



Dear New Patient,

We are so glad you have chosen Nicole Stahl, M.D. to provide a very important part of your health care. Our staff is committed to providing you with the most caring, professional and confidential services possible. We want you to feel comfortable and at ease in our office. This letter will provide details on what to expect at your first visit.

Your first appointment is a complete Psychiatric Evaluation. When you arrive, our patient service specialist will have you complete some initial paperwork. This will take approximately 15-20 minutes. After this is complete, Dr. Stahl will call your name and invite you into her office where you will spend up to an hour and a half in an interview type setting. Dr. Stahl will discuss with you the current problems that prompted you to seek treatment. She will also review your complete medical history, psychiatric history, social history and family history. At the end of the interview she will discuss diagnostic impressions and treatment recommendations.

Important Issues:

1) INITIAL PAPERWORK

The Intake Questionnaire is required to be completed **prior** to your appointment. The estimated time to complete the initial paperwork is 30 to 60 minutes. The doctor needs ALL the requested information in order to make an accurate differential diagnosis. Please bring the **completed** paperwork with you to your first appointment. We will have some additional paperwork for you to complete when you arrive for your appointment. Please plan on arriving at least 15-20 minutes prior to your scheduled initial appointment time to take care of paperwork. If you arrive at your appointment time, the time for the evaluation may have to be abbreviated in order to stay on schedule and not delay the next patient's appointment. If we do not have enough time to complete the evaluation, you may have to schedule an additional appointment to complete the initial evaluation. We try our best to stay on schedule for our patients so you are not waiting to see the doctor!

2) OFFICE LOCATION- **Please do not rely on your GPS as our location is new!!**

FROM I-10:

Travel west on I-10. Take Grand Parkway South Exit 743B and merge onto TX-99 S. Take exit for Cinco Ranch Blvd. Turn Right onto Cinco Ranch Blvd. In 5.4 miles, turn left on FM 1463. In approximately 0.8 miles (immediately after you pass Fry Rd), take a right into the driveway of Well Pet Center. Continue straight over the speed bumps until you come to the third building on your right after passing by the Well Pet Center. Turn right to get to our office parking lot and we are the fourth office on your right, Suite 304. The address is: 5757 Flewellen Oaks Lane, Suite 304, Fulshear TX 77441.

FROM WESTPARK TOLLWAY:

Travel west on Westpark Tollway/FM1093 until you reach FM 1463. Take a right onto FM 1463. Immediately before you reach Fry Rd, take a left into the driveway of the Well Pet Center Veterinary Hospital. Continue straight over the speed bumps until you come to the third building on your right after passing by the Well Pet Center. Turn right to get to our office parking lot and we are the fourth office on your right, Suite 304. The address is: *5757 Flewellen Oaks Lane, Suite 304, Fulshear TX 77441.*

Please call our office at (713) 332-4388 if you get lost or have any additional questions.

3) FINANCIAL POLICY

Payment information is taken when you make your initial appointment. For the first appointment, a credit card must be left on file to be charged 2 business days prior to your initial appointment. If this card declines, you will be taken off the schedule if we are unable to reach you to obtain an alternative payment method. For all follow up appointments, we accept CASH, CHECKS, and all major CREDIT CARDS.

The following is a brief list of services:

Initial Evaluation \$350.00
Medication Therapy \$160.00

Regarding Insurance

We will provide you with all the documentation necessary to file an insurance claim on your own. Your insurance plan will reimburse you directly. Please contact your insurance company to find out what your benefit amount is. Dr. Stahl does not accept assignment of benefits and does not participate in any network. She will be considered an out of network provider by your insurance plan. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We have no agreements to offer discounts for specific plans.

Missed Appointments

Unless canceled, at least 2 business days in advance, our policy is to charge the credit card left on file for missed appointments at the full fee. Dr. Stahl does not double book appointments. Your appointment time is reserved for you. Please help us to serve you better by keeping scheduled appointments.

I have read and acknowledge the above financial policies regarding service fees and missed appointments.

Name

Signature

Date

Adult Intake Questionnaire

Thank you for taking the time to answer the following questions. Please fill out this form to the best of your knowledge. If some questions are not applicable to you, write N/A. If you need additional space, please feel free to write on the back of the sheet. This information is very helpful in making an accurate diagnosis.

Date _____ Referred by _____

Person completing this form _____

What is the reason that you have sought an appointment at this time?

A. General Information

First Name:		Address:	
Last Name:		City:	
DOB:		State:	
Current Age:		Sex: M F	Zip Code:

Primary Phone:		Drivers License:	
Secondary Phone:		Marital:	Single Married Divorced Widowed
Email:		Student Status:	None Part Time Full Time
Employer:			

Emergency Contact:		Primary Phone:	
Relationship to patient:		Secondary Phone:	

B. Developmental and Social History

Family Background and Childhood History

Where were you raised? _____

Were you adopted? Yes No List your brothers and sisters and their ages: _____

Father's Occupation _____ Mother's Occupation _____

Did your parents divorce? Yes No If so how old were you? _____

Did your father remarry? Yes No If so how old were you? _____

Did your mother remarry? Yes No If so how old were you? _____

Describe your relationship with your father _____

Describe your relationship with your mother _____

How old are your parents now? Father _____ Mother _____ How old were you when you left home? _____

Has anyone in your immediate family ever died? Yes No Who and when? _____

Were you ever physically and sexually abused? Yes No If so at what age(s) _____ By whom? _____

Educational History

Did you enjoy school? _____

What kind of grades did you make? _____

Describe your social life at school _____

What things got you in trouble in school? _____

Did you attend college? Yes No Where? _____ Major? _____

Highest educational level or degree attained? _____

Occupational History

Are you currently working? Yes No How long in current position? _____

What is your occupation? _____ Where do you work? _____

Where have you worked before and for how long? _____

Marital Status/ Current Family

Marital Status: Single Married Separated Widowed Divorced

How long in current status? _____ If married, what is your spouse's occupation? _____

Describe your relationship with your spouse or significant other: _____

Have you had any previous marriages? Yes No If so, how many? _____ For how long each? _____

Do you have children? Yes No Names and ages: _____

Religion

What is your religious affiliation? _____ Where do you attend services? _____

For how long? _____ Do you attend regularly? Yes No

Please rate the importance of your religion or spiritual beliefs in your life:

All Important Very Important Important Somewhat Important Not Important

Stressors

Have you experienced any of the following stressors (check all that apply)

- recent move
- change in schools
- job change
- financial problems
- personal/ family health problems
- marriage
- divorce
- death
- violence
- substance abuse
- Other (please explain) _____

C. Previous Mental Health History

Have you been seen by any of the professionals listed below for emotional/ behavioral problems such as ADHD, depression, anxiety, bipolar disorder, substance abuse, etc.

Check all that apply

- Physician
- Psychiatrist
- Psychologist
- Licensed Professional Counselor
- Social Worker

For any blanks checked yes, please provide the following information. (Please list current or most recent treatments first)

By Whom	When	Duration	For What	Results
		From: To:		
		From: To:		
		From: To:		
		From: To:		

Have you ever been placed on medication for treatment of emotional/ behavioral problems?

No Yes, please list below

Name of Medication	Dose	Length of Trial	Effects (improvement)			Side Effects (Please specify)
			None	Slight	Much	
Past		From: To:				
		From: To:				
		From: To:				
		From: To:				
		From: To:				
		From: To:				
Current		From: To:				
		From: To:				
		From: To:				
		From: To:				
		From: To:				

Have you ever been admitted to an inpatient psychiatric hospital, a residential treatment program, or a rehabilitation facility? No Yes, please list below.

Name of hospital/ Facility	Date of admission	Duration of stay	Reason for admission

Have you ever attempted suicide? No Yes, please explain method and date of attempt

D. Substance Abuse History

Chemical	Last Use	Amount	How Often Used	How Long Used
Alcohol				
Marijuana				
Cocaine/ Crack				
Inhalants				
LSD				
Prescribed Pills				
Heroin				
Other (specify)				

Have you experienced any of these due to alcohol and/or illegal substance use:

Blackouts Withdrawal symptoms Cravings Overdoses

Have you ever experienced legal problems (including arrest) due to alcohol and/or illegal substances.

No Yes, please explain _____

E. Medical Information and History

Primary Care Physician

Name _____ Phone # _____ Address _____

Date of last physical exam _____

Is your primary care physician aware of this appointment? Y N

Preferred Pharmacy

Name _____ Phone # _____ Nearest Intersection _____

Specialist

Have you ever seen a specialist such as a neurologist or cardiologist? ___ No ___ Yes, please list below

Name	Date	Reason for Consultation

Have you ever had a seizure? Y N

Have you ever had a head injury? Y N

Have you ever lost consciousness? Y N

Have you ever had any heart problems? Y N
(Including murmur, arrhythmias, high blood pressure, prolonged QT syndrome, high cholesterol/triglycerides, other heart problems) Please specify _____

Do you have any thyroid abnormalities? Y N

Do you have any genetic syndromes? Y N

Have you ever had diabetes? Y N

Have you ever had any vision difficulties? Y N

Have you ever had any hearing difficulties? Y N

Please list any other medical illnesses you have (such as asthma, anemia, etc.)

Have you ever been medically hospitalized or had surgery? ___ No ___ Yes, list below

Immunizations up to date Y N

Allergies _____

Current non-psychiatric medications (please include current dose and reason for medication)

Current supplements and/or vitamins

F. Family Mental Health History (please notate whether on maternal or paternal side)

Please list any blood relatives that have been treated or hospitalized for any mental/ behavioral problems.

	Relationship to patient	Outpatient Treatment (specify)	Medications (specify)	Hospitalizations (specify number)
Depression				
Bipolar disorder				
Anxiety disorder				
Eating disorder				
Learning disorder				
Substance Abuse ___ Alcohol ___ Drugs				
ADHD				
Suicide or suicide attempt				
Schizophrenia				
Legal problems				
Other (specify type)				

G. Family Medical History

	Relationship to patient
Cardiac disease (including arrhythmias, sudden death, QT prolongation, hypertension)	
Diabetes (specify Type 1 or 2)	
Thyroid disease	
Seizures	
High Cholesterol/ Triglycerides	
Other:	

Please complete this form and bring it with you to your initial appointment.



Credit Card Authorization

I understand that payment is expected at the time of service by either cash, check, or credit card. I understand that the financial responsibility for services provided is mine, and that insurance is for my reimbursement if I choose to do so. I understand that I must file the insurance claim and that the physician will not file it for me.

I understand that the credit card listed below will be charged for missed appointments and cancellations with less than 2 business days notice. I am aware that insurance will not cover charges for missed or cancelled appointments. With appropriate notice, appointment slots can almost always be used to serve another patient.

I understand that if this credit card declines for a charge, that I will be billed for the missed appointment. No further appointments may be scheduled until the outstanding balance is paid.

I agree to notify the receptionist when I become aware of any changes in my address, phone number, marital status or responsible party that has occurred since my last appointment.

I, _____, hereby authorize Nicole Stahl, M.D., P.A. to charge my credit card for services rendered and time allotted for treatment at a rate of \$350 for an initial appointment or \$160 for a follow up appointment. If I am leaving this credit card on file for someone other than myself, I understand that my credit card can be charged for the patient's **appointments, unpaid fees, missed appointments or cancellations with less than 2 business days notice.**

Credit card # _____ Security Code _____ Exp. date _____

Name as printed on card _____

Billing Address: _____ City: _____ State: _____

Zip _____ (Note: zip code must be for where the credit card statement is sent to.)

By signing below I am authorizing Nicole Stahl M.D. P.A. or Cinco Ranch Psychiatry to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this page and can thereby authorize this card to be charged:

Patient's Name

Date

Responsible Party's Name

Date

Responsible Party's Signature

Date