Paul B. Bohn, M.D., Psy.D
12300 Wilshire Blvd. #330
Los Angeles, CA 90025
Telephone (310) 829-1924
(310) 442-5936
Fax (323) 925-1063
www.paulbohn.com

Welcome to our office!

Enclosed is an important questionnaire for you to fill out and bring with you to the appointment. Completing the questionnaire in advance allows Dr. Bohn to focus his time and energy with you on assessment and treatment.

Dr. Bohn received his psychiatric residency training at UCLA-Neuropsychiatric Institute. After residency, he went on to complete a fellowship in anxiety disorders and cognitive behavior therapy at the University of Southern California, and a psychoanalytic training program at the Institute for Contemporary Psychoanalysis. Dr. Bohn is a general adult psychiatrist specializing in psychopharmacology (medication) and psychotherapy (both cognitive-behavioral and relational). He is also involved in mentoring and lecturing as a Clinical Professor of Psychiatry at UCLA. If you would like to know more about Dr. Bohn, please go to his website @ www.paulbohn.com.

Dr. Bohn and I look forward to meeting you.

Sincerely,

Office Manager

Nora

Paul Bohn, M.D., Psy.D.

Consent for Evaluation or Treatment

Please take a moment to review some information to which you are entitled before receiving psychiatric services.

Any information you disclose will be maintained in the strictest confidence, unless you specifically authorize its release, or unless law or professional standards of practice require its release. In particular, your right to confidentiality may not be maintained if you are in immediate danger to yourself or to someone else, and steps must be taken to assure your own or another's safety. Also, any clinician hearing that a child or elder is being or has been physically or psychologically abused is required by law to report this information to a designated agency. If it is necessary to disclose information to anyone else pertaining to you, this will be discussed with you.

All outpatient visits must be paid for at the time of the visit. At the time of your outpatient visit, you will be provided with an insurance statement to submit to your insurance company. We cannot accept responsibility for negotiating claims with insurance companies or other persons. You are responsible for payment of your medical care regardless of the status of your claim. Any other financial arrangement must be made with us prior to service.

Fees will increase two to five percent at the beginning of each new year.

Any outstanding bills will be billed again monthly. If payment is not received after two successive billings, your account may be sent to a collection service. **Should you need to cancel a session, please do so at least 24 hours in advance. Otherwise, the time will be held open, and you will be charged at your regular rate for the canceled session.** Under circumstances where a party other than the patient is responsible for payment, that party must sign a separate agreement guaranteeing payment of the bill.

I agree in the event of non-payment to bear the cost of collection and/or court costs and legal fees should this be required.

I have read and understood the foregoing, and I consent to this evaluation or treatment.

_____ _____

Signature **Date**

Paul Bohn, M.D., Psy.D.

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_____ _____

Signature **Date**

PATIENT COPY

Paul Bohn, M.D.

Patient Information Sheet

Name: _____

Date: _____

Referred By: _____

Date of Birth: _____ **Social Security #:** _____

Home Address: _____

_____

Billing Address: (If different from above) _____

_____

E-Mail Address: _____

Home Phone: _____ Okay to leave message here?

Work Phone: _____ okay to leave message here?

Cell Phone: _____ okay to leave message here?

Spouse's / Significant Other's Name: _____

Primary Care Doctor Name and Phone: _____

Therapist's Name and Phone: _____

Medical Insurance Company: _____**ID#**_____

Person to Contact in an Emergency: _____

Name Phone

_____

Address City State Zip Code

Primary Reason for Seeking Treatment or Evaluation: _____

_____

_____

Fees

Initial Evaluation (typically 90 minutes)	$550.00
Medication Visits (typically 25 minutes)	$215.00
Psychotherapy (typically 45 minutes)	$335.00
Other services (billed in 5 minute increments)	$400.00/hr

We accept Visa, MasterCard, Checks and Cash

Please complete the following to allow us to automatically bill your credit card for visits. Note that all charges, including missed appointments, will be billed to your credit card on file unless you instruct us otherwise.

Please bill my:

□ Visa □ MasterCard □ American Express

Cardholder Name: _____

Account Number: _____

Expiration Date: _____

Confirmation Code (3 digits on back of card): _____

Billing Zip Code:_____

Signature: _____

PAUL BOHN, M.D.
MEDICAL EVALUATION

Patient's Name:

I. TO BE COMPLETED BY PATIENT

Please complete the following questions to the best of your ability

A. Identifying Data:

Name: _____Home Phone: ( )_____

Address: _____ Marital Status _____

_____ Date of Birth _____/_____/_____
Zip Code MO DY YR

Occupation: _____ Work Phone: ( )_____

Educational Level: _____

B. What brings you in to see the doctor?

_____

_____

C. Personal Medical History:

1. Do you receive regular medical care from a physician or clinic? □ No □ Yes
   If yes, please provide the following information:

   Name of Physician or Clinic: _____Phone ( )_____

   Address: _____
   (Zip Code)

2. Have you ever had any of the following illnesses?

	Yes	No		Yes	No
High Blood Pressure			Migraine Headaches		
Diabetes			Peptic Ulcers (stomach ulcers)		
Cancer			Colitis		
Thyroid Disease			Irritable Bowel Syndrome		
Other Hormone Problem			Tuberculosis		
Alcoholism			Stroke		
Heart Disease			Rheumatic Fever		
Glaucoma			Asthma		
Epilepsy			Birth Defects		

(a) Have you had any other disease? □ No □ Yes If yes, explain:

_____

_____

_____

(b) What is your current weight (estimate if you do not know exactly)?
_____lbs.

C. **Personal Medical History: (continued)**

(c) What is the most you have ever weighed? _____lbs. When? _____

(d) Can you explain any recent weight loss or weight gain? _____

_____

(e) What is your height? _____ft. _____in.

3. Have you ever had to be hospitalized? □ No □ Yes If yes, complete the following:

Year	Doctor's Name	Name of Hospital	Reason
_____	_____	_____	_____
_____	_____	_____	_____

4. Have you ever had surgery or been advised to have surgery? □ No □ Yes If yes, complete the following:

Year	Doctor's Name	Name of Hospital	Name of Operation or Procedure
_____	_____	_____	_____
_____	_____	_____	_____

5. Have you ever had any injuries?

	Yes	No	When	How did it happen?
Head Injury				
Concussion (ever been knocked unconscious)				
□ Food □ Chemical □ Drug Poisoning				
Broken Bone				
Severe Cuts or Lacerations				
Other _____				

6. Do you have any allergies?

	Yes	No	How are you affected?
Penicillin			
Other Medication Allergies			
_____			
_____			
_____			

7. Have you recently had any of the following tests?

	Yes	No	When	Where	Results
Physical Exam					
Thyroid Blood Test					
Blood Tests					
Chest X-Ray					
TB Skin Test (PPD)					
Electrocardiogram (EKG)					
Brain Scan or MRI					
EEG					

8. Are you in the habit of using any of the following items?

	Amount Currently Using	Most Ever Used
Coffee (cups/day)		
Cigarettes (packs/day)		
Alcohol (amounts and types of alcohol used daily)		
Marijuana (joints/day)		
Vitamins		
Sleeping Pills		
Herbs		
Aspirin		
Laxatives or Diuretics		

D. Family History:

	Father	Mother	Brother			Sister			Spouse	Children					
			1	2	3	1	2	3		1	2	3	4	5	6
Age (if deceased give date and age at Death)															
Anxiety Disorder of Phobia															
Psychosis or Schizophrenia															
Shyness															
Obsessive Compulsive Disorder															
Manic Depression															
Heart Attack or Heart Trouble															
Epilepsy or Convulsions															
Nervous Breakdown or Depression															
Alcoholism															
Suicide or Suicide Attempt															
Drug Abuse															
Hospitalization for Psychiatric Problem															
Thyroid Problem															
Attention Deficit Disorder															
Alzheimer's Disease															
Migraine Headaches															

E. Review of your current health:

1. Do you have?	Yes	No		Yes	No
Lumps anywhere			Unusual excessive thirst		
Double vision or poor vision			Urine problems, blood in urine		
Difficulty hearing			Indigestion, gas, heartburn		

	Yes	No		Yes	No
Fainting spells, blackout spells			Stomach pain or stomach ulcer		
Convulsion			Diarrhea		
Paralysis			Constipation		
Dizziness			Vomiting, vomiting blood		
Headaches			Blood in stool		
Thyroid problem, goiter			Change in appetite or eating habits		
Skin problem			Trouble sleeping		
Cough or wheeze			Sexual problems		
Spitting up blood			Depression		
Palpitation or heart fluttering			Suicidal thoughts		
Chest pain			Weight loss or weight gain		

F. Review of your current health: (continued)

1. Do you have?

	Yes	No		Yes	No
Shortness of breath at night or with mild exercise			Problems with memory, thinking or concentration		
Swelling of hands or feet			Weakness or tiredness		
Visual hallucinations			Joint pain		

Please describe or explain any of the positive answers above

_____

_____

_____

Please list all of your current medications:

Questionnaire

Have you taken any of the following medications? Please circle Yes or No and if "Yes" please write a few words about your response to the medication, good, bad or otherwise.

fluoxetine (Prozac) (Y / N) _____
sertraline (Zoloft) (Y / N) _____
citalopram (Celexa) (Y / N) _____
escitalopram (Lexapro) (Y / N) _____
venlafaxine (Effexor XR) (Y / N) _____
desvenlafaxine (Pristiq) (Y / N) _____
duloxetine (Cymbalta) (Y / N) _____
bupropion (Wellbutrin) (Y / N_____
selegiline (Emsam) (Y / N) _____
mirtazapine (Remeron) (Y / N) _____
nefazodone (Serzone) (Y / N) _____
desipramine (Norpramin) (Y / N) _____
nortriptyline (Pamelor) (Y / N) _____
phenelzine(Nardil) (Y / N) _____
vortioxetine (Trintellix) (Y / N) _____
vilazodone (Viibryd) (Y / N) _____
levomilnacipran (Fetzima) (Y / N) _____
modafinil (Provigil) (Y / N) _____
armodafinil (Nuvigil) (Y / N) _____
atomoxetine (Strattera) (Y / N) _____
dextroamphetamine (Dexedrine) (Y / N) _____
amphetamine/dextroamphetamine (Adderall) (Y / N) _____
methylphenidate (Ritalin) (Y / N) _____
lithium (Y / N) _____
valproic acid (Depakote) (Y / N) _____
oxcarbazepine (Trileptal) (Y / N) _____
carbamazepine (Tegretol) (Y / N) _____
lamotrigine (Lamictal) (Y / N) _____
topiramate (Topamax) (Y / N) _____
gabapentin (Neurontin) (Y / N) _____
pregabalin (Lyrica) (Y / N) _____
buspirone (BuSpar) (Y / N) _____
alprazolam (Xanax) (Y / N) _____
lorazepam (Ativan) (Y / N) _____
temazepam (Restoril) (Y / N) _____
oxazepam (Serax) (Y / N) _____
diazepam (Valium) (Y / N) _____
clonazepam (Klonopin) (Y / N) _____
zolpidem (Ambien) (Y / N) _____
eszopiclone (Lunesta) (Y / N) _____
zaleplon (Sonata) (Y / N) _____
olanzapine (Zyprexa) (Y / N) _____
risperidone (Risperdal) (Y / N) _____
ziprasidone (Geodon) (Y / N) _____
quetiapine (Seroquel) (Y / N) _____
aripiprazole (Abilify) (Y / N) _____
lurasidone (Latuda) (Y / N)_____
asenapine (Saphris) (Y / N) _____
brexpiprazole (Rexulti) (Y / N) _____