Michael C. Boyle, PhD, LPC-S
1101 Ridge Road #232
Rockwall, TX 75087
(469) 769-1744

New Patient Information

These questions will help me get to know you and to ensure that I provide you with the appropriate care. Feel free to leave any questions blank that you are uncomfortable with until you talk to me. Thank you.

Patient's Name: ____ Today's Date: ____/____/____

Birthday: ____/____/____ Age: ________ Gender: _________

Home Phone: ___________________ Cell Phone: _____________________

Have you ever seen a Psychologist or Psychiatrist before? ☐ Yes ☐ No

If Yes, Reason: _______________________

If Yes, Who? ___________________________ Phone: _____________ When? _______________

Education Level: ☐ GED / H. S. ☐ College ☐ Graduate School

Marital Status: ☐ Married ☐ Single ☐ Divorced

Number of Marriages: _____ Years Married: _____

Number of Children: ____ Ages: ____ ____ ____ ____ ____ ____ ____

Are your Parents living? Father: ☐ Yes ☐ No Mother: ☐ Yes ☐ No

Are they still married? ☐ Yes ☐ No If not, how old were you when they divorced? _______

Do you have any Brothers? ☐ Yes ☐ No If yes, how many? ______

Do you have any Sisters? ☐ Yes ☐ No If yes, how many? ______ Good Childhood? _______

Medications and how many per day: ____

____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much in the past week? _____________________________

Do you have a plan to harm yourself or anyone else? ☐ Yes ☐ No

Have you ever had a history of drug or alcohol addiction? ☐ Yes ☐ No

If yes, what drugs and when did you quit? ____

Do you have any other Medical Issues? ☐ Yes ☐ No If yes, what? _______________________

____

____

____

____

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Symptom Checklist

Average number of hours of sleep per day: _____

Please check all that apply:

____ Difficulty Sleeping
____ Crying Spells
____ Loss of Sex Drive
____ Memory Loss
____ Temper Outbursts
____ Frustration
____ Rapid Heart Beat
____ Difficulty in Catching Your Breath
____ Lightheaded
____ Sense of Impending Doom
____ Nausea
____ Isolate
____ Negative Thinking

_____ Change of Appetite
_____ Loss of Enjoyment
_____ Difficulty with Concentration
_____ Anger
_____ Panic Attacks
_____ Stomach Knots
_____ Tightness in Chest
_____ Shortness of Breath
_____ Profuse Sweating
_____ Nervousness
_____ Headaches
_____ Poor Self-esteem
_____ Loss of Energy

Additional information you would like to share about yourself and your situation:

____
____
____
____
____
____
____

Michael C. Boyle, PhD, LPC-S

New Patient Private Insurance Intake Form

Date: ____/____/____

Patient Name (First): _________________ (M.I.): ___ (Last): ____________________

Birthday: ____/____/____ Sex: ________ SSN: ______-_____-________

Address: ____ Apt#: _______

City: ___________________________ State: __________ Zip Code: _______________

Home Phone: (_____) ______________ Cell Phone: (_____)______________

Person completing form: ________________________ Relationship w/patient: _____________

(If other than Patient) (Mother/Father/Guardian/Spouse/Etc)

*****Please fill out Employment History*****

Patient's Current Employment: ____

Position: __________________________________ Length of Employment: _____years _____months

Phone: (_____) ______________

Address: _________________________________ City: __________________ State: ___ Zip: _______

Insurance Information

Primary Insured Name: ____

Insured SSN: ______-_____-________ DOB: ____/____/____

Relationship w/ Patient: ____

Insurance Company Name: ____

Insurance Company Address: _______________________________________

____

Insurance Co. Phone: (____) ______________

Policy#: __________________ Group: __________________

Insured Employer: ____________________________________

If you have secondary insurance, please ask for another form and complete just this section.

I hereby authorize the release of any medical information necessary to process my insurance claims. I permit a copy of this authorization to be used in place of the original. By signing this form, I am authorizing counseling and therapy by Dr. Michael C. Boyle, PhD, LPC-S. I also authorize payments of medical benefits directly to this doctor for services received in this office, if assigned.

I give my permission for information and a treatment report to be disclosed to the referring doctor.

I understand that I am financially responsible for all fees incurred for services rendered by this doctor, which are not paid by my insurance.

Signature: X____ **Date: ____/____/____**

This must be signed by the patient or by their legal guardian (if underage) prior to any services being rendered.

CANCELLATION POLICY

We look forward to working with you. Our appointment sessions are approximately fifty (50) minutes long. It is our strict policy to stay on time for all scheduled appointments. Therefore, if at all necessary, your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that we receive twenty-four (24) hour notice for all cancellations. We also request any cancellation for Monday morning appointments be made no later than 3:00pm Friday prior to your appointment. Insurance companies will not pay for "No Shows or Late Cancellations," therefore you will be responsible for $50.00 for missed individual appointments. **______: INITIAL HERE**

CONFIDENTIALITY POLICY

Limits of confidentiality include suicidal threats, homicidal threats, or any type of physical or sexual abuse of a child. We are mandated by our state licensing board to report any suspicion of child abuse to Child Protective Services (CPS). I give my permission for my treating therapist to consult with Michael C. Boyle, PhD, LPC-S, to insure quality of care. **______: INITIAL HERE**

PAYMENT ARRANGEMENTS – DELINQUENT ACCOUNTS

To avoid any unpaid balance, we request you pay each co-payment or co-insurance amount due at the time the services are provided to you. If there are any problems with your insurance carrier we will attempt to notify you and keep you informed of any details, requests for information, or insurance termination notices. Thus, we can work together to fully pursue payment from the insurance carriers.

If for any reason your account with us becomes delinquent for more than ninety (90) days, it is our policy to attempt to resolve the matter with you directly. We can make payment arrangements if you are unable to pay in full.

If we are unable to resolve the account with you, our policy is to turn over the account to our collection agency. This agency will be given only your name and the charges on the account. Once the account is forwarded, we will no longer be able to make any private arrangements with you. **______: INITIAL HERE**

Signature: X____________________________________ Date: ____/____/____

This must be signed by the patient or by their legal guardian (if underage) prior to any services being rendered.

Michael C. Boyle, PhD, LPC-S

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for Michael C. Boyle, PhD, LPC-S

Signature: X____________________________________ Date: ____/____/____

This must be signed by the patient or by their legal guardian (if underage) prior to any services being rendered.