## COORDINATION OF CARE AUTHORIZATION — OPTIONAL

**Patient authorizes communication with:**

Primary care physician Yes / No
Psychiatrist Yes / No
Referring physician Yes / No
Other treating providers Yes / No

## HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient acknowledges receipt of Notice of Privacy Practices describing rights and protections of protected health information and methods for filing complaints.

## ASSIGNMENT OF BENEFITS

Patient authorizes insurance payment directly to provider for covered services.

## SIGNATURES

Patient Name [Print clearly]:_____

Signature:_____

Date:_____

Guardian Name if applicable:_____

Signature:_____

Date:_____

Secondary Guardian if required:_____
Signature:_____
Date:_____