Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Cell Phone #:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone #: ( )

Email:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to our clinic by (please check one box):	❑ Dr.	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Online	❑ Other

Other family members seen here:

BILLING INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Treatment Agreement

Welcome to my practice! This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

NEUROPSYCHOLOGICAL/PSYCHOLOGICAL SERVICES

Assessment: Neuropsychological/psychological assessment can last anywhere from 2 to 6 hours depending on the nature of the referral question. Following administration of tests, I spend additional time scoring, interpreting, and writing a narrative report summarizing the findings. The results are then discussed in a feedback session which is conducted in the office.

Therapy: Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. If you have questions about my procedures, we should discuss them whenever they arise.

MEETINGS

Therapy: Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 business hours advance notice of cancellation. Failure to provide 24-business hours advance notice will result in a cancellation fee of **$50.00** for therapy sessions.

Assessment: Due to the several hours reserved for neuropsychological evaluations, we require at least a 48-business hour advance notice for cancellations. Failure to provide a 48-business hour advance notice will result in a cancellation fee of **$500.00** for neuropsychological/psychological evaluations.

PROFESSIONAL FEES

Fees are due at the time of service.
My fee for an initial appointment is $ 195.00. Thereafter, my session fee is $165.00 for psychotherapy.
My hourly fee for neuropsychological assessment purposes is $230.00. Assessment refers to the administration, scoring, interpretation, and report writing. Other services may include telephone conversations, consulting with other professionals with your permission, and preparation of records or

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

treatment summaries. If you are or become involved in legal proceedings that require my participation, you will be expected to pay for my professional time. If you are here for evaluation at the request of a third party, signing this notice acknowledges that the limits of confidentiality have been explained to you and you understand these limits with respect to the evaluation and test results. This form serves as written, informed consent to all aspects of evaluation and treatment by Dr. Legler.

You agree that the fee for services is payable by:

☐ Myself. Though my health insurance may reimburse me for some of these fees, I understand that I am fully responsible for payment for these services.

☐ I recognize that I am ultimately responsible for fees incurred on behalf of my care, which are the reasonable and customary fees of Dr. Legler.

CONTACTING ME

Due to my office schedule, I am often not immediately available by telephone. I will be unable to answer the phone when I am with another patient. I will make every effort to return your call on the same day you make it (with the exception of weekends/ holidays). If you experience an emergency, you should contact the nearest emergency room, or dial 911.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU BEEN PROVIDED WITH THE HIPAA NOTICE FORM DESCRIBED ABOVE FOR YOUR REVIEW.

_____ _____

Signature of patient/guardian Date

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

PATIENT ACKNOWLEDGEMENT FORM

By providing your signature on this form, you have acknowledged receipt of Dr. Legler's Notice of Practice Privacy Policy. Thank you for your cooperation.

_____	_____	_____
Patient Name (print)	**Patient Signature (Or Guardian)**	**Date**

_____
Employee Signature

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Client HIPAA Acknowledgment and Consent Form

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

Dr. Legler's clients may be contacted via email and/or text messaging to remind you of an appointment and/ or to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____(Client initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (include area code)_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

Dr. Legler does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name (Print Clearly)_____

Patient Signature_____Date _____

Revocation: ***I hereby revoke my request for future communications via email and/or text.***

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

___I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

*Date:*_____*Time:* _____

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Name: _____
(Last) (First) (Middle Initial)

Are you Right or Left handed? □Right □Left □Ambidextrous

Current Height: _____ **Current Weight:** _____

What brings you to our office?

_____

_____

EDUCATION

Did you graduate from high school? _____. **If so, where?** _____

If not, what was your highest level of high school _____

Did you attend college? _____. **If so, where?** _____

Did you earn a degree? _____. **Type of degree**:_____ **Major**:_____

If no degree, how many credits did you earn ? _____

Did you attend any special classes for difficulties with:
Reading □**Yes** □**No** **Writing** □**Yes** □**No** **Spelling** □**Yes** □**No** **Math** □**Yes** □**No**

Do you have any vocational training/special job skills? List_____ □Yes □No

Any behavioral difficulties in school (e.g. suspension, detentions, fighting, drugs, etc.)? □Yes □No

Do you live: □ Alone □ With Children □ Significant other □ Spouse □ Family

Do you require assistance with: □ Preparing your meals □ Self-care □ Travel the community □ Shopping
□ Keeping appointments □ Laundry □ Bathing □Cleaning □Paying bills

OCCUPATIONAL INFORMATION

Are you currently employed? □ No □ Yes
If yes, who is your employer?_____
What do you do (did you do if retired) for work? _____

MILITARY SERVICE

Have you ever served in the military? Which branch? ---------- □ No □ Yes

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

LEGAL HISTORY

If you have been arrested, if so when? _____
If you have been arrested, please explain _____
Are you currently on legal probation or have pending charges?
If yes, explain (duration of probation, when did your probation start and when does it end)
_____

SUBSTANCE ABUSE HISTORY

How much alcohol do you drink weekly? _____
When did you last drink alcohol? _____
How often do you use street drugs? □ Daily □ Weekly □ Monthly □ Rarely □ Never
List type of drug(s) using/used: _____
Do you use nicotine or any nicotine products? ---------- □ No □ Yes
Describe your frequency of nicotine use (e.g. daily, weekly, etc) _____

HEALTH AND SOCIAL INFORMATION

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed
How long have you been married/divorced/widowed/separated? _____
City/State where were you born? _____ **Who raised you?** _____
Any childhood developmental delay/problems? □Sitting □Standing □Walking □Talking □None
Any history of physical, verbal, sexual abuse? (circle) □Yes □No
Have you witnessed domestic violence? □Yes □No
Number of Children & their ages: _____ **Number of Boys:** _____ **Number of Girls:** _____
Do your children live with you? □Yes □No
Are you having any problems with your sleep habits? □ No □ Yes If yes, please indicate below:
□ Sleeping too little/much □Trouble falling asleep □ Trouble staying awake □ Disturbing dreams
Do you snore? _____
Are you having any problems with appetite or eating habits? ---------- □ No □ Yes
If yes, please indicate: □ Eating less □ Eating more □ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes
if yes, how much gained/lost ____lbs.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

MEDICAL CONDITIONS

Please check any current applicable conditions and provide date diagnosed with condition(s):

Self	Family Member (whom)		Self	Family Member (whom)	
___	_____	AIDS	___	_____	Thyroid problems
___	_____	Asthma	___	_____	Female problems
___	_____	Autoimmune disorders	___	_____	HIV positive status
___	_____	Blood disease	___	_____	Hepatitis
___	_____	High blood pressure	___	_____	High cholesterol
___	_____	Low blood pressure	___	_____	Heart disease
___	_____	Cancer	___	_____	Hearing disorder
___	_____	Diabetes	___	_____	Kidney disease
___	_____	Eating disorders	___	_____	Ringing of the ears
___	Pain	Please rate level: 1 – 10 ___	___	_____	History of head trauma
			___	_____	Seizures

Please list any difficulties not noted above: _____

Please list any surgeries you have had: _____

Have you ever lost consciousness? □ No □ Yes **How long were you unconscious:** _____

Please list CURRENT medications or attach separate sheet.

START DATE	NAME OF MEDICATION / DOSE	How do you take it? (e.g., by mouth, injection, inhale, etc)	Dr. who Prescribed

Please list <u>ANY ALLERGIES</u> you have: _____

_____

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

MENTAL HEALTH

Are you currently receiving psychiatric/psychological services? ---------- □Yes □No
If yes, where do you receive services and how long_____
Have you had previous talk therapy? ---------- □Yes □No
Previous therapist's name_____
Has psychotherapy been effective for you? □Yes □No
Have you had recent thoughts of suicide? □ Frequently □ Sometimes □ Rarely □ Never
Have you ever been admitted to a psychiatric facility? ---------- □ Yes □ No
If yes, how many times, where and why?
_____
Have you ever experienced any of the following?
Depressed mood ---------- yes/no
When did you first become depressed (age)? _____
When were you last depressed? _____

Circle what happens when you are depressed (e.g., isolate, cry, suicidal thoughts, feelings of guilt, loss of interest in activities or hobbies, persistent sad, anxious, or "empty" feelings, persistent aches or pains hopeless, worthless, fatigue, etc.)

Do you experience any of the following (please circle)?
Inflated self-esteem or grandiosity, reduced need for sleep, more talkative than usual, racing thoughts, distractibility (i.e., attention too easily drawn to unimportant things), increase in goal-directed activity (either socially, at work or school, or sexually), excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)?

Have you experienced or witnessed a traumatic event which involved death or serious injury, or a threat to the physical integrity of oneself or others? ---------- yes/no
Your response to the event involved intense fear, helplessness, or horror ---------- yes/no
You persistently re-experience the event in one of the following ways:
Recurrent distressing thoughts, perceptions, or images of the event ---------- yes/no
Recurrent distressing dreams of the event ---------- yes/no
Feeling as if the event was happening again through flashbacks---------- yes/no
Psychological/physical distress upon exposure to things that remind you of the event ---------- yes/no
Do you attempt to avoid situations, people, or things that remind you of the traumatic event? ------ yes/no
Have your symptoms lasted longer than one month? ---------- yes/no
Have the above symptoms resulted in significant distress in social situations or work? ---------- yes/no

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Do you suffer from Anxiety? ---------- yes/no
Do you suffer from Panic Attacks? ---------- yes/no
When did you first start experiencing panic attacks (what age)? _____
When did you last experience panic attacks? _____
How many panic attacks do you experience on average in a month? _____
What causes your panic attacks? (e.g., going outside, talking to others, etc.) _____
During a panic attack, do you experience (circle): Heart palpitations, chest pains, stomach upset, dizziness, difficulty breathing, tingling, hot flashes, trembling, dreamlike sensations or perceptual distortions, terror, a need to escape, nervousness about the possibility of losing control and doing something embarrassing, fear of dying.

Hallucinations ---------- yes/no
What type of hallucinations? Visions or sounds? _____
When did you first start experiencing hallucinations (what age)? _____
Were you under the influence of drugs when you experienced hallucinations? □Yes □No
Unexplained losses of time or memory lapses? ---------- yes/no

Repetitive Thoughts (e.g., Obsessions) ---------- yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)---------- yes/no
Homicidal Thoughts ---------- yes/no
When did you last experience homicidal thoughts? _____
Did you ever act on such thoughts? □Yes □No
Suicide Attempt(s) ---------- yes/no

FAMILY/HEALTH HISTORY

Has anyone in your family (immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., sister, Parent, Uncle, etc):

Depression	yes / no	Who: _____	Bipolar Disorder	yes / no	Who: _____
Anxiety Disorders	yes / no	Who: _____	Panic Attacks	yes / no	Who: _____
Schizophrenia	yes / no	Who: _____	Suicide Attempts	yes / no	Who: _____
Alcohol/Substance Abuse	yes / no	Who: _____	Eating Disorders	yes / no	Who: _____
Learning Disabilities	yes / no	Who: _____	Trauma History	yes / no	Who: _____