Dear Patient,

Thank you for selecting me as your psychologist. As a bilingual - English/Spanish, Ph.D., Level Clinical Psychologist with over 20 years of experience in psychological diagnostics, I treat a variety of patients, ranging in age from infancy to adulthood.

Below you will find an overview of what to expect. Please read and initial each point.

_____ Your will be scheduled for three appointments. **Please note, the first two appointments have the potential to last anywhere from two (2) to four (4) hours.**

_____ **First Appointment:**
Initial Consultation and Assessment, Diagnosis and Treatment Plan
***NOTE: Patients who have completed paperwork first, will be seen first.**

_____ **Second Appointment:**
Psychological Testing
Testing consists of the following: Intelligence, Achievement and Emotional State and Reality Testing. These tests assist in determining the diffe ential diagnosis; such as ADHD, Clinical Depression and Academic Placement. A Screening Tes ay also be administered to rule out emotional factors that may be contributing to negative behav

_____ **Third Appointment:**
Results of the Psychological Testin d the Screening Test
You will receive a full detailed Psyc gical Report at this time. Verbal results are only available for the Screening Test. Additionally rrals will be given based on your diagnosis.

_____ **Phone/Electronic Device Policy: Out of respect for our patients, we have a no cell phone policy. If you need to use your phone, please step into the hallway. If you wish to listen to music/watch videos on your electronic device, a headset is required. For patient privacy, no photos are to be taken in our office. Thank you for respecting all our patients.**

_____ **Once again, your wait can be anywhere between two (2) to four (4) hours for any given appointment. During your visit, no food is allowed in our waiting area. We appreciate your patience and respecting our no food policy.**

My staff and I look forward to assisting your child and family.

Sincerely,

Dr. Charles E. Gutierrez, Ph.D.

Dr. Charles E. Gutierrez, Ph.D.

Informed Consent

Patient's Name _____

To better serve our patients, we have implemented important office policies and procedures regarding your treatment with Dr. Charles E. Gutierrez. **Please read them carefully and initial.** If you have any questions, please raise them with your doctor or our office staff.

_____ **Appointments:** Patients are seen by appointment only. Punctuality is important! If you are more than 15-minutes late, Dr. Gutierrez WILL NOT see you and your appointment will be rescheduled. You will need to present your insurance/Medicaid card at each appointment. **Patients who have submitted their completed paperwork, prior to their appointment, will be seen first. The first two appointments have the potential to last anywhere between two (2) to four (4) hours.** A detailed Scheduling Policies and Procedures can be found in your New Patient Packet.

_____ **Payment of Fees:** Payment is appreciated at each visit. We will assist in completing your health insurance claim; however, the CLIENT, NOT THE INSURANCE is responsible for payment of the bill. If another arrangement is needed, please consult with our staff. All efforts will be made to work out an acceptable method of payment. If the client fails to comply with attempts to negotiate payment, Dr. Gutierrez's office will utilize an outside collection agency for delinquent accounts.

_____ **Cancellation Policy:** If you need to cancel an appointment, please notify our office as soon as possible. ***A missed appointment without 24-hour notice will be charged as a session and you will be charged a $25.00 "no show" fee.***

_____ **No Show Policy:** As a courtesy to our patients and office, it is important you keep your scheduled appointments. A no show means a loss to us and another patient to receive treatment. Therefore, after three (3) consecutive no shows, we will refer you elsewhere for your mental health needs.

_____ **Emergency Call Services:** In case of an emergency, please go to the nearest hospital or dial 911, as Dr. Gutierrez does not provide 24-hour service.

By signing below, I agree to the Informed Consent, set forth by Dr. Gutierrez's office.

PRINTED _____ _____

Patient/Personal Representative's First and Last Name — Relationship to Patient

SIGNATURE _____ DATE _____

Patient/Personal Representative's First and Last Name

ELECTRONIC SIGNATURE (IF APPLICABLE)

☐ I understand that checking this box constitutes a legal signature confirming I acknowledge and agree to the above information.

Dr. Charles E. Gutierrez, Ph.D.

Scheduling Policies and Procedures

1. On the business day before your appointment, we will call to confirm your appointment.
***This will be done Monday - Thursday between the hours of 9:00 a.m. and 11:30 a.m. and Friday 9:00 a.m. and 12:00 p.m.**

2. If we call and receive no answer, we will leave a voice mail explaining:
If we do not receive a confirmation for your appointment by 2:00 p.m., that same afternoon, we will cancel your appointment.

3. If we left you a voice mail on our 1st attempt to confirm your appointment and have not heard back from you, we will call a 2nd time, between 2:00 p.m. and 3:00 p.m.

4. If we cannot directly reach you on the 2nd attempt, we will leave a voice mail advising you to call our office to reschedule your appointment, since your original appointment has been canceled.

If your contact number has changed or your phone service has been interrupted, it is your responsibility to contact our office and furnish us with a new contact number.

DUE TO THE LARGE NUMBER OF PATIENTS SCHEDULED AT THIS OFFICE, THESE POLICIES WILL BE ENFORCED AND NO EXCEPTIONS WILL BE MADE.

By signing below, I agree to the scheduling policies and procedures, set forth by Dr. Gutierrez's office.

PRINTED _____ _____

Patient/Personal Representative's First and Last Name | Relationship to Patient

SIGNATURE _____ DATE _____

Patient/Personal Representative's First and Last Name

ELECTRONIC SIGNATURE (IF APPLICABLE)

☐ I understand that checking this box constitutes a legal signature confirming I acknowledge and agree to the above information.

HIPAA PRIVACY AUTHORIZATION FORM

** Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. AUTHORIZATION

I authorize ***Dr. Charles E. Gutierrez, Ph.D.*** (healthcare provider) to use and disclose the protected mental health information described below to:

Individual(s) seeking the information
(Doctors, School, Attorneys, Family Members, etc.)

2. EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from:

a. ☐ Date [ ] to Date [ ]

OR

b. ☐ all past, present and future periods (for one year only)

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes I may direct.

4. This authorization shall be in and effective for one (1) year from today's date [ ], at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest the claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

SIGNATURE [ ] PRINTED NAME [ ]

PATIENT/PERSONAL REPRESENTATIVE PATIENT/PERSONAL REPRESENTATIVE

TODAY'S DATE [ ] RELATIONSHIP TO PATIENT [ ]

ELECTRONIC SIGNATURE (IF APPLICABLE)

☐ I understand that checking this box constitutes a legal signature confirming I acknowledge and agree to the above information.

Dr. Charles E. Gutierrez, Ph.D.

ADULT - PATIENT/INSURANCE INFORMATION

'ATIENT'S INFORMATION:

FIRST NAME | MIDDLE | LAST NAME

SSN | DATE OF BIRTH | AGE | SEX

MARITAL STATUS | DRIVER'S LICENSE # | STATE

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | WORK PHONE

PERSONAL EMAIL | WORK EMAIL

EMPLOYMENT STATUS | EMPLOYER | JOB TITLE

PRIMARY CARE PHYSICIAN | PHYSICIAN PHONE

PHYSICIAN ADDRESS

CITY | STATE | ZIP CODE

MAY WE CONTACT YOUR PHYSICIAN SO THAT THIS PROVIDER MAY BE FULLY INFORMED AND WE MAY COORDINATE YOUR TREATMENT? ☐ YES ☐ NO

REFERRED BY

EMERGENCY CONTACT INFORMATION:

NAME | RELATIONSHIP TO PATIENT

HOME PHONE | CELL PHONE | WORK PHONE

PRIMARY INSURANCE INFORMATION:

POLICY HOLDER | EMPLOYER

SSN | RELATIONSHIP TO PATIENT | INSURANCE NAME

INSURANCE PHONE # | I.D. # | GROUP #

SECONDARY INSURANCE INFORMATION:

POLICY HOLDER | EMPLOYER

SSN | RELATIONSHIP TO PATIENT | INSURANCE NAME

INSURANCE PHONE # | I.D. # | GROUP #

HOW DID YOU HEAR ABOUT US?

☐ DOCTOR REFERRAL ☐ INSURANCE COMPANY ☐ MAGAZINE/NEWS ARTICLE ☐ YELLOW PAGES

☐ FRIEND/RELATIVE ☐ INTERNET/WEBSITE ☐ TELEVISION ☐ OTHER

I hereby give Dr. Charles Gutierrez, Ph.D., authorization to release any information necessary to process medical insurance claims to authorize payments of benefits to him for services rendered.

SIGNATURE _____ PRINTED NAME _____

PATIENT/PERSONAL REPRESENTATIVE PATIENT/PERSONAL REPRESENTATIVE

Today's Date _____ RELATIONSHIP TO PATIENT _____

ELECTRONIC SIGNATURE (IF APPLICABLE)

☐ I understand that checking this box constitutes a legal signature confirming I acknowledge and agree to the above information.

Dr. Charles E. Gutierrez, Ph.D.

ADULT QUESTIONNAIRE

TODAY'S DATE

PATIENT'S NAME

DATE OF BIRTH EMAIL

ADDRESS

CITY STATE ZIP CODE

MARITAL STATUS DIVORCED - MO/YR SEPARATED - MO/YR

HIGHEST GRADE OF EDUCATION COMPLETED SPECIAL EDUCATION IF YES, WHAT GRADE(S) RACE

CURRENTLY EMPLOYED IF YES, LIST EMPLOYER & TYPE OF WORK

LANGUAGES SPOKEN AT HOME

FAMILY HISTORY

WERE YOU ADOPTED? ◯ YES ◯ NO IF YES, AT WHAT AGE?

PARENTS/SIBLINGS (Relationship to Patient)	FIRST/LAST NAME	MARITAL STATUS	AGE

IF OTHER, SPECIFY

OTHERS LIVING IN YOUR HOUSEHOLD

FIRST/LAST NAME	RELATIONSHIP TO YOU	AGE

FAMILY MEDICAL HISTORY

CHECK ALL THAT APPLY - (FAMILY MEDICAL HISTORY)

- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ BONES
- ☐ CANCER
- ☐ CARDIAC
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ LIVER FUNCTION
- ☐ RENAL
- ☐ SUBSTANCE ABUSE
- ☐ SURGERY
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ NONE LISTED

OTHER

CHECK ALL THAT APPLY - (FAMILY PSYCHIATRIC HISTORY)

- ☐ ADHD
- ☐ ADDICTION DISORDER
- ☐ ANXIETY
- ☐ AUTISM
- ☐ BI-POLAR
- ☐ DEPRESSION
- ☐ EATING DISORDER
- ☐ IMPULSE CONTROL DISORDER
- ☐ LEARNING DISABILITY
- ☐ OBSESSIVE-COMPULSIVE DISORDER (OCD)
- ☐ PERSONALITY DISORDER
- ☐ POST-TRAUMATIC STRESS DISORDER (PTSD)
- ☐ SCHIZOPHRENIA

OTHER

LIST ANY PSYCHIATRIC HOSPITAL STAYS

Dr. Charles E. Gutierrez, Ph.D.

ADULT QUESTIONNAIRE

PATIENT INFORMATION

WHY ARE YOU SEEKING TREATMENT/CHIEF COMPLAINT

HOW WOULD YOU RATE THE SEVERITY OF THE PROBLEM RIGHT NOW? (0 - MILD ...10 - SEVERE)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

AGE OF ONSET OF SYMPTOMS, PROBLEMS & PROGRESSION OF PROBLEMS

PATIENT MEDICAL HISTORY

PRIMARY CARE PHYSICIAN

PSYCHIATRIST

CHECK ALL THAT APPLY - (PATIENT MEDICAL HISTORY)

☐ ALLERGIES	☐ BONES	☐ DIABETES	☐ RENAL	☐ TUMORS
☐ ANEMIA	☐ CANCER	☐ EPILEPSY	☐ SURGERY	☐ NONE LISTED
☐ ASTHMA	☐ CARDIAC	☐ LIVER FUNCTION	☐ TUBERCULOSIS	

OTHER

PLEASE LIST ANY MEDICAL CONDITIONS AND/OR ILLNESSES FOR WHICH YOU ARE CURRENTLY BEING TREATED OR HAVE BEEN TREATED FOR IN THE PAST AND GIVE DATES OF TREATMENT

LIST ANY PAST SURGERIES/HOSPITALIZATIONS (INCLUDE DATE)

LIST ANY ALLERGIES (IF PRESENT)

DO YOU SUSPECT YOU ARE PREGNANT? ○ YES ○ NO ARE YOU BREAST FEEDING? ○ YES ○ NO

DATE OF LAST MENSTRUAL PERIOD

Dr. Charles E. Gutierrez, Ph.D.

ADULT QUESTIONNAIRE

TRAUMA HISTORY

DOMESTIC VIOLENCE..... ◯ YES ◯ NO PHYSICAL ABUSE..... ◯ YES ◯ NO VICTIM OF VIOLENT CRIME.. ◯ YES ◯ NO

EMOTIONAL ABUSE..... ◯ YES ◯ NO SEXUAL ABUSE..... ◯ YES ◯ NO OTHER INCIDENT..... ◯ YES ◯ NO

IF OTHER, DESCRIBE

SUBSTANCE HISTORY

PAST OR PRESENT HISTORY OF DRUG/ALCOHOL ABUSE

INDICATE IF YOU USE ANY OF THE FOLLOWING SUBSTANCES

☐ COFFEE/CAFFEINE _____ CUPS/DAY ☐ ALCOHOL _____ DRINKS PER WEEK

☐ CIGARETTES PER DAY _____ FOR HOW LONG? _____

☐ ILLEGAL DRUGS IF YES, LIST THE TYPE, AMOUNT AND FREQUENCY

MOST RECENT USE OF ANY ILLEGAL DRUGS

HOW MANY YEARS OF USE

HAS ANYONE EVER TOLD YOU THAT YOUR USE OF ANY SUBSTANCE IS A PROBLEM? ◯ YES ◯ NO

WHICH ONES?

HAVE YOU EVER RECEIVED ANY KIND OF SUBSTANCE ABUSE TREATMENT? ◯ YES ◯ NO

IF YES, PLEASE DESCRIBE AND GIVE DATES (I.E. DETOX, 12-STEP, ETC.)

PSYCHIATRIC HISTORY

CHECK ALL THAT APPLY - (PATIENT PSYCHIATRIC HISTORY)

☐ ADHD	☐ BI-POLAR	☐ LEARNING DISABILITY	☐ SCHIZOPHRENIA
☐ ADDICTION DISORDER	☐ DEPRESSION	☐ OBSESSIVE-COMPULSIVE DISORDER (OCD)	
☐ ANXIETY	☐ EATING DISORDER	☐ PERSONALITY DISORDER	
☐ AUTISM	☐ IMPULSE CONTROL DISORDER	☐ POST-TRAUMATIC STRESS DISORDER (PTSD)	

OTHER

HAVE YOU EVER SEEN A PSYCHIATRIST/THERAPIST BEFORE TODAY? ◯ YES ◯ NO

IF SO, WHEN WAS THE TREATMENT?

FOR HOW LONG?

NAME OF PROVIDER(S)

HAVE YOU EVER BEEN HOSPITALIZED IN A PSYCHIATRIC FACILTY? ◯ YES ◯ NO

HOSPITAL(S)

DATES

REASON FOR ADMISSION(S)

LENGTH OF STAY

MEDICATION HISTORY

WERE ANY MEDICATIONS EVER PRESCRIBED TO YOU BY A PSYCHIATRIST/PRIMARY CARE PHYSICIAN/OTHER PROVIDER (OB/GYN, NURSE PRACTITIONER) FOR ANY PSYCHIATRIC ILLNESS OR OTHER MEDICAL ISSUES? ◯ YES ◯ NO

IF YES, WHAT MEDICATIONS/DOSES WERE YOU PRESCRIBED?

DATES (FROM/TO)	MEDICATION/DOSES	YOUR RESPONSE

WHY DID YOU STOP TAKING YOUR MEDICATION, IF YOU DID?

DO YOU TAKE ANY OVER THE COUNTER MEDICATIONS/VITAMINS/SUPPLEMENTS? (INCLUDE DOSAGE AND HOW OFTEN)

PATIENT PROBLEM CHECKLIST

PLEASE INDICATE WHICH PROBLEMS ARE BOTHERING YOU AT THIS TIME
0 - NONE.....1 - MILD.....2 - MODERATE.....3 - SERIOUS.....4 - SEVERE

PREVIOUS EPISODES OF DEPRESSION	○0	○1	○2	○3	○4	PREVIOUS EPISODES OF ELATION.....	○0	○1	○2	○3	○4
FEEL SAD.....	○0	○1	○2	○3	○4	CRY EASILY.....	○0	○1	○2	○3	○4
FEEL HOPELESS.....	○0	○1	○2	○3	○4	FEEL GUILTY.....	○0	○1	○2	○3	○4
FEEL IRRITABLE.....	○0	○1	○2	○3	○4	FEEL ANXIOUS.....	○0	○1	○2	○3	○4
FEEL WORTHLESS.....	○0	○1	○2	○3	○4	THINK ABOUT SUICIDE.....	○0	○1	○2	○3	○4
PAST SUICIDE ATTEMPTS.....	○0	○1	○2	○3	○4	NOT ABLE TO HAVE FUN.....	○0	○1	○2	○3	○4
LOSS OF INTEREST-USUAL PLEASURES	○0	○1	○2	○3	○4	UNMOTIVATED TO COMPLETE TASKS	○0	○1	○2	○3	○4
LOSS OF INTEREST IN SEX.....	○0	○1	○2	○3	○4	SEXUAL PERFORMANCE PROBLEMS..	○0	○1	○2	○3	○4
CONFUSION.....	○0	○1	○2	○3	○4	LOSS OF ENERGY.....	○0	○1	○2	○3	○4
FATIGUE.....	○0	○1	○2	○3	○4	BODY FEELS SLOWED DOWN.....	○0	○1	○2	○3	○4
THOUGHTS FEEL SLOWED DOWN.....	○0	○1	○2	○3	○4	BODY FEELS SPED UP.....	○0	○1	○2	○3	○4
RACING THOUGHTS.....	○0	○1	○2	○3	○4	UNHAPPY WITH WEIGHT.....	○0	○1	○2	○3	○4
RECENT WEIGHT GAIN/LOSS.....	○0	○1	○2	○3	○4	NO APPETITE.....	○0	○1	○2	○3	○4
BINGE EATING.....	○0	○1	○2	○3	○4	INTENTIONAL VOMITING.....	○0	○1	○2	○3	○4
TROUBLE FALLING ASLEEP.....	○0	○1	○2	○3	○4	SLEEPING TOO MUCH.....	○0	○1	○2	○3	○4
TROUBLE STAYING ASLEEP.....	○0	○1	○2	○3	○4	WAKING UP TOO EARLY.....	○0	○1	○2	○3	○4
NIGHTMARES.....	○0	○1	○2	○3	○4	PROBLEMS CONCENTRATING.....	○0	○1	○2	○3	○4
MEMORY PROBLEMS.....	○0	○1	○2	○3	○4	INDECISIVENESS.....	○0	○1	○2	○3	○4
WITHDRAW FROM OTHERS.....	○0	○1	○2	○3	○4	EPISODES OF PANIC.....	○0	○1	○2	○3	○4

FEAR OF BEING IN PUBLIC	○0	○1	○2	○3	○4	PHOBIAS	○0	○1	○2	○3	○4
FEAR OF WEIGHT GAIN	○0	○1	○2	○3	○4	TROUBLE MAKING FRIENDS	○0	○1	○2	○3	○4
LONELINESS	○0	○1	○2	○3	○4	UNWANTED, DISTRESSING THOUGHTS	○0	○1	○2	○3	○4
REPETITIVE BEHAVIORS	○0	○1	○2	○3	○4	TROUBLESOME DREAMS, THOUGHTS/ FEELINGS ABOUT TRAUMATIC EVENTS	○0	○1	○2	○3	○4
CONSTANT WORRY	○0	○1	○2	○3	○4	ANXIOUS, ON EDGE	○0	○1	○2	○3	○4
BOWEL DISTURBANCES	○0	○1	○2	○3	○4	ONGOING LAXATIVE USE	○0	○1	○2	○3	○4
CHRONIC PAIN	○0	○1	○2	○3	○4	WORRY OVER HEALTH	○0	○1	○2	○3	○4
MEDICAL PROBLEMS	○0	○1	○2	○3	○4	SKIPPED MENSTRUAL PERIODS	○0	○1	○2	○3	○4
HEAR VOICES	○0	○1	○2	○3	○4	SUSPICIOUS/PARANOID THOUGHTS	○0	○1	○2	○3	○4
SEE THINGS THAT AREN'T THERE	○0	○1	○2	○3	○4	STRANGE THOUGHTS	○0	○1	○2	○3	○4
FITS OF RAGE	○0	○1	○2	○3	○4	THINKING ABOUT HURTING SOMONE	○0	○1	○2	○3	○4
POOR SELF CONTROL	○0	○1	○2	○3	○4	WORK PROBLEMS	○0	○1	○2	○3	○4
RELATIONSHIP PROBLEMS	○0	○1	○2	○3	○4	PROBLEMS WITH FOOD	○0	○1	○2	○3	○4
PROBLEMS WITH MONEY	○0	○1	○2	○3	○4	PROBLEMS WITH HOME	○0	○1	○2	○3	○4
LEGAL PROBLEMS	○0	○1	○2	○3	○4						