KATHERINE M KILGORE, PHD
CLINICAL PSYCHOLOGIST
LIC # PSY 14094

_____/_____/_____ _____ _____
DATE NAME AGE

_____
STREET CITY ZIP

_____ _____ _____/_____/_____
MOBILE PHONE EMAIL DATE OF BIRTH

_____ _____
SOCIAL SECURITY # (REQUIRED) MARITAL STATUS

_____ _____
EMPLOYER OCCUPATION

_____ _____
PRIMARY CARE PHYSICIAN SPECIALIST PHYSICIAN

_____ _____
INSURANCE COMPANY WHO REFERRED YOU TO THIS OFFICE?
Note: You are responsible for the entire fee. Without prior authorization your carrier may refuse reimbursement.

_____ _____
NAME OF INSURED RELATIONSHIP TO PATIENT

_____ _____ _____
PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP TO PATIENT PHONE
(If in the case of an emergency it becomes necessary to contact this individual, only that information required to keep you safe will be released.)

I assign all medical benefits to which I am entitled, including private insurance and other health plans, to Katherine M Kilgore, PhD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that payment in full is expected at the time of service, and that I am responsible for all charges regardless of insurance coverage. I authorize the release of all information necessary to process claims. I also give my consent for Dr. Kilgore to release all required billing information to any provider I may contact while that provider is taking calls for Dr. Kilgore. In the event that I pay for services via approved credit card charges, I agree that no dispute with Katherine M Kilgore, PhD will be raised with, or adjudicated by, the credit card company. I acknowledge that credit card payments are non-refundable by or through the credit card company.

I give Dr. Kilgore consent to contact my physician as necessary to inform her/him of my treatment and progress.

_____ _____
PATIENT OR AUTHORIZED PERSON/GUARDIAN DATE

Katherine M Kilgore, PhD
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I, _____, am authorizing Katherine M Kilgore, PhD to charge my credit card as payment for services provided. She may also charge fees incurred in the event that I do not notify her of my inability to attend a scheduled therapy appointment and/or do not cancel my appointment at least 24 hours in advance, as agreed to in the signed Office Policy/Informed Consent.

Card Type (circle one):

Visa MasterCard Debit

_____ _____
CARD # EXPIRATION DATE

_____ _____
NAME ON CARD VERIFICATION/SECURITY CODE
(3-DIGIT CODE ON BACK OF CARD)

_____
BILLING ADDRESS

_____
CITY STATE ZIP

_____ _____
SIGNATURE DATE

Personal History

_____ _____

Name Date

Gender: _____ Pronouns: _____

Can you briefly describe the current concerns or problems that you want to work on?

_____

_____

_____

What caused you to decide to call at this time, rather than last week or next month?

_____

_____

What are your goals for treatment?

_____

_____

What is your general medical history, e.g., serious illnesses, accidents, injuries, operations?

_____ Date: _____

_____ Date: _____

_____ Date: _____

How is your general health today? ___ Excellent ___ Good ___ Fair ___ Poor

Have you ever had any head injuries, been knocked unconscious, or had a seizure? ___ Y ___ N

Current medications: Prescribing doctor

_____ ___mg 1/day 2/day 3/day 4/day _____

_____ ___mg 1/day 2/day 3/day 4/day _____

_____ ___mg 1/day 2/day 3/day 4/day _____

_____ ___mg 1/day 2/day 3/day 4/day _____

Have you had any previous psychological therapy? When and with whom?

_____

_____

Have any of your family members been treated for a psychological complaint?

_____

What is your current use of alcohol, drugs, and tobacco? Have you ever had problems with them?

_____

What is your family's history of alcohol, drug, and tobacco use/abuse?

_____

With whom do you currently live?

_____

Military history:

_____

What is your marital/significant other history:

#1 Name: _____ From: _____To: _____

Reason for ending:_____ Children: _____

#2 Name: _____ From: _____To: _____

Reason for ending:_____ Children: _____

#3 Name: _____ From: _____To: _____

Reason for ending:_____ Children: _____

Mother living? [ ]Y [ ] N Age: ___ Year of death: _____ Cause of death: _____

Father living? [ ]Y [ ] N Age: ___ Year of death: _____ Cause of death: _____

Are your parents married? [ ]Y [ ] N Divorce date: _____ Your age at time of divorce: _____

Who are your sisters and brothers?

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

What is the quality of your relationships with your family members?

_____

Where were you born and raised?

_____

Did you graduate high school? [ ]Y [ ] N Year: _____ Receive a G.E.D.? Year _____

Did you attend trade school? [ ]Y [ ] N Year: _____ Degree/certificate: _____

Did you attend college? [ ]Y [ ] N Did you graduate? [ ]Y [ ] N Year: _____ Degree: _____

What is your work history over the past several years?

_____ From: _____ To: _____

_____ From: _____ To: _____

_____ From: _____ To: _____

Have you ever been suspended [ ] expelled from school [ ] arrested [ ] sued [ ] had legal trouble [ ] initiated a lawsuit [ ] been fired [ ] suspended from work [ ]

Have you ever been abused physically [ ] sexually [ ] emotionally [ ]

Details of any of the above:

_____

_____

_____

Name _____ Date _____

If present, please indicate by letter how long you have been experiencing any of these symptoms:
Days **W**eeks **M**onths **Y**ears

A.
___ Acting out of character
___ Difficult to remain awake or alert
___ Difficult to express myself
___ Difficult to move easily
___ Mind wandering
___ Staring often
___ Difficult to focus on one task
___ Mood is depressed, angry, or irritable
___ Dress or grooming has changed lately
___ Trouble going to sleep
___ Trouble staying asleep &/or waking early
___ Sleeping too much
___ Needing very little sleep
___ Feeling guilty
___ Feeling more depressed in the morning
___ Thoughts of suicide
___ Have made suicide attempts
___ Fatigue, loss of energy
___ Mood euphoric or manic
___ Poor concentration
___ Spending lots of money
___ Full of great ideas of how to make money
___ Feeling especially sexual, excited
___ Easily distracted, poor attention
___ Changes in memory
___ Decreased sexual appetite
___ Restlessness, can't relax
___ Loss of pleasure in usual activities
___ Reduced appetite
___ Increased appetite
___ Noticeable weight change up __ down __
___ Feeling worthless
___ Feeling sad
___ Withdrawing from others
___ Being more active than usual
___ Talking in circles, can't stay on topic
___ Confusion
___ Crying easily for almost no reason
___ Emotionally sensitive, easily hurt

B.
___ Rapid or pounding heart
___ Dizziness/lightheadedness
___ Cold, clammy hands
___ Numbness/tingling in arms, hands, legs
___ Unusual sweating
___ Sense of dread
___ Frequent urination
___ Panic or terror for no apparent reason
___ High anxiety
___ Trembling
___ Fear of losing control
___ Avoidance of certain situations
___ Sense that I am not real
___ Sense that the world is different or not real

C.
___ Nausea, upset stomach, ulcers
___ Headaches
___ Lower back pain
___ Vomiting
___ High blood pressure
___ Menstrual irregularities
___ Asthma
___ Irritable bowels
___ Constipation
___ Diarrhea
___ Use of street drugs, excessive alcohol
___ Eating disturbance/over focusing on food
___ Thyroid dysfunction
___ Diabetes or hypoglycemia
___ Heart disease

D.
___ Tics or motor "habits"
___ Intrusive or unwanted thoughts
___ Rituals that must be performed
___ Checking
___ Counting
___ Need for symmetry, having things "just so"
___ Excessive washing or cleaning
___ Uncontrollable habits or behaviors
___ Sense of constant internal pressure or drive

E.
___ Asking the same questions repeatedly
___ Forgetting how to do basic tasks
___ Problems paying bills/balancing checkbook
___ Getting lost in familiar places.
___ Being told you are neglecting personal hygiene
___ Relying on someone else to make decisions
___ Argue with others over small things
___ Feel that people don't like you
___ Want to be alone more than with others
___ Difficulty communicating with others
___ Feel inadequate, less than others

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I have read the Office Policies and HIPPA Notice of Privacy Practices for psychotherapy services. I understand and agree to the conditions under which Dr. Kilgore and I will work including that she may contact someone to help if I am unable to take adequate care of myself. I am aware that email and cell phone voice mail are not guaranteed to be secure and private. I agree, in the case of a dispute, to use mediation and will not begin a litigated case.

I understand that in the case of my death I have to option to have my complete file destroyed, or I can appoint someone as my representative and custodian of my record.

____ Destroy my file

____ I appoint _____ as custodian.

_____
Phone/email

My signature indicates my understanding of and agreement with all of the Office Policy terms and conditions.

_____ _____
Signature Date

_____
Print name

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CONSENT TO PARTICIPATE IN TELETHERAPY TREATMENT

NATURE OF TELETHERAPY TREATMENT

Teletherapy is psychotherapeutic consultation with Katherine M Kilgore, PhD, a clinical psychologist, via videoconference technology. This means that information related to my mental health is electronically transmitted in the form of images, audio, and data through an interactive video connection to and from Dr. Kilgore. I acknowledge that such electronic transmission of data carries the possibility of interception, corruption, or misdirection. I acknowledge that I am using my own equipment to communicate and not equipment owned by another person, and specifically not using my employer's computer or network. I have been supplied, have read, understand, and agree to, all the terms and conditions regarding teletherapy services provided by Dr. Kilgore.

RISKS, BENEFITS AND ALTERNATIVES

The benefits of teletherapy include having access to Dr. Kilgore's psychotherapy services without having to travel outside of my local health care community. A potential risk of teletherapy is that because of my specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to teletherapy consultation is a face-to-face visit with Dr. Kilgore.

MEDICAL INFORMATION AND RECORDS

All laws concerning patient access to medical records and copies of medical records apply to teletherapy. Dissemination of any patient identifiable images or information from the teletherapy consultation other entities shall not occur without your consent.

RIGHTS

I understand I may withhold or withdraw my consent to a teletherapy session at any time before and/or during the session without affecting my right to future care or treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
I am a citizen of California. I voluntarily agree to participate in teletherapy as described above and explained by Dr. Kilgore. I have read this document and understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.

These are the names and telephone numbers of my local emergency contacts.

_____	_____	_____
Police	Phone	Email
_____	_____	_____
Primacy Care Physician	Phone	Email
_____	_____	_____
Local Emergency Contact	Phone	Email

_____	_____
Signature	Date
_____	_____
Printed name	Birth date