Grant Aram Killian, Ph.D.

Licensed Psychologist FL # PY 3298 **WWW.KILLIANPHD.COM**

LOCATIONS

***Mailing Address*:**
2871 N.E. 30 Street
Lighthouse Point FL 33064-8524
954-786-9000
954-782-9000 (fax)

The Preserve
7700 Congress Avenue, #2110
Boca Raton, FL 33487
954-786-9000
(fax) 954-782-9000

Please complete all information for the identified patient.

Name First: _____ **Last:** _____

Street Address: _____

MUST HAVE 9 Digit Zip Code on *YOUR DRIVER'S LICENSE* or Any Bills or Go To WWW.USPS.COM Look Up Your 9 Digit Zip Code

City :_____**State:**_____**Zip: __ __ __ __ __ - __ __ __ __**

Phone Numbers: What number do you prefer the office use to contact you? Please check.
☐ **Home**_____ ☐ **Cell** _____ ☐ **Work** _____

Email Address: _____

Social Security Number:_____ **Race:** _____

Date of Birth: _____ ☐ **Male** ☐ **Female**

Name & Relationship and phone number of who to contact in emergency for Assistance:

_____
I am giving permission to Dr. Killian to speak with the above person in an emergency.

Status: ____ years married ☐ **Married** ☐ **Single** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Cohabitating**

Occupation/Title: _____

Name of Insurance and ID# (*From Ins. card*): _____

Authorization # from insurance company if needed: _____

Name of school if patient is a student: _____

Place of employment of primary insured: _____

Primary or Family Doctor and phone number:_____
I authorize the release of my treatment reports to my PCP or behavioral health practitioners. ☐ **Agree** ☐ **Decline**
How do you prefer the office confirm appointments? ☐ **Phone** ☐ **Text** ☐ **Email**

Please complete all information for the identified patient.

Who referred you: _____

Please state why you are attending therapy:_____

_____

Children or stepchildren's name and ages:

_____

Who are you living with at home: please list names ages & relationships:

_____

Previous therapy ☐ **Yes** ☐ **No if yes, when/how long**_____

Are you under Psychiatric care: ☐ **Yes** ☐ **No Psychiatrist:** _____

Describe your alcohol use: ☐**Yes** ☐**No** _____**wkly average**

Describe your nicotine use: ☐**Yes** ☐**No** _____**wkly average**

Describe your other substances used ☐**Yes** ☐**No** _____**wkly average**

Parents: ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Deceased**

Mother's age, health condition, if living, or age of death_____

Father's age, health condition, if living, or age of death_____

Brothers: names and age_____

_____

Sisters: names and age_____

_____

Describe the relationship you had with your grandmother

_____

Describe the relationship you had with your grandfather

_____

Please complete all information for the identified patient.

Check any history of abuse for the patient of-- ☐Physical ☐Verbal ☐Emotional ☐Sexual

Any members in your family diagnosed with:

☐ **Schizophrenia** **Who** _____

☐ **Depression** **Who** _____

☐ **Mania** **Who** _____

☐ **Bipolar** **Who** _____

☐ **Committed Suicide** **Who** _____

☐ **Alcohol or substance abuse** **Who** _____

Describe any health problems you have_____

_____

List any allergies if any_____

_____

List all major events and/or traumas with dates, if more room is needed attach a list.

_____

_____

List any pets, type and names_____

Education:	**Year completed**	**Location**
☐ **Completed H.S.**	_____	
☐ **College**	_____	
☐ **Post Graduate**	_____	
☐ **Doctoral**	_____	

Please read all pages and sign all designated places

CONSENT and CONFIDENTIALITY

I agree to seek treatment &/or evaluation for myself, child, spouse, or family, participate actively in treatment planning, provide information to Dr. Killian, which will enable delivery of appropriate care and give permission for my signature be on file. Laws protect confidentiality of communications between client and psychologist, information can only be released with a prior written authorization. Exceptions are: (a) in certain legal proceedings Dr. Killian may be required to testify and/or release records. (b) Dr. Killian is legally required to take action to protect patients and others from harm even though that requires revealing information about treatment and diagnosis. If there is evidence of a child, elderly person, or a disabled person being abused, Dr. Killian must file a report with the appropriate state agency and/or police. (c) If Dr. Killian believes a client is threatening serious bodily harm to another Dr. Killian is required to take protective actions, which may include notifying the potential victim, notifying the police and/or seeking appropriate hospitalization. If a client threatens to harm him/herself, Dr. Killian may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection. Dr. Killian may occasionally consult about a case with other professionals or may be required by your insurance company to consult. In these cases, every effort is made to avoid revealing the identity of the client. Consultants and insurance company are bound to keep the information confidential. As a parent you have the right to general information about treatment, but not necessarily the complete record or specific test scores and/or answers. This written summary of exceptions to confidentiality should prove helpful in, but you may discuss any questions or concerns you may have, these governing laws are complex, but since I am not an attorney, if you need specific advice, you should consult an attorney.

READ CAREFULLY this section SCHEDULING APPOINTMENTS Monday through Saturday.

Because time has been reserved exclusively for me and/or my family members, **I AM REQUIRED TO PROVIDE AT LEAST TWENTY-FOUR (24) HOURS' ADVANCE NOTICE IF UNABLE TO KEEP THE SCHEDULED APPOINTMENT SCHEDULED MONDAY THROUGH SATURDAY.** In the event I do not provide the required notice prior to canceling I will be charged rate of what my insurance company or the managed care company allows for the failed session or I will be discharged due to noncompliance. Payment must be received before another appointment will be scheduled. All future appointments already scheduled will automatically be canceled**.** If I am late for an appointment, no attempt is made to contact office, Dr. Killian will see the next patient scheduled if they arrive during my scheduled appointment.

BILLING and PAYMENTS

You are expected to pay for each session or co-payments at the time of the session or unless you have insurance coverage, which requires another arrangement. You are responsible for any co-payments required or deductibles that must be met by you at the time of service. Payment for professional services you may require such as report writing, telephone conversations, and preparation of records will be charged at my hourly rate at the time these services are requested. If you become involved in litigation which requires my participation, you will be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, I will charge my hourly rate for the preparation, for attendance at any legal proceeding, and travel portal to portal which is different and cannot be billed to the insurance company.

INSURANCE and MANAGED CARE REQUIREMENTS

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have for your treatment. Many HMO's and PPO's require advance authorization and are oriented toward short-term treatment approach designed to resolve specific problems. Dr. Killian is required to complete some Managed Care Forms by the 1st or 2nd session pertaining to the therapy and will release such information necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes with representatives of my insurance or managed care company. Due to the specific nature of these forms, this information may be completed during the 1st session. Insurance and managed care companies may ask to review the entire record and file. By signing this form you are giving permission to send notes when they

are requested, managed care forms, and claims with dates of service, diagnosis & **procedure codes. In addition, these companies require a release of records to your PCP and other behavioral health practitioners.**

CONTACTING ME

The office telephone voice mail system is monitored frequently and we make every effort to return your call the same day. If you are difficult to reach, please leave times when you are available. If there is a **life threatening** emergency please call 911 immediately or go to the nearest hospital. If you wish to leave an emergency message for Dr. Killian press 0 and leave your name, number and a brief message as to the nature of the emergency and Dr. Killian will be paged. If Dr. Killian is out of town the doctor's name and number providing backup coverage will be on the voice mail. An emergency is when a "patient is suicidal and may harm themselves or may harm others." Please do not abuse the privilege of paging Dr. Killian for non-emergency situations. LEAVE YOUR MESSAGE ON THE OFFICE VOICE MAIL 954-786-9000.

PROFESSIONAL RECORDS

Both law and the standards of my profession require that I keep legible appropriate treatment records. Statue 456.057 states: "when a patient's…chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's records shall be provided directly to a subsequent treating professional upon receipt of a signed release of records, I will forward a copy or a summary (Statute 456.057) of your records to another appropriate professional. Clients will be charged an appropriate fee for any preparation time, which is required to comply with an information request and you will be informed by the office manager if there is any request for your information before any information is given out. **According to the Florida Psychological Association, "records could be deficit" if there is no attempt by the psychological provider to "obtain past mental health records". It is the obligation of you the patient, parent or guardian to obtain copies of all these health records and provide copies of these records or have these records sent to Dr. Grant A. Killian, Ph.D., P.A. at his mailing address in Lighthouse Point.** Based on Florida medical laws for records, I therefore would like as many past records as you might be able to acquire; thus, you must **sign** one of these lines.

☐ There are no past psychological or psychiatric records_____

☐ I refuse to release past psychological or psychiatric records_____

☐ I will have past psychological or psychiatric records forwarded_____

I have read the information in this document, agree to abide by its terms during our professional relationship, my signature authorizes payment of medical benefits to Dr. Killian for services rendered and authorizes Dr. Killian to take my photograph for identification purposes and/or medical documentation for electronic medical records (EMR). I am aware that the privacy rule gives the right to request restrictions on uses of my protected health information. I can request a copy of the Privacy Practices or obtain them on Dr. Killian's website, www.killianphd.com. I am giving permission for Dr. Killian's office to call me and leave a message to confirm an appointment and if necessary send a bill to my home address. If I do not agree I need to contact Janie Killian, Privacy Officer to request changes. By signing this form I am giving consent for my behavioral healthcare practitioner to release the information to my active Insurance or Managed Care Company until the period of time at which I am no longer an active. I understand that my records are protected under Federal and/or State Confidentiality Regulations. This authorization may be revoked at any time except to the extent that action has already occurred. If I do not revoke it, this consent will expire one (1) year after I have terminated treatment with Dr. Killian. This consent is given of my own free will.

_____

Client's, Patient, Parent, Guardian Signature **Date Signed**

Print Name that was signed

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Name of Patient: _____

Date Completed: _____ Relationship to patient: _____

Completed by (FIRST & LAST Name): _____

CHECK ALL THAT APPLY TO YOU OR TO THE PATIENT.

1. ☐ Have had a loss of reputation?
2. ☐ Have had feelings of emptiness?
3. ☐ Are you having worsening depression?
4. ☐ Feeling rejection, hopeless &/or helpless?
5. ☐ Feeling guilty or want to punish someone?
6. ☐ Feeling isolated and withdrawal from the world?
7. ☐ Feelings detached from yourself, or unreality, feeling you are going crazy, losing control, or feeling paranoia?
8. ☐ Have had a loss of ability to meet obligations?
9. ☐ Have you been suffering from a chronic illness?
10. ☐ Have you been giving away important belongings?
11. ☐ Have had an unplanned pregnancy or recent abortion?
12. ☐ Have you made efforts to get help that has been unsuccessful?
13. ☐ Have had thoughts that you want to change what is happening in your life by leaving?
14. ☐ Do you tend to be extremely accident-prone?
15. ☐ Do you tend to avoid taking care of your health?
16. ☐ Do you tend to be reckless and do not think about risks?
17. ☐ Intense anger or controlling anger, temper problems, recurrent fighting with others and then feel guilty?
18. ☐ Tend to use drugs or alcohol to change bad feelings?
19. ☐ Tend to over use or over dose with either drugs or alcohol?
20. ☐ Has something stressful happened recently that has made you feel negative about life?
21. ☐ Are guns, throwing knives, knives as weapons, brass knuckles, swords, or other weapons in the home?
22. ☐ Do you tend to listen to music, movies, videos or books about death?
23. ☐ Do you dwell on issues of death or have an attraction or obsession to death?
24. ☐ Thinking you would like to go to sleep and not wake up?
25. ☐ Has anybody close to you died recently and you had thoughts of wishing it were you or joining him or her?
26. ☐ Know anyone that has committed suicide and you had thoughts of wishing it were you or joining him or her?
27. ☐ Have or had fantasies of jumping off a building?
28. ☐ Have or had thoughts that you might drown yourself?
29. ☐ Have or had fantasies of seeing you dead surrounded by others alive?
30. ☐ Have or had thoughts about hanging yourself or using a gun on yourself or others?
31. ☐ Have or had thoughts about using the car to harm yourself in an accident or by carbon monoxide?
32. ☐ Have or had any other suicidal behaviors, thoughts about killing, gestures, self-mutilation, plans, or threats?
33. ☐ Are here because you tried to hurt yourself?
34. ☐ Received treatment for self-harm in the past?
35. ☐ Is there a specific time you think you will die?

Name of Patient: _____

36. ☐ Feel you need to keep yourself safe from yourself to avoid doing self-harm?
37. ☐ Have you ever said in the past 6 months any of the following?

CHECK ALL THAT APPLY TO YOU OR TO THE PATIENT.

a. ☐ "I am a loser"
b. ☐ "I am a failure"
c. ☐ "I hate my life"
d. ☐ "I am worthless"
e. ☐ "I have no future"
f. ☐ "I wish I were dead"
g. ☐ "I wish I did not exist"
h. ☐ "I have nothing to lose"
i. ☐ "I have nothing to live for"
j. ☐ "I have nothing in my life"
k. ☐ "I will be dead soon anyway"
l. ☐ "I would be better off not alive?
m. ☐ "I am going to have a heart attack"
n. ☐ "I am worth more dead than alive"
o. ☐ "I am going to blow my brains out"
p. ☐ I am to blame for all my troubles"
q. ☐ "If I die so what"
r. ☐ "I'll show them"
s. ☐ "Life is not worth living"
t. ☐ "My family would be better off without me"
u. ☐ "Nobody needs me"
v. ☐ "Nobody cares anyway"
w. ☐ "There is no reason to keep living"

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Name of Patient: _____

Insurance I.D. of Patient: _____Date Completed: _____

Completed by FIRST LAST: _____Relationship to patient: _____

Check the symptoms that develop abruptly & reach a peak within 10 minutes.

- ☐ 1. Start sweating
- ☐ 2. Heart pounds, palpitates or accelerates.
- ☐ 3. You shake or tremble.
- ☐ 4. Do you feel as though you are smothering or have shortness of breath?
- ☐ 5. Choking feeling.
- ☐ 6. Chest discomfort or pain.
- ☐ 7. Nausea.
- ☐ 8. Do you have feelings that you are detached from yourself or have feelings of unreality?
- ☐ 9. Do you fear you are going crazy or losing control?
- ☐ 10. Do you feel dizzy, unsteady, or going to faint?
- ☐ 11. Are you afraid of dying?
- ☐ 12. Do you have numbness or tingling?
- ☐ 13. Do you have hot flushes or chills?

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Name of Dr. Prescribing	Medication name Prescribed	Mg (Dosage) of the Medication	Frequency / Day	Date Medication was First Started

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Name of Patient:_____

Insurance I.D. of Patient:_____Date Form Completed:_____

Completed by (First/Lastname):_____Relationship to patient:_____

Gen Anx Dis 300.02

Check any item that applies:

☐ 1. Excessive anxiety and worry almost every day for at several months.

☐ 2. Difficulty controlling the anxiety and worry.

3/6

☐ 3. Any of the following symptoms for most days for the past 6 months.
- ☐ Keyed up, restless, or on edge
- ☐ Easily tired
- ☐ Difficulty with concentration
- ☐ Irritable
- ☐ Tension in muscles
- ☐ Difficulty with sleep (falling asleep or staying asleep, or unsatisfying sleep)

☐ 4. Does the anxiety and worry cause you to have trouble with your social events, your job, or other important areas in your life.

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Name of Patient: _____

Date Form Completed: _____

Completed by (First/Last name): _____Relationship to patient: _____

Check any item that applies:

- ☐ 1. Depressed or irritable mood during the day.
- ☐ 2. Diminished interest in activities tending to be apathetic.
- ☐ 3. 10 pound or more weight loss or weight gain not due to dieting in less than a few months.
- ☐ 4. Unable to sleep at night or difficulty sleeping or sleeping too much.
- ☐ 5. Either agitated or slowdown everyday.
- ☐ 6. Fatigue or loss of energy every day.
- ☐ 7. Feelings of worthlessness or guilt during the week or day.
- ☐ 8. Less able to think, concentrate or tending to be indecisive.
- ☐ 9. Thinking/wishing for death, harming oneself, suicidal thoughts, planning/attempting to.

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Name of Dr. Prescribing	Medication name Prescribed	Mg (Dosage) of the Medication	Frequency / Day	Date Medication was First Started