7611 State Line Road, Suite 319
Kansas City, MO 64114
(816)786.1772

PATIENT INFORMATION

Today's Date: ______

Name: ______
First M.I. Last

Email: ______ SSN: ______

Address: ______

City: ______ State: ______ Zip: ______

Home Phone: ______ Cell Phone: ______

Date of Birth: ______ Age: ______

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

Sex: ☐Male ☐Female ☐Other Spouse's Name: ______

List children or dependents *(please list names and ages)*

______

______

______

Emergency Contact (*Name and Phone*): ______

EMPLOYMENT INFORMATION

Employer: ______

Employer's Address: ______

City: ______ State: ______ Zip: ______

Work Phone: ______

RESPONSIBLE PARTY

Name: ______ Relationship to Patient: ______

Address: ______

City: ______ State: ______ Zip: ______

Phone: ______ SSN: ______ Date of Birth: ______

INSURANCE INFORMATION

Insurance Company: ______ Member ID: ______ Effective Date: ______

Mental Health Insurance Phone Number: ______

Do you have any other insurance? ☐No ☐Yes *(If yes, please provide copy)*

Fill out section below IF INSURED IS DIFFERENT THAN PATIENT

Name of Insured: ______ Relationship to Patient: ______

Name of Employer: ______ Employer Phone: ______

Employer Address: ______

City: ______ State: ______ Zip: ______

Home Address: ______

City: ______ State: ______ Zip: ______

SSN: ______ Date of Birth: ______ Age: ______

Continue next page...

dD david DONOVAN
PHD | PSYCHOLOGIST | PSYCHOANALYST

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FEES

$175 Initial Diagnostic Consultation (first session); $150 each subsequent 45 minute psychotherapy appointment. Reduced fees may be discussed on a case by case basis.

I hereby authorize David Donovan, PhD to release any information acquired in the course of my treatment or examination to my insurance company for billing purposes only.

Signature ______________________________

I authorize payment directly to David Donovan, PhD if any, that would be otherwise payable to me or my dependent(s) for services rendered in the course of examination or treatment.

Signature ______________________________

I understand that I am fully responsible for all services and charges, including any balance due after payment of insurance, and that insurance coverage may not pay for all charges. I also understand that copays and office fees are due and payable when services are rendered. I authorize treatment by this practitioner, David Donovan, PhD.

Signature ______________________________

MEDICAL HISTORY

List previous counseling experiences including therapists' names and dates: ______________________________

____

List previous psychiatric hospitalizations and dates: ______________________________

____

List all medications you are taking: ______________________________

____

List medical conditions and past hospitalizations for non-psychiatric diagnoses: ______________________________

____

Please circle the level of symptoms you are currently experiencing:

	None	Mild	Moderate	Severe
Sadness or Depression	0	1	2	3
Suicidal Thoughts	0	1	2	3
Sleep Problems	0	1	2	3
Change in Appetite	0	1	2	3
Weight Change	0	1	2	3
Inability to Concentrate	0	1	2	3
Obsessive Thoughts	0	1	2	3
Tension /Anxiety	0	1	2	3
Memory Problems	0	1	2	3
Compulsive Behavior	0	1	2	3
Feelings of Hostility	0	1	2	3
Acts of Violence	0	1	2	3
Social Isolation	0	1	2	3
Strange Thoughts	0	1	2	3
Sexual Problems	0	1	2	3
Panic Attacks	0	1	2	3

Substance Use Assessment *(Please circle)*

Alcohol Use
Never 1 - 4 per month 2 - 3 per week Daily

Level of Consumption
None 1 - 2 per sitting 3 - 4 per sitting 5+ per sitting

Substances Used
None Marijuana Sedatives Stimulants
Methamphetamine Hallucinogens Heroin

Frequency of Use
Never 1 - 4 per month 2 - 3 per week Daily

Do you have Family Members or Family History with Addiction?
Yes No

Continue next page...

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INFORMED CONSENT CONTRACT

Welcome,
I am governed by various laws and regulations and by the code of ethics of my profession. I am required to inform you about specific office policies and how these procedures may affect you.

CLIENTS RIGHTS: Our relationship is strictly voluntary and you are free to discontinue psychotherapy at any time.

LIMITS OF CONFIDENTIALITY: Therapy sessions are strictly confidential except under certain legally defined situations involving self-harm or harm to another, and cases of child abuse, elder abuse or abuse of otherwise dependent individuals. In the case of self-harm, I am ethically bound to inform those in a position to help, or to otherwise enlist methods to prevent self-harm or suicide. In the case of danger to others, I am required by law to notify the police and to inform any intended victim(s). In instances of child abuse, elder abuse, or dependent abuse, I must notify the appropriate social service agencies. Other situations that require me by law to reveal information about you to others include a legitimate subpoena by a court of law or if you are being treated by court order.

PROFESSIONAL FEES: Payment for a session is due at time of that session unless other arrangements have been made. Fees will be increased once yearly.

CANCELLATION POLICY: If you need to cancel or reschedule an appointment, please notify me as soon as possible. You will be charged for any missed sessions that are not canceled or rescheduled at least 48 hours in advance. This is necessary because a professional time commitment is set aside and held exclusively for you.

CONTACTING ME: I will return calls as soon as possible should you need to speak with me between sessions. I will make every effort to return your call on the same day it was received, with the exception of weekends and holidays. In case of immediate emergency, if you cannot reach me and feel that you cannot wait for me to return your call, please call 911 or the nearest emergency room. In the event of a lengthy telephone session, you will be charged the hourly session fee. If I will be unavailable for an extended amount of time, I will provide you with the name of a colleague to contact if necessary. If you have any questions regarding the above or any other questions or concerns, please feel free to mention them to me.

I HAVE READ, UNDERSTOOD AND AGREED TO THE CONDITIONS STATED ABOVE.

Client Name: ______________________________

Client or Responsible Party Signature:

______________________________ Date: ______________

PLEASE REMEMBER TO BRING TO FIRST SESSION. THANK YOU.