Mary Beth Johnston, Ph.D.

900 Straits Turnpike• Middlebury, CT 06762
Phone: 203-270-5575 • Fax: 203-883-0365

CLIENT QUESTIONNAIRE

Name:____ Date:______________________

Address:____ Home Phone:_________________

Street

____ Cell Phone: ______________________

City ZIP

May we have permission to leave a message with a family member ____________________________

Date of Birth:________________ Age:_______ Marital Status: Single Married Divorced Widow

Referral Source:____

Employment Status: (Please circle) Full Time Part Time Retired Not employed Student

Employer:_______________________________Occupation:______________________________

May we contact you at work?_____________ Work Phone:_________________________________

If student, name of school: ____

In Case of Emergency, call ____

Relationship: ______________________ Phone: _______________ Cell Phone: _______________

Is your visit related to a disability caused by: an accident at work, auto accident, or other accident.?
(Please circle) Yes or NO

MEDICAL HISTORY:

Who is your medical doctor? ________________________________Date of last physical:___________

May we contact your medical doctor to coordinate your treatment? ______________________________

Please list any current medical problems: ____

____

____

Please list any medication you are taking at present:

Name Dosage Prescriber What is the medication prescribed for?

____

____

____

____

Describe your use of the following. Please be specific.

Coffee:____

Alcohol:____

Illegal Drugs:____

Smoking:____

Have you had psychotherapy and/or been prescribed psychotropic medications in the past? If so, please complete the following:

Date MD/Therapist Reason for Treatment

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FINANCIAL ARRANGEMENTS

MTBC prepares my billing. MTBC is fully aware of the laws and proper procedures regarding patient confidentiality.

I authorize the release of any medical or other information necessary to process this claim.

I authorize payment of medical benefits to Mary Beth Johnston, Ph.D. for services rendered.

I give my consent for treatment.

I am aware of the limitations on confidentiality as delineated in the Health Insurance Portability and Accountability Act (HIPPA).

Please pay your copay for each appointment or the full cost of the appointment if you have a deductible at the time of the visit.

We will gladly assist you in filing for payment by your insurance carrier. However, regardless of insurance, payment remains your personal responsibility. I agree that I am financially responsible for any and all monies due.

Signature:____Date:_________________________

Dr. Johnston is a sole practitioner. Her practice is located within the office space of The Healthy Mind Psychiatric Services, which provides administrative services for her. While she often refers patients to programs run by The Healthy Mind, her practice is independently owned.

Attendance at scheduled appointments is necessary in order to make progress in treatment. If you need to cancel an appointment, please give 24-hour notice. There is a $30 charge for appointments missed or canceled without appropriate notice.

Three consecutive cancellations or two consecutive No Shows without explanation will be grounds for termination from treatment. You may return to treatment after six months if your schedule becomes more amenable to treatment.

Dr. Johnston has 24-hour answering service coverage. For routine after-hours calls, please call her office (203-270-5575) and leave a message on the voice mail (The Healthy Mind). She will return your call on the next business day. For emergency after-hours calls, the answering service will contact Dr. Johnston. In case of an emergency where an immediate response is required, please call the Crisis Center at Waterbury Hospital (203-573-6500) or go the emergency room at your local hospital.