Please complete the "online" client questionnaire (you were provided a login and a password). Also complete these forms.

Beckie Grgich, Psy.D.
Psychological Services

Bring these forms with you to the appointment.

Client Name: ________________________Gender M / F Date: __________________

Client Birth Date: _____________ SSN _ _ _ - _ _ - _ _ _ _ Age:_______

Client Address: ____

Other Address (i.e. other legal parent):

________________________________ ________________________________

___________, _______ _____________ _________________, ____, __________

Is it okay to leave messages/email? (initial below):

Home Phone: ____ _____initial

Cell: _______________ Who's cell number is this? ________________ _____initial

Cell: _______________ Whose cell number is this? ________________ _____initial

Your initial authorizes phone messages, including voicemail and answering machine messages, about scheduling, canceling, or confirming appointments.

Email: ____ _____initial

Your initial authorizes use of email communication as a means of responding to my inquiries or contacting you, including sending protected reports and or identifying information.

Person (not living with you) in case of emergency: Name:__________________________

Relationship: ___________________________ Phone: ________________________

Address: ____

Please mark all that apply to the client:

Please place a “ ” next to the items checked if they are of MOST concern.
You may add additional information on the back of this page.

☐ Adjustment difficulties
☐ Cultural issues
☐ Adoption/placement
☐ Death of family: _________
☐ Death of friend: _________
☐ Legal issues or involvement
☐ Financial stress/issues
☐ Loss of relationship _______
****
☐ Truancy/no work or school
☐ Lying
☐ Poor attachment
☐ Violating the rights of others
☐ Aggression / hurtful
☐ Argumentative / defiant
****
☐ Eating disorder history
☐ Binge/purge eating/vomiting
☐ Excessive intake of calories
☐ Purposeful vomiting / purging
☐ Starving / not eating
☐ Poor food choices
☐ Emotional eating behaviors
☐ Vegan/Vegetarian Eating
****
☐ Sense of detachment
☐ Flashbacks to trauma
☐ Frightening waking images
☐ Nightmares
☐ Avoidance of reminders/trauma
☐ Emotional numbing
****
☐ Academic problems
☐ Learning disorder
☐ Dyslexia
☐ Academic 504 plan
☐ Academic IEP in place
****
☐ Physical abuse history
☐ Emotional abuse history
☐ Sexual abuse history
☐ Victim of neglect
☐ Trauma ________________
****
☐ High IQ / gifted functioning
☐ Academic ALP in place
☐ Asperger’s (mild autism)
☐ Autism spectrum disorder
****
☐ Mental Delays / Low IQ
☐ Developmental disability
☐ Inability to do daily living tasks

☐ Nervousness
☐ High levels of anxiety
☐ Shortness of breath
☐ Heart pounding
☐ Fear of being around others
☐ Trembling / shaking
☐ Fear of leaving parents
☐ Fear of abandonment
☐ Dependency in relationships
☐ Panic attacks
☐ Difficulty leaving the house
☐ Obsessive checking (things)
****
☐ Bipolar disorder - history
☐ Excessive talking (mania)
☐ Poor sleep (not enough)
☐ Excessive activities (mania)
☐ Rapid change of ideas (mania)
☐ Impulsive decision-making
☐ High self-esteem
☐ Sense of conquering anything
☐ Excessive energy
☐ Elevated mood
☐ Excessive gambling
☐ Over spending=financial probs.
****
☐ Depressed mood
☐ Loss of energy
☐ Moodiness / irritability
☐ Suicidal thoughts
☐ Suicide attempts
☐ Poor concentration
☐ Low Self-esteem
☐ Worthlessness
☐ Loss of interest
****
☐ Threatening others
☐ Mood swings
☐ Fire setting (# times_____)
☐ Cruelty to animals
☐ Theft / stealing
☐ Runaway / disappearances
☐ Homicidal (killing) thoughts
****
☐ Sexual abuse perpetrator
☐ Physical Abuser (DV)
☐ Verbal Abuser
****
☐ Legal issues by history
☐ Current legal issues
****
☐ Sexual dysfunction

☐ Poor work perf./write-ups
☐ Frequent work absences
****
☐ Others put thoughts in my head
☐ Feel others are out to get me
☐ Feel persecuted
☐ Paranoia (fear of others)
☐ Audio (sound) hallucinations
☐ Visual (sight) hallucinations
****
☐ Caffeine use
****
☐ Nicotine use
☐ Drug use (not prescribed)
☐ Alcohol use
****
☐ Forgetfulness
☐ Confusion
☐ slow processing
☐ Poor memory
☐ History Brain Injury (TBI)
****
☐ Encopresis (soiling)-self
☐ Enuresis (wetting)-self
☐ Smearing/wetting in other places

☐ Repeating actions often
☐ Doesn’t consider consequences
☐ Interrupts others
☐ Impulsive / reactive
☐ Hyperactivity
☐ Excessive movement
☐ Distractibility
☐ Dislikes tasks with mental effort
☐ Poor organization
☐ Trouble staying on tasks
☐ Doesn’t seem to finish things
****
☐ Excessive (too much) sleep
****
☐ Burning self
☐ Cutting self
☐ Head banging
☐ Other injuries to self
Type: _____________
☐ Sexual activity (child/teen)
☐ Tantrums, length: _________
****
☐ Unexplained medical issues
☐ Serious medical diagnosis
☐ Chronic physical pain

Child or Adolescent Clients:

Name of the person completing this form: ____

If client is a minor child, please list both biological parents below or guardian/s if the child is not in parent's custody. Guardians, you will need to submit an official document detailing your custody in order to schedule an appointment. Without such document, we will be unable to schedule your child.

☐ The biological parents of this child are married (you do not need to complete this section):

Child's Mother: ____ *Custody: legal or physical*

Email Address for mother: ______________________________ Mother's phone: ___________________

What % of time does the child spend with this parent? ______

Child's Father ____ *Custody: legal or physical*

Email Address for father: ______________________________ Father's phone: ___________________

What % of time does the child spend with this parent? ______

Please understand that psychological evaluations often involve input from individuals who are involved in the child or adolescent's life. It is important to understand that legal guardians have the right to access their children's medical records. In addition, if one of the guardians does not want the child to receive services at this clinic, Dr. Grgich cannot procced in working with the child.

Is there any reason Dr. Grgich cannot or should not contact the other legal guardian? ______________
____

Adolescent Consent:

(Please review with teens ages 13 and above & ask them to acknowledge this):

I understand Dr. Beckie Grgich with be working with me and my family to complete a psychological evaluation as discussed in the first appointment.

I understand I am a minor and my legal guardians / parents have the right to access information that Dr. Grgich obtains, documents and compiles. I understand my guardians / parents may share this information with others (at their discretion).

I agree to work with Dr. Grgich.

Adolescent's signature: ____ Date: ____________

Acknowledgment of Receipt of Notice
Beckie Grgich, Psy.D.

Print Name: (Client) ____

Initial: _______ **Informed Consent:** I hereby acknowledge that I received a copy of this practice's 2013 HIPAA Omnibus Final Rule Notice of Privacy Practices (client, guardian, personal representative). In addition, I have received the documents pertaining to Client Rights and Responsibilities and the Outpatient Services Contract

Initial: _______**Payments:** I request the payment of authorized health insurance benefits be made on my behalf to: Insights LLC / Beckie Grgich, Psy.D. for any services furnished to me. This provider and/or business associates will submit claims to my medical insurance company, at the time of service. After the insurance carrier processes my claim/s, this provider will send a statement with any unpaid balance. I agree to have my credit card charged for any remaining balance due. Any remaining balance is due within 30-days of the statement date to avoid collection and late-payment fees.

Initial: _______**Claims:** I understand Dr. Grgich will not change the diagnosis or represent inaccurate billing information in order to seek a claims payment from insurance companies.

Initial: _______**Authorization:** I authorize Beckie Grgich, Psy.D. to provide mental health services for myself or for the above-named individual. If the individual named above is a minor or an adult who has been adjudicated legally incompetent, I certify that I am the legal guardian of such person and have the legal right to approve of such services.

Initial: _______ **Consent for Evaluation:** I voluntarily consent to an evaluation for myself, or my minor child, by Beckie Grgich, Psy.D. I am aware that there are no guarantees with regard to the outcome or results of the evaluation. I understand that I have the right to consent to, or refuse to consent to, a proposed evaluation and I have the right to a second opinion.

Initial: _______ **Client Contact:** I have completed page 1 of the client packet indicating my contact information and preferences regarding contacting me, messages, and reminders (as applicable).

Initial: _______ **I acknowledge** that missing or canceling appointments without giving a minimum of 48-hours advance notice, or if I arrive late for a scheduled appointment, I may not be seen and agree that unattended or late appointments may result in a 50.00 fee, due at the time of rescheduling an appointment. If the late cancellation is a psychological testing appointment, I will be billed $50.00 for each hour of time that was set aside for my appointment (up to $250.00). In addition, I understand I may be required to pay a deposit for the next appointment I schedule.

____

Client Signature　　Date of Birth　　Printed Name　　Date

____

Legal Guardian Signature (if applicable)　　Printed Name　　Date

Beckie Grgich, Psy.D.
FAX: 719-313-9210

Authorization Form to Release my Protected Health Information

This form, when completed and signed by you, authorizes the release of your protected health information (PHI) from your clinical record to the person you designate.

Patient: _________________________Birth Date: ___________ SS# XXX-XX- _ _ _ _

I hereby authorize staff to: (initial) ____obtain from ____ release to ____obtain/ release

From: Insights LLC / Dr. Beckie Grgich, Psychologist PO Box 3392 Monument, CO 80132

Information to: Person/organization receiving/communicating the information:
Name: ____
Address/City/State: ____
Phone: ________________________ Fax: __________________________

Description of individually identifiable health information to be released/exchanged/obtained (initial each item that applies):
____Service Packet ____Contact Record ____Treatment Plan ____Progress Notes
____Diagnosis ____Intake History ____Testing Report ____Progress Report
____Progress Report, Treatment Plan, Diagnosis, Intake Info. ____Testing Forms
____Any/all necessary information ____Other: ____________________________________

The purpose of this release is:
____ To facilitate treatment ____ Subpoena/legal process ____Court-ordered evaluation
____ Psychological testing ____ Other: ____

This authorization will expire one year from the date of the signature below unless otherwise specified: __________

I understand this is a voluntary authorization that may be revoked at any time. I understand my health information may be protected by federal laws/rules for privacy of individually identifiable health information and/or state laws. I understand that my records may contain information regarding my mental health, substance use/abuse/dependency or sexuality and may also contain confidential HIV/AIDS-related information. I further understand that by signing below, I am authorizing the release of these records to/from the parties or organization outlined above. I understand that my treating professional generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_________________________________ _____________________________ ___________
Signature of Client or Legal Guardian Print Name Date

_________________________________ _____________________________ ___________
Relationship Witness Date

**I understand I may revoke this authorization at any time by notifying this staff in writing. If I do, it will not affect the information that was disclosed prior to the revocation of my consent.

TO REVOKE CONSENT: ________________________________ Date: ______________

A copy/facsimile of this release/authorization is as valid as the original

Beckie Grgich, Psy.D.
CREDIT CARD ON FILE POLICY

I (client) ______________________________ authorize Beckie Grgich, Psy.D. to complete a psychological evaluation on my behalf and to retain my billing information for any unpaid balance due.

I understand that if I am using a third-party payer (i.e. insurance), the payer may request a copy of the evaluation in order to pay the claim.

I acknowledge that at times a payer will pay partially for testing units billed or refuse payment all together. Third party payers (insurance companies) may authorize services but payment is not guaranteed. In this case, I understand Dr. Beckie Grgich will retain my credit card information and I will be charged for the portion of the evaluation the insurance does not pay or the entire cost of the evaluation if the claim is denied. I understand I will be charged at the contracted rate of my insurance company as a courtesy. All remaining balances, after the insurance has paid will be charged to my credit card on file. Late cancellation and no-show fees will also be billed to my credit card on file, at the time they occur.

Without this authorization, a billing fee of $30.00 will be added to my account for any balances that need to be collected through mailing a monthly statement. Furthermore, any outstanding balance will be charged 1.5 percent of the total bill for each month the bill remains unpaid, plus a $75.00 collection fee for any balance that remains unpaid 30-days after the statement billing date.

I understand my credit card information will be kept confidential and secure payments to my card are processed only after a no-show / late cancellation has occurred or after the claim has been filed and processed by my third-party payer, after the insurance portion of the claim has been paid and posted to my account, whichever applies.

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number:____

Expiration Date _____ / _____ / _____ CVV/code: _____________

Cardholder Name ____

Billing Zip Code: _________________________

Signature ____

I This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Dr. Beckie Grgich, in writing and the account must be in good standing.
Patient Name (Print): _____________________________________

_________________________________ _______________
Client Signature: Date:

Beckie Grgich, Psy.D.
Financial / Insurance Informed Consent

Client: _______________________________ Date: _________________

Medical Insurance: ______________________ ID# _______________________
(Tricare-Service members SSN)
Primary Insured's Name: ______________________ Birthdate: _______________
Circle: Self Parent Spouse Other: ___________________
Tricare Only (circle two): Prime / Standard + Active Retired Reserve Other: ___________

Annual deductible: _____________ Copay amount: _________

The services rendered by Dr. Beckie Grgich will be billed to my health plan. Dr. Grgich will bill primary insurance only, no secondary insurance plans. Therefore, the balance due after the primary insurance is billed, will be the responsibility of the client, regardless of secondary insurance coverage.

I understand that my insurance company may quote benefits, coverage, copays and/or deductible amounts to this office. However, if the insurance company has quoted information that is different than my plan, I understand I will be financially liable for any unpaid balance remaining and according the insurance company's 'explanation of benefits' document. I understand that an insurance company's quote of benefits does not guarantee payment. Therefore, if the insurance company determines that the services are not covered or are not medically necessary, I will be responsible for the balance due.

I agree that I will pay the balance due within 30-days of any billing statement that I receive from this office. The 30-day due date will be calculated exactly 30-days from the date located on the billing statement/invoice. I understand if my payment is 31 days or more past due, the payment may be sent to collections and Dr. Grgich and/or staff will disclose my identifiable information to other parties for the purpose of collections.

I understand that I will be charged a collection fee of $75.00 for my account if it is 31 days or later and in a collections status. I understand that any past due payment of 31 days or beyond will be assessed a monthly late payment penalty of 1.5%.

I understand the terms and conditions of billing as outlined above:

Client / Guardian (Sign): ______________________________ Date: __________

**I DO NOT have Medicare or Medicaid (sign) ________________________________