KEITH E. KESLER, D.O.

2525 Wallingwood Dr., Bldg 7, Suite 7D
Austin, TX 78746
(512) 347-0650 Office
(512) 329-5108 Fax

www.drkkesler.com

Initial Letter to Patients

Self-Assessment Form. Before your evaluation, it is important that you complete the enclosed form in as much detail as possible. Much of the information will be readily available to you, but some of it may require an effort to obtain. The information will not only be of use during your evaluation, it will also help organize your thinking about your psychiatric history.

After completing the form, make a copy for yourself and bring the original to the evaluation. If there is a question on the form that you do not wish to answer or cannot answer, leave it blank.

To make it possible for me to spend more time on items directly related to medical care, I request that the bill be paid at the time of your visit. If you cannot afford the fee or are not able to make the payment at the time of the consultation, please discuss the issue with me during the appointment. I will be pleased to see you anyway.

Insurance. Because insurance plans have become more numerous and complex in the past few years, it has become impossible for me to monitor the status of patient claims. Consequently, it is now my policy to have patients fill out and monitor their own insurance forms. The amount of reimbursement from the insurance company will depend upon your policy.

Some insurance companies ask that physicians give patients they insure preferential treatment. Under the preferential plan, a patient might be charged a different fee depending on which insurance company the payment is coming from (patients with no insurance might end up paying the highest fee). Some physicians have decided against giving preferential treatment to one insurance company--I am one of them. For example, although I do not "participate" in Blue Cross/Blue Shield, I see patients covered by Blue Cross/Blue Shield. The patient is responsible, however, for making his or her own application for reimbursement. I can print out and send you an insurance claim form along with your monthly statement, to assist you in filing. If you would like to set up this arrangement, just let me know and make sure that I get a copy of your insurance card.

If you are eligible for Medicare or are presently receiving Medicare medical benefits, please be aware that I have opted out of billing Medicare. This means that you will not be able to send my statements to Medicare for reimbursement. The details of this will be explained more fully during your initial visit.

Sincerely,

Keith E. Kesler, D.O.

KEITH E. KESLER, D.O.
2525 WALLINGWOOD DR., BLDG 7, SUITE 7D
AUSTIN, TX 78746
PHONE (512)347-0650 FAX (512)329-5108

Patient Guidelines and consent for use of e-mail Communications

To better serve our patients, this office has established an e-mail address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at drkkesler@drkkesler.com. Please remember, however, that this form of communication is **not appropriate for use in an emergency**. The turnaround time for patient communications is one business day. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

Types of communication that are appropriate for e-mail include:

- Scheduling inquiries
- Non-urgent medical advice
- Billing questions
- Test and lab results
- Educational materials

When sending e-mail, please put the subject of your message in the subject line so we can process it more efficiently. Some forms of communication (e.g., HIV, mental health, work-related injuries, and disability) are not appropriate for e-mail. Also, be sure to put your name and return telephone number in the body of the message. We also ask that you acknowledge receipt of e-mails coming from this office by using the autoreply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping our medical record information confidential. **Despite our best efforts, due to the nature of e-mail, third parties may have access to messages.** When communicating from work, you should be aware that some companies consider e-mail corporate property and your messages may be monitored. In addition, you should be aware that, although addressed to me, my staff would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above e-mail policy.

_____ _____

Patient Signature Date

Keith E. Kesler, D.O.
Adult and Adolescent Psychiatry
2525 Wallingwood Dr., Bldg 7, Suite 7D
Austin, TX 78746
Phone: 512-347-0650 Fax: 329-5108

Request/Authorization to Release Confidential Records and Information

I hereby authorize the release of information from records about (patient's name)

_____born on _____and whose Social Security number is _____

to/from Dr. Keith Kesler and (Person or facility):

_____

Address:_____

_____

Phone number: _____
*They may release information in written and/or verbal form to/from Dr. Kesler
Information will be release for the following purpose(s). Please initial each.

- ❑ Further psychiatric evaluation, treatment, or care. Initial _____
- ❑ Rehabilitation program development or services. Initial _____
- ❑ Treatment planning. Initial _____
- ❑ Research. Initial _____
- ❑ Other, specify:_____. Initial _____

The information to be disclosed is marked by an "x" in the boxes below, and the items not to be released have a line drawn through them. Page numbers are indicated when appropriate. Please initial each.

- ❑ Intake and discharge summary. Initial _____
- ❑ Medical history and evaluation(s). Initial _____
- ❑ Mental health evaluations. Initial _____
- ❑ Developmental and/or social history. Initial _____
- ❑ Educational records. Initial _____
- ❑ Laboratory reports. Initial _____
- ❑ Progress notes, and treatment or closing summary. Initial _____
- ❑ Other, specify:_____. Initial _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here

- ❑ Do not release. Initial _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of patient	Printed name	Date

_____	_____	_____
Signature of Parent	Printed name	Date

KEITH E. KESLER, D.O.
Adolescent and Adult Psychiatry
Board Certified Psychiatrist
2525 Wallingwood Dr. Ste. 7D
Austin, TX 78746
PHONE (512)347-0650 FAX (512)329-5108
DRKKESLER@DRKKESLER.COM

Authorization for credit card charges

I, _____, authorize Keith E. Kesler, D.O. to charge my credit card for payment of my session fees, and to keep my credit card number on file for future use.

_____ _____
Signature Date

Please note: a 3% processing charge will be added to all balances charged to credit cards.

Name: _____

Credit Card # _____

Exp: _____/_____ CV# (3 digits in signature box on back of card) _____

Credit Card Billing Address:
_____

City: _____ State:_____ Zip:_____

KEITH E. KESLER, D.O.
2525 WALLINGWOOD DR., BLDG 7, SUITE 7D
AUSTIN, TX 78746
PHONE (512)347-0650 FAX (512)329-5108

Please Print

Patient Name _____ **Date** _____

Address _____

City _____ **State** _____ **ZIP** _____ **Email** _____

Phone: home _____ **work** _____ **cell** _____

Sex M / F **Social Security Number** _____ - _____ - _____

Age _____ **Date of birth** _____

If applicable, Parent name(s)
_____

Parent Phone: home _____ **work** _____**cell** _____

Send bill to: _____

Emergency Contact _____ **Phone** _____

Who referred you to me? _____

Check all that apply:
Race: African American ( ) Asian American ( ) Caucasian ( ) Native American ( ) Other ( )

Religion: Protestant ( ) Catholic ( ) Jewish ( ) Muslim ( ) Hindu ( ) Other ( )

Residence: house ( ) apartment ( ) dormitory ( ) other ( )

Marital Status:
never married ( ) married ( ) living cooperatively ( ) divorced ( ) separated ( )
widow/widower ( ) marriage annulled ( ) other ( )

If married, how many times? 1 2 3 Other _____
If divorced, how many times? 1 2 3 Other _____

Occupation _____

Education (highest completed)

High School/Earlier	College/University	Degree(s)
8th/earlier 9th 10th 11th 12th	1 2 3 4 5 _____	BA BS MA MS MBA PhD MD JD Other _____

KEITH E. KESLER, D.O.
2525 WALLINGWOOD DR., BLDG 7, SUITE 7D
AUSTIN, TX 78746
PHONE (512) 347-0650 FAX (512)329-5108

Please state the principal reason you are requesting a consultation or treatment.
If necessary, use another sheet of paper.
Please describe your illness from the time of your first symptom to the present.
Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers who have treated you as you can.
Also, please provide the kinds of treatment you have received, including names of medications and your response to them.

Suicide

Have you ever thought about suicide? _____

If "yes" when was the last time? _____

Have you ever attempted suicide? _____

If "yes" when and how? _____

Do you have thoughts about suicide now? _____

Injury to Self

Have you ever thought about hurting yourself? _____

If "yes" when was the last time? _____

Have you ever hurt yourself? _____

If "yes" when and how? _____

Do you have thoughts about hurting yourself now? _____

Injury to Others

Have you ever thought about hurting someone else? _____

If "yes" when was the last time? _____

Have you ever hurt someone else? _____

If "yes" when and how? _____

Are you thinking about hurting someone now? _____

Recent Stressful Life Events

Comments

Check any of the following events that have occurred during the last 2 years.

married	( )	_____
engaged	( )	_____
separated	( )	_____
divorced	( )	_____
serious argument	( )	_____
breakup of important relationship	( )	_____
child left home	( )	_____
death of a spouse, other	( )	_____
bad health / behavior of family member	( )	_____
difficulties with family member	( )	_____
personal injury, illness	( )	_____
sexual difficulties	( )	_____
difficulties, changes at school, work	( )	_____
retired or lost job	( )	_____
changed residence	( )	_____
legal difficulties, multiple traffic tickets	( )	_____
owe money	( )	_____

Drinking (Alcohol Use)

How many drinks do you have in the average day? _____

At what time of day do you have your first drink? _____

What is the most you have had to drink in a 24-hr period during the last year? _____

Have you ever felt that you were, or someone told you that you were, drinking too much? _____

If "yes", under what circumstances? _____

Drugs of Abuse — Comments

Check if you have ever taken any of the following drugs:

none	( )	_____
marijuana	( )	_____
amphetamines/speed	( )	_____
heroin/opiates	( )	_____
PCP	( )	_____
LSD/hallucinogens	( )	_____
cocaine/crack	( )	_____
barbiturates/sedatives/downers	( )	_____

If you checked one or more the drugs, under what circumstances did you take it(them)?

_____

When did you most heavily use drugs? _____

When was the last time you took such drugs? _____

Personal History

Comments

Check any items that apply to you and explain:

Mother's pregnancy with you was abnormal ( ) _____

Mother's delivery with you was abnormal ( ) _____

Check if during childhood you...

were afraid to go to school ( ) _____

had difficulty with reading, writing, or arithmetic/math ( ) _____

were truant ( ) _____

failed or repeated a grade ( ) _____

had frequent falls ( ) _____

were awkward at games ( ) _____

wet bed after age 5 ( ) _____

had tics ( ) _____

had trouble with eyes ( ) _____

were (are) left-handed ( ) _____

mispronounced words, had a lisp, stutter/stammer ( ) _____

had nightmares, disturbed sleep, fear of the dark ( ) _____

ran away from home ( ) _____

were cruel to animals ( ) _____

often lied to families or others ( ) _____

set fires ( ) _____

moved often ( ) _____

were exposed to incest ( ) _____

were promiscuous ( ) _____

Weight and Height

What is your current weight in pounds? _____

Has your weight has increased or decreased by more than 10 pounds during the last 5 years?_____

If “yes”, explain circumstances: _____

What is your height? _____ft. _____in.

Sleep

Comments

Do you...

have difficulty falling asleep? ( ) _____

have difficulty waking up and falling back to sleep ? ( ) _____

are tired upon waking ? ( ) _____

have bad dreams, wet bed, sleepwalk, or other sleep disturbances ( )_____

Smoking

Do you smoke? How much? _____

How long have you smoked?_____

Caffeine

Do you drink coffee, tea or colas? _____

If “yes”, how much? _____

Do you believe you are sensitive to caffeine? _____

Allergies

List all allergies. Be sure to include medication allergies.

_____

_____

_____

Medical History List all past and present medical problems as well as any surgeries or accidents.

Age when first occurred **Comments**

_____

_____

_____

_____

_____

Females: Menstrual History

What is the date of your last period? _____ What is the duration of your periods? _____

Are your periods irregular?____ If "yes", explain _____

Do you have any pain or discomfort with your periods? _____

Do you have any of the following with your periods: changes in mood, depression, irritability, or irrationality?_____

Are you taking an oral contraceptive?____ If "yes", which one and how long? _____

If you are taking an oral contraceptive, does it affect your mood? _____

Family History

	Name	Age	Occupation	All major illnesses, including psychiatric, neurologic, alcoholism, drug abuse, suicide, and suicide attempts.
Mother				
Father				
Brothers				
Sisters				
Children				
Grandparents				
Uncles				
Aunts				