MARY BETH VALIULIS, M.D.

BOARD CERTIFIED PSYCHIATRIST
BOARD CERTIFIED SLEEP SPECIALIST

Mary Beth Valiulis, M.D. offers a comprehensive approach to mental health treatment and sleep medicine evaluations. This includes both psychotherapy and pharmacotherapy. She conducts cognitive behavioral therapy for anxiety, depression and sleep disorders, such as insomnia. She also offers Home Sleep Testing for adults, available at Valiulis Sleep Clinic.

Enclosed is the New patient packet for you to complete and return to the office. Dr. Valiulis reviews the packet to determine if this is the appropriate treatment setting for your needs. They can be emailed, mailed, faxed or dropped off at the office. If the office is closed, you can place the packet in the locked mailbox to the right of the front door. It is important to read "Office Policies" carefully before becoming a patient, as Dr. Valiulis is not a provider for any insurance or Medicare. If this is an appropriate treatment setting, your care will begin at your first appointment. In order to reserve your appointment time, the initial visit is prepaid and will be scheduled at the earliest convenience. If you have any questions you can reach us at 318-797-3350.

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MARY BETH VALIULIS, MD
OFFICE POLICIES

CONFIDENTIALITY

All information between provider and patient is strictly confidential unless:

- The client authorizes release of information with his/her signature.
- The client presents a physical danger to self.
- The client presents a danger to others.
- Child/elder abuse/neglect is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken. The release of information form must be signed in order to authorize any release of data regarding your medical care.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24 hours notice, you will be billed and held responsible for payment in full.

EMERGENCY PROCEDURES

If you need to contact Dr. Valiulis, leave a message and your call will be returned in a timely manner. If your call is urgent please leave a detailed message. If an emergency situation arises, you may need to go straight to the emergency room. If phone calls are over several minutes then, there may be a charge for lengthy telephone consultations.

FINANCIAL TERMS

You will be responsible for payment at the time services are rendered. Full payment may be Cash, Check or Credit Card (Visa or MasterCard).

Dr. Valiulis is NOT a provider for Medicare or Medicaid, therefore no services rendered by Dr. Valiulis can be submitted to Medicare or Medicaid. An OPT-OUT contract will be necessary to sign stating that the bill will not be sent for reimbursement to Medicare or Medicaid.

A statement will be provided after payment for services rendered that may be used for filing claims with your insurance company or to save for tax purposes. AGAIN, this statement may NOT be used for Medicare or Medicaid claims.

Your appointment is reserved for you. Therefore, you will be charged the session fee for any appointment either missed or not cancelled within twenty-four hours in advance. .

I further authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. *Please sign below to acknowledge that you understand and agree to all of the above information.*

_____ _____

PRINT NAME OF PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

PATIENT INFORMATION RECORD TODAY'S DATE _____

LAST NAME_____FIRST_____

ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE_____CELL PHONE_____

EMAIL_____ (Please circle the preferred method of contact)

AGE_____ DATE OF BIRTH_____ SSN _____

MARITAL STATUS (circle): single married divorced widowed separated

OCCUPATION: _____ EMPLOYER_____

WORK ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

WORK PHONE_____

MEDICAL INSURANCE: _____

Do you have MEDICARE? Yes or No Do you have MEDICAID? Yes or No

_____
RESPONSIBLE PARTY How are you related to the patient _____

LAST NAME_____FIRST_____

DATE OF BIRTH_____ AGE_____ SSN _____

ADDRESS_____

HOME_____CELL_____EMAIL_____
(Please circle the preferred method of contact)

OCCUPATION: _____EMPLOYER_____WORK PHONE_____

WORK ADDRESS_____

Name of person completing this form _____ Relation to child _____

How did you hear about Dr. Valiulis? (Please specify) Friend/Family, a current patient/previous patient, Yellow pages, Internet, Websites: www.valiulis.com or www.mcgannmedical.com or Other:
_____

If you were referred to our office by a physician or therapist, please list the name:
_____

Please briefly describe the problems for which you are seeking help at this time.
_____
_____
_____
_____
_____
_____
_____
_____
_____

Approximately when did the problem(s) begin? _____
_____
_____

Are there any known stressors that have caused or contributed to your problems? (If yes, please explain)
_____
_____
_____

Has your child shown any significant mood changes recently? YES or NO (If yes, please explain)
_____
_____

Does your child have any anxiety or specific fears? YES or NO (If yes, please describe)
_____
_____

Has your child shown any significant behavioral changes recently? YES or NO (If yes, please describe)
_____
_____

Does your child have trouble with personal relationships? (i.e. friends, family) YES or NO (If yes, please describe)
_____
_____

Does your child show any physical symptoms relating to his or her problem? YES or NO (If yes, please describe)

_____

_____

Has your child ever threatened, attempted or done harm to others? YES or NO (If yes, please describe)

_____

_____

Has your child ever threatened or attempted suicide? YES or NO (If yes, please describe)

_____

_____

IF YOUR CHILD IS CURRENTLY EXPERIENCING SUICIDAL OR HOMICIDAL THOUGHTS PLEASE GO TO THE NEAREST EMERGENCY ROOM ASAP.

Has the patient ever received inpatient or outpatient mental health treatment? YES or NO
(If yes, please list in chronological order)

Doctor/Hospital/Therapist	Reason for treatment/ hospitalization	Diagnosis	Dates of treatment	Medicines prescribed

Has your child ever been arrested or had legal charges? YES OR NO (If yes, please explain)

_____

Has your child or do you suspect your child of ever using tobacco, alcohol or drugs? YES or NO (If yes, please explain)

_____

_____

MEDICAL HISTORY:

Who is your child's Pediatrician or Family Doctor? _____
When was your child's last physical examination? _____
Are his or her vaccinations up to date? _____
Has your child shown any developmental delays? YES OR NO (If yes, please explain)

_____

_____

Does your child have any drug allergies? (please list) _____
Does your child have any environmental allergies? (please list) _____
Does your child have any food allergies? (please list) _____

Please list current medications: (include over the counter meds, vitamins, herbs or supplements)

Rx name	Dosage	Frequency	Prescribing M.D.

Does your child have any current medical problems? YES or NO (If yes, please explain)

_____
_____
_____
_____
_____

Has your child had any surgeries? YES or NO (If yes, please explain and give approximate dates)

_____
_____
_____
_____
_____

Child is now living with: ____ Both Biological parents ____ Biological Father ___ Biological Mother
____Other _____

Other children in the family: (Please list names and ages)

_____ _____
_____ _____

Is the child adopted? YES or NO
Were the any complications with pregnancy? YES or NO (If yes, please explain)

_____
_____

Were there any complications with labor or delivery? YES or NO (If yes, please explain)

_____
_____

Name _____ Date_____

Was the baby premature? YES or NO If yes, how premature? _____

SLEEP HABITS:

Please answer the following questions to the best of your knowledge concerning your child's sleep habits. If any questions are answered YES, please use the space provided to explain.

Does your child have any problems going to bed? YES or NO _____

_____

Does your child have difficulty waking in the morning or take long naps during the day? YES or NO _____

_____

Does your child wake often during the night? YES or NO _____

_____

Does your child have difficulty falling back asleep after night waking? YES or NO _____

_____

Does your child have a regular bedtime and wake time? YES or NO

Please list the regular bed and wake times for your child: Weekdays: _____

Weekends: _____

Does your child snore or have difficulty breathing at night? YES or NO _____

Does your child have nightmares? YES or NO (please describe, including reactions and frequency)

_____

_____

_____

SCREEN TIME:

Please answer the following questions to the best of your knowledge concerning your child's use of electronic devices, i.e. TV, video games, IPad, phones, Kindle, ect.

Please give the average number of hours per day your child has screen time.

During the week: _____

On the weekends: _____

Does your child get to have screen time before school? YES or NO How much? _____

What time, on average, is the device turned off before bed? _____

Are there TVs or other electronic devices kept in your child's room? YES or NO Please list the devices:

_____

EATING HABITS:

Please answer the following questions to the best of your knowledge concerning your child's eating and food habits.

How many caffeinated drinks does your child drink daily? (coffee, tea, cola) _____

How many carbonated drinks does your child drink daily? (Sprite, Ginger Ale, ect. without caffeine) _____

How much sugar does your child consume daily? (i.e. 2 cakes, 3 popsicles, ect.) _____

Does your child have any other eating difficulties? _____

_____

_____

SCHOOL HISTORY:

Name of School: _____ Grade: _____

Current Academic Performance: …….. ___Good ___Fair ___Poor
Past Academic Performance: ……... ___Good ___Fair ___Poor
Current Behavior Performance: …… ___Good ___Fair ___Poor
Past Behavior Performance: ……. ___Good ___Fair ___Poor

Is your child in any gifted or accelerated programs? YES or NO (Please list): _____
Is your child in any special education programs? YES or NO (Please list): _____
Are there any known learning disabilities? YES or NO (Please list): _____
Has your child repeated any grades? YES or NO (Please list): _____
Please list any psychological or IQ/school testing that your child has received, including report cards or teacher evaluations. _____

_____

_____

_____

FAMILY HISTORY: (Please Mark all that Apply)

	Depression or Bipolar	Anxiety	Alcohol or Drug problems	Schizophrenia or psychosis	Suicidal thoughts or attempts	Psychiatric hospitalization
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparents						
	Sleep apnea	Heavy Snoring	Narcolepsy	Insomnia	Restless legs syndrome	Other sleep disturbances
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparents						

Please use additional paper to complete any questions or give us any more information concerning your child that you feel is relevant.