Alex L. Andrade Jr., PsyD
Licensed Clinical Psychologist

Welcome! Please complete the following forms. The first page asks for basic information, acknowledgement of HIPPA, payment information, and consent for treatment. The second page includes treatment guidelines. The third page is the email and credit card form. Finally, the Patient Information Form, starting on the fourth page, will help me better understand your treatment needs and will help guide recommendations. Thank you for taking the time to complete these important forms prior to your first appointment.

Full Legal Name: _____ Date of Birth: _____

Race/Ethnicity: _____ Age: ____ Sex: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work (A number ok to leave message)

Marital Status: ☐ Married/Relationship ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Presently living: ☐ Alone ☐ With others (please specify):_____

Home Address: _____

Referred by: _____

HIPAA: I was offered a copy of the HIPAA form concerning privacy protection by Dr. Andrade.

_____ _____
Signature Date

Payment Information: The full amount of fee-for-service payment is required at the time services are rendered. Initial intake is $225 and follow up sessions are $175.

Person Responsible for Payment: _____

Date of Birth: _____

Address: _____

I hereby authorize treatment for the individual listed above and accept responsibility for the charges incurred for this treatment. I also understand that if I do not give 24 hours notice when canceling an appointment, I will be charged a $100 cancellation fee. In the unlikely failure to remit payment and the credit/debit card is denied, the account will be sent to collections and/or legal action will be pursued. Individuals will be held responsible for all associated fees, including, but not limited to, the cost of collection services, attorneys, administrative support, and the psychologist's time.

_____ _____
Signature Date

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Treatment Guidelines

Emergency Contact: Dr. Alex L. Andrade Jr., PsyD is not available on an emergency or "on-call" basis. Individuals may leave a message, but there may be an extended period of time before Dr. Andrade receives it and/or responds. Individuals requiring immediate assistance must call 911 or go to the nearest emergency room. If patients require additional support, Dr. Andrade will provide a referral that can provide emergency services.

Limits of Treatment: There are rare circumstances in which Dr. Andrade may be obligated to make a unilateral decision to terminate therapy. Such circumstances include, but are not limited to: the current treatment appears to be ineffective; threats are made against Dr. Andrade or his family; Dr. Andrade does not believe he has the necessary training to address a specific problem; or there is a significant therapeutic impasse. In such cases, Dr. Andrade will attempt to find a suitable referral. Dr. Andrade cannot be responsible as to whether this referral is accepted.

Email Communication: Email communication should be limited to issues related to scheduling and billing only. If you have clinical concerns or questions, they are best addressed during your session, or in some cases, over the phone. Email is not an appropriate way of communicating urgent or emergency information. Dr. Andrade will use reasonable means to protect the security and confidentiality of email information sent and received. However, because email is not a totally secure medium, Dr. Andrade cannot guarantee the security of email communication, and is not liable for improper or unintentional disclosure of confidential information.

_____ _____

Signature Date

Alex L. Andrade Jr., PsyD
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Patient Legal Name: _____

Responsible Party: _____

Credit/Debit Card Attestation of Signature on File

Name of Cardholder_____

Credit Card #_____ (☐ Mastercard ☐ Visa ☐ Amex ☐ Discover)

Expiration Date_____

Security Code_____

Zip Code (from the credit card billing address)_____

By signing below, I agree to be charged for the services initialed above. I understand that the fee-for-service amount is due at the time services are rendered.

Also, I agree to have my credit/debit card kept on file for the purpose of the $100 cancellation fee (which only applies if I do not give 24 hours notice when canceling a scheduled appointment).

_____ _____
Signature Date

Receipts for each charge are available upon your request. Please let Dr. Andrade know if there is a change in the credit/debit card.

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Patient Information Form

Patient Legal Name: _____

Briefly state the main concerns you would like to discuss:
_____
_____
_____

How long have you had these issues/concerns:
_____
_____
_____

What things have you tried to deal with these issues/concerns:
_____
_____
_____

Have you had any prior therapy experience? (Please describe length of treatment and frequency of visits)
_____
_____
_____

Please check any of the following stresses that apply to you and describe:
☐Major Relocations: _____
☐Job change: _____
☐Deaths: _____
☐Illnesses: _____
☐Marital/Relational Problems: _____
☐Familial Problems: _____
☐Someone significant moving out of the area: _____
☐Experiencing or witnessing a traumatic event: _____
☐Physical or sexual abuse or neglect: _____
☐Legal issues: _____

Occupational History:
Are you currently employed? ☐ Yes ☐ No
If so, how long have you worked in this position? _____
Job/Type of Work: _____

Medical History:
Medical Conditions/Concerns:
_____
_____
_____

Are you taking any medications on an ongoing basis? ☐ Yes ☐ No

Name of Medication	Dosage	Date Started	Name of Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical/Psychiatric Hospitalization: (Please describe and include dates)

_____
_____
_____

Family history of emotional, behavioral, psychological concerns:

_____
_____
_____

Family history of medical problems:

_____
_____
_____

Please indicate if you have had any history of the following medical problems:

	Check One	**Ages**	**Describe**
Asthma	☐ Yes ☐ No		
Chronic Ear Infections	☐ Yes ☐ No		
Headaches	☐ Yes ☐ No		
Hearing/Ear Problems	☐ Yes ☐ No		
Loss of Consciousness	☐ Yes ☐ No		
Nightmares	☐ Yes ☐ No		
Seizures	☐ Yes ☐ No		
Sleep Apnea/Snoring	☐ Yes ☐ No		
Surgeries	☐ Yes ☐ No		
Tics/Twitching	☐ Yes ☐ No		
Vision/Eye Problems	☐ Yes ☐ No		
Alcohol Use/Abuse	☐ Yes ☐ No		
Illicit Drug Use/Abuse	☐ Yes ☐ No		
Risky Behaviors	☐ Yes ☐ No		

Additional Information:
Please list some of your personal strengths:

_____
_____
_____
_____