**Bridges to Wellbeing, LLC**
Kathleen M. Wong, M.D, PLLC

Last: _____ First: _____ M.I.: ____ D.O.B: _____ SS #: _____

Street: _____ City: _____

State: _____ Zip Code: _____ Place of Employment: _____

Home Phone: _____ Bus/Cell: _____ Gender: Male____ Female ____

Marital Status: Married___ Single___ Widowed___ Divorced___ Domestic Partnership___

Who is responsible for payment of bill? _____Relationship: _____

Address of responsible party: _____ City: _____

State: ____ Zip Code: _____ Responsible parties phone (with area code): _____

Responsible parties SS #: _____

Who is to be notified in case of emergency: _____ Relationship _____ Address:_____

_____ City: _____ State: ____ Zip Code: _____

Emergency contacts phone #: _____

Name of Insurance Company? _____ Member ID: _____

Group Number: _____ Phone Number (area code included): _____

Name of Insured: _____ Insured's Social Security Number: _____

Insured's Date of Birth: _____

I have read office policies and HIPAA Rules:

Signature_____

Date: _____

I authorize the release of medical information to my insurance company to process claims

Signature: _____ Date: _____

I authorize Insurance to make payment to Kathleen M. Wong, M.D.

Signature: _____ Date: _____

# Bridges to Wellbeing, LLC

Kathleen M. Wong, M.D. PLLC

## Consent to treat and professional Disclosure

**Consent**

I hereby give my consent for me (or my child) to receive psychological services from **Kathleen Wong, MD, PLLC.** I understand that I am free to terminate services at any time.

**Confidentiality**

I understand that the information I provide is confidential and, in general, will be released to others only by my written consent (or the written consent of the custodial parent in the case of a minor child). Mental health providers are mandated by law to report when a person is **(1)** and imminent danger to him/herself or to others, **(2)** and instances of abuse. Courts, legal proceedings, insurance and billing services may also require information with in the normal limits of standard practices. All of our providers are licensed in their respective areas of expertise and adhere to their professional code of ethics.

**Contact Emergency**

I understand that most questions and concerns will be addressed in session. In the event of an emergency, I should call 911 or proceed to the nearest hospital emergency room.

_____ _____

Print Name of Patient

Signature of patient or
Parent/Guardian (if minor child)

## Return Check Policy

Please be advised that a **$35.00** fee will be charged for all returned checks.

_____ _____

Signature

Date

# Bridges to Wellbeing, LLC

Kathleen M. Wong, M.D. PLLC

## Authorization to Individuals

This release authorizes our clinicians and staff to communicate with individuals such as family members. Due to HIPAA regulations, if their name is not listed below we will not be able to speak with them.

I give all therapist and professional staff associated with **Bridges to Wellbeing** permission to disclose the private health information set forth below to the following people at the request of one or more of these individuals/

The specific information these persons may receive are as follows:

_____

_____

_____

**Name (please print)** **Relationship**

_____

_____

_____

I understand that **Bridges to Wellbeing** will not release any information to any person(s) not listed above.

In addition, I understand and/or acknowledge that I have the right to revoke this authorization at any time by giving **Bridges to Wellbeing** a written notice. I understand that this release will expire one (1) year from the date below unless written notice is given.

Patient Name: _____ Date of Birth: _____
Please Print

Signature: _____ Date: _____

In the event the Authorization is being executed by a personal representative, parent/guardian, please print your name and relationship to the patient.

# Kathleen M. Wong, M.D., PLLC

**Bridges to Wellbeing, LLC**



**Name:** _____ **Date:** _____

**Address:** _____ **City/State/Zip:** _____

**Home Phone:** _____ **Work Phone:** _____ **Cell:** _____

**DOB:** _____ **SSN:** _____ **Age:** _____ **Gender:** Male _____ Female ____

**Religion:** (1) Protestant (2) Roman Catholic (3) Jewish (4) Baptist (5) None (6) Other Active or Inactive

**Present Marital Status:** (1) Never Married (2) Married (3) Remarried (4) Separated (5) Divorced (6) Annulled (7) Widow(ed)

**Household Composition:** (1) Live Alone (2) With Spouse (3) With Children (4) With Parents (5) Brother (6) Sister (6) Other Relations

**Referral Source:** _____

**Time of Last Psychiatric Visit or Counseling Service:** (1) No Prior (2) Within last 7 days (3) last 30 days (4) Within last 6 months (5) Within last year (6) Over one Year **Was Treatment Inpatient or Outpatient**

**Where or with whom:**_____ **Address:** _____

**City/State/Zip:** _____ **Office Number:**_____

**Have you taken Tranquilizers, Sleeping Pills or Antidepressants?** _____

**Family Doctor (Name and Address):** _____

_____

**What is your present state of Health?** _____

**When did you have your last Physical Check-up?** _____ **By Whom?** _____

## Family History

**Fathers Name:** _____ **Mother's Name:** _____

**Is he still alive?** _____ **Is she still alive?** _____

**If so, how is his health?** _____ **If so, How is her health?** _____

**Present age:** _____ **Present age?**_____

**If deceased, cause?** _____ **If deceased, cause:** _____

**Date of death?** _____ **Date of death:** _____

## Brother(s) and/or Sister(s)

| Name | Age | Occupation | Health | If deceased, cause. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**What is your Numerical Order in Family (i.e. First born, middle etc.....):** _____

## Education

Circle the highest grade you completed in school: ELEMENTARY: 1 2 3 4 5 6 7 8
High School: 1 2 3 4 College: 1 2 3 4 _____ Other: _____
Name of last School attended: _____ Degree Received: _____

## Military History

Branch Served In: _____ Dates Served: _____
Type of Discharge: _____

## Occupational History

Present Position: _____ Previous Positions: _____
_____

## Hobbies and Interests

_____
_____

## Marital History

Name of Spouse: _____ Age: _____ Date Married: _____
Occupation of Spouse: _____ Other Marriages: _____

## Children

| Name | Age | Sex | Living at home | Occupation | Marital Status | Health |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

What medical illnesses or operations have you had and when? _____
_____
_____
_____

What medication(s) are you currently taking and what strength? _____
_____
_____
_____

Do you have any allergies? _____
_____
_____

**Please check the following that apply to you or any relative you are aware of**

| | You | Relative | Relationship | Was treatment required |
|---|---|---|---|---|
| Depression | | | | |
| Manic Depression | | | | |
| Schizophrenia | | | | |
| Hallucinations | | | | |
| Alcohol | | | | |
| Drug Abuse | | | | |
| Severe Anxiety | | | | |
| Phobias | | | | |
| Bulimia | | | | |
| Anorexia Nervosa | | | | |
| Suicide Attempts | | | | |
| Suicide | | | | |
| Sexual Abuse | | | | |
| Caffeine Intake Daily | | | | |
| Tobacco Use Daily | | | | |
| Convulsions/Seizures | | | | |
| Other | | | | |

**Please check any of the following that applies to you.**

____ Sleep
____ Increased talking
____ Concentration
____ Sadness
____ Difficulty breathing
____ Hopelessness
____ Lightheadedness
____ Chest discomfort
____ Appetite
____ Energy level
____ Poor judgment
____ Racing Heart
____ Sweats/Chills
____ Guilt
____ Fears of dying
____ Excessive worry
____ Elation (feeling on top of the world)
____ Racing thoughts
____ Memory
____ Irritability
____ Non-enjoyment of usual activities
____ Numbness/tingling in fingers or legs
____ Fears of going crazy
____ Compulsive behavior