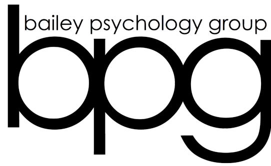

Melissa Ann Bailey Psy,D.
clinical psychologist, PSY17402

assessment • therapy • consultation

1536 W. 25th Street, Suite 108 • San Pedro, CA 90732 • 310-913-1136
Fax: 877.454.6994 • drmelissabailey@gmail.com • drmelissabailey.com

RE: Psychological Evaluation

Dear Patient:

Prior to surgery every patient must have a psychological evaluation. This is a normal part of the pre-operative procedures. Your surgeon requires it, as does your insurance company in order to get approval for the surgery. There is no reason to be nervous. The evaluation process is a tool to help make your surgery and post-operative journey a success.

Enclosed are some assessments that you are required to complete for your psychological evaluation. The American Society of Bariatric Surgeons has established guidelines on how Bariatric psychological evaluations are to be performed. Testing instruments are a required part of the process. It is very important that you complete these forms yourself and by yourself using a pen. Being honest in your answers will help us develop a program that is right for you**. This service is billed to your insurance but there is a discount for cash paying patients.** Please note that I am completely separate from your surgeon and the facility.

I look forward to helping you with this process. And remember, I am here to help you and provide support. I will be calling or meeting with you to go over this information.

Sincerely,

Melissa Ann Bailey, Psy.D.
Licensed Clinical Psychologist

MELISSA BAILEY, PSY.D.
WWW.DRMELISSABAILEY.COM
310-913-113 FAX: 310-988-2883
DRMELISSABAILEY@GMAIL.COM

PLEASE FAX OR SCAN TO EMAIL, SCAN PREFERRED

TO: Melissa Bailey, Psy.D.	FROM:
COMPANY:	DATE:
FAX NUMBER: 877-454-6994 or scan to drmelissabailey@gmail.com	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
RE: Psychological Screening Attached	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

PLEASE FILL THIS OUT COMPLETELY SO I KNOW WHERE TO SEND YOUR REPORT AND HOW TO CONTACT YOU.

CONFIDENTIAL INFORMATION

Psychological Screening Information Attached

Your Name: ____________________________

Your Surgeon or surgery centers name (this is important so I know where to send the report):

____

Your Email address (so I can let you know I received your fax and send you important support information):

____

Your Contact number and best time to call:

____

Consent and Agreement for Psychological Testing and Evaluation

I, ____________________, agree to allow licensed clinical psychologist, Dr. Melissa Bailey (PSY17402, 3796), and/or her psychological assistants to perform the following services:

- Psychological testing, assessment, screening and/or evaluation
- Report writing
- Consultation with other providers outside of the surgeon if needed (with additional release of information)
- Other: ____

I understand that these services may include direct, face-to-face contact, record reviewing, phone contact, interviewing, and/or testing and scoring. There is a fee for these services and it will be billed to your insurance. **There is a discount for patients paying cash**. These fees also include the psychologist's time required for the reading of records, consultations with other providers, scoring, interpreting the results, and any other activities to support these services. I also understand that the results of the evaluation will be given to my physician to assist in making medical decisions. Once the report is completed it will become part of my permanent medical record with the surgeon. I understand that Dr. Bailey is completely separate from the surgeon and the facility.

I understand that this evaluation is to be done for the sole purpose of:

- Psychological screening prior to bariatric surgery

I also understand the psychologist agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting and scoring the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations.
2. Tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.) These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a safe place.

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate. I also agree that if the psychologist gives me any forms to fill out while not in the presence of the psychologist (i.e. at home) that I will be the one filling out the form without the help of anyone else. I also agree to this screening taking place on the phone, if necessary, and that I am in one of the four states that Dr. Bailey is licensed in: Arizona, California, Florida and Nevada.

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE&MEDI-CAL: I certify that the information given by my in applying for payment under XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the provider or organization furnishing the services or authorize such provider or organization to submit a claim to Medicare for payment to me. I request that payment under the medical insurance program be made either to me or to Melissa Bailey, Psy.D./Bailey Psychology Group/, PA services furnished me by Dr. Bailey during the next 12-month period.

ALL OTHER INSURANCE: I herby authorize Dr. M. Bailey, Psy.D, to submit a claim to my insurance carrier or its intermediaries for all covered services by the provider and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the provider or organization rendering the covered services for the next 12-month period. I authorize Dr. Bailey to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

I understand that services may be billed under Dr. Melissa Bailey, Psy.D, or Seven Star Billing, which supply support services for Dr. Bailey,./The Bailey Psychology Group, P.A. I have been given a copy of privacy policies.

PAYMENT DEFAULT: in the event of payment default, I agree to be responsible for any and all collection fees.

______________________________________ ____________________

Signature of Client (or parent/guardian) Date

Patient Information/Billing

Melissa Bailey, Psy.D. Licensed Clinical Psychologist

PLEASE SUPPLY FRONT AND BACK OF INSURANCE CARD ALSO

PATIENT: This section refers to the Patient Only

Name ________________________________ Sex____ Age___ Date of Birth____________
Address ____________________________________ Home Phone: (____)___________________
City __________________________ State ______ Zip ___________ SS# __________________
Marital Status __Single ___Married ___ Separated ___ Divorced ___Widowed
Employer ____ Occupation ___________________
Work Address _____________________________________ Work Phone (____)______________
City __________________________ State ____ Zip ______ Cell Phone (____)_______________

BILLING: Please complete if person responsible for bill is other than above patient

Name _____________________________________ Relationship to Patient __________________
Address ____________________________________ Home Phone: (____)___________________
City __________________________ State ____ Zip _______ SS# _________________________
Employer ____ Occupation ___________________
Work Address _______________________________ Work Phone (____)___________________
City __________________________ State ____ Zip ______ Cell Phone (____)_______________

INSURANCE: IF SELF PAY DO NOT FILL OUT- ONLY FILL OUT TOP DEMOGRAPHICS

Please give all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information of both carriers.

Primary Insurance: _______________
Insured Name _______________________
Relationship to Patient _______________
Subscriber ID Number _______________
Group Number______________________
Effective date _______________________
DOB of INSURED:_________________

Other Insurance: ___________________
Insured Name_________________________
Relationship to Patient _________________
Subscriber ID Number________________
Group Number ________________________
Effective date _________________________

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE&MEDI-CAL: I certify that the information given by my in applying for payment under XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the provider or organization furnishing the services or authorize such provider or organization to submit a claim to Medicare for payment to me. I request that payment under the medical insurance program be made either to me or to Melissa Bailey, Psy.D./ or. services furnished me by Dr. Bailey during the next 12 month period.

ALL OTHER INSURANCE: I herby authorize Dr. M. Bailey, Psy.D., to submit a claim to my insurance carrier or its intermediaries for all covered services by the provider and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the provider or organization rendering the covered services for the next 12 month period. I authorize Dr. Bailey to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

I understand that services may be billed under Dr. Melissa Bailey, Psy.D., or the following organizations which supply support services for Dr. Bailey, Inc.

PAYMENT DEFAULT: in the event of payment default, I agree to be responsible for any and all collection fees.

Signature: ____ Date:__________________
Patient/Guardian/Parent

Psychological Evaluation for Insurance Verification

Please complete the following. Our psychologist will review this along with all of your other pre-operative information and will be contacting you.

Name: ____________________________________

Date of Birth: ______________________________

Height: ________ Weight:___________

__Married __single __divorced __ widow

Who do you live with?:______________________

Do you have any history of any type of abuse—physical, sexual, emotional, domestic violence? And if so, when did it occur, did you get treatment for it?
____
____

Do you currently have any pending legal problems or lawsuits? Are you suing anyone? Current Bankruptcy?: ___________________________

What are some of the recent stressful events in your life? ______________________________________

What is your highest level of education?:
____

What is your current job? Where do you work and how long have you been in your current position:
____

Do you have any current or past workman's compensation claims? If so, then please describe:

(Please note having a psychiatric history does not exclude you from surgery.)
Are you currently seeing a psychologist/psychiatrist/therapist/counselor? And if so, for how long and for what issue:
____

Have you ever been hospitalized in a psychiatric facility? And if so, where and when?
____

Do you have a history of depression, anxiety or panic attacks? Please describe:
____

Do you ever get depressed about your weight? :
____

Are you currently taking any anti-depressant, anti-anxiety or any other psychotropic medication? Who prescribes it for you and what are the doses?
____

Do you smoke? Y N If yes, how long and how many cigarettes a day?____________________

Do you drink alcohol and if so when, how much?
____

Do you have any history of drug or alcohol abuse?
____

Have you ever been in a drug or alcohol rehabilitation facility?__________________

Have you ever been diagnosed by a professional with an eating episode?___________________

Do you ever feel out of control when you are eating? Please describe: __________________

Have you ever made yourself vomit, used diuretics, fasted, used laxatives or enemas, or engaged in excessive exercise after a large meal? Please describe: ___________________________

What is the #1 reason you want weight loss surgery?_______________________________
____

Has a medical doctor ever recommended the surgery? Y N

How long have you been thinking about the surgery?
____

What is your goal weight?________________

How long do you think it will take to accomplish your goals?________________________

PLEASE WRITE ANY OTHER COMMENTS ON THE REVERSE SIDE.

The psychologist will contact you for additional information. Your insurance will be charged for this service.

Melissa Bailey, Psy.D. 310-913-1136

THESE TESTS ARE SCREENING TOOLS AND ARE REQUIRED BY THE ASMBS FOR THE EVALUATION

Name: ____ Date completed: ________________

Below is a list of problems that a lot of people have. Read each one carefully and rate how much that problem has distressed you over the last 7 days. Please rate them as follows:

0 = not at all, 1=a little bit, 2=Moderately, 3=Quite a bit, 4= Extremely
Please circle the number next to the statement

How much were you distressed by:

1. Nervousness or shakiness inside	0	1	2	3	4
2. Faintness or dizziness	0	1	2	3	4
3. The idea that someone else can control your thoughts	0	1	2	3	4
4. Feeling others are to blame for most of your troubles	0	1	2	3	4
5. Trouble remembering things	0	1	2	3	4
6. Feeling easily annoyed or irritated	0	1	2	3	4
7. Pains in heart or chest	0	1	2	3	4
8. Feeling afraid in open spaces or on the streets	0	1	2	3	4
9. Thoughts of ending your life	0	1	2	3	4
10. Feeling that most people cannot be trusted	0	1	2	3	4
11. Poor appetite	0	1	2	3	4
12. Suddenly scared for no reason	0	1	2	3	4
13. Temper outbursts that you could not control	0	1	2	3	4
14. Feeling lonely even when you are with people	0	1	2	3	4
15. Feeling blocked in getting things done	0	1	2	3	4
16. Feeling lonely	0	1	2	3	4
17. Feeling blue	0	1	2	3	4
18. Feeling no interest in things	0	1	2	3	4
19. Feeling fearful	0	1	2	3	4
20. Your feeling being easily hurt	0	1	2	3	4
21. Feeling that people are unfriendly or dislike you	0	1	2	3	4
22. Feeling inferior to others	0	1	2	3	4
23. Nausea or upset stomach	0	1	2	3	4
24. Feeling that you are watched or talked about by others	0	1	2	3	4
25. Trouble falling asleep	0	1	2	3	4
26. Having to check and double-check what you do	0	1	2	3	4
27. Difficulty making decisions	0	1	2	3	4
28. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
29. Trouble getting your breath	0	1	2	3	4
30. Hot or cold spells	0	1	2	3	4
31. Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
32. Your mind going blank	0	1	2	3	4
33. Numbness or tingling in parts of your body	0	1	2	3	4
34. The idea that you should be punished for your sins	0	1	2	3	4
35. Feeling hopeless about the future	0	1	2	3	4
36. Trouble concentrating	0	1	2	3	4
37. Feeling weak in parts of your body	0	1	2	3	4

38. Feeling tense or keyed up	0	1	2	3	4
39. Thoughts of death or dying	0	1	2	3	4
40. Having urges to beat, injure, or harm someone	0	1	2	3	4
41. Having urges to break or smash things	0	1	2	3	4
42. Feeling very self-conscious with others	0	1	2	3	4
43. Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
44. Never feeling close to another person	0	1	2	3	4
45. Spells of terror or panic	0	1	2	3	4
46. Getting into frequent arguments	0	1	2	3	4
47. Feeling nervous when you are left alone	0	1	2	3	4
48. Others not giving you proper credit for your achievement	0	1	2	3	4
49. Feeling so restless you couldn't sit still	0	1	2	3	4
50. Feeling of worthlessness	0	1	2	3	4
51. Feeling that people will take advantage of you if you let them	0	1	2	3	4
52. Feeling of guilt	0	1	2	3	4
53. The idea that something is wrong with your mind	0	1	2	3	4

1. I eat sweets and carbohydrates without feeling nervous.	0	1	2	3	4
2. I think that my stomach is too big.	0	1	2	3	4
3. I eat when I am upset.	0	1	2	3	4
4. I stuff myself with food.	0	1	2	3	4
5. I think about dieting.	0	1	2	3	4
6. I think that my thighs are too large.	0	1	2	3	4
7. I feel extremely guilty after overeating.	0	1	2	3	4
8. I think that my stomach is just the right size.	0	1	2	3	4
9. I am terrified of gaining weight.	0	1	2	3	4
10. I feel satisfied with the shape of my body.	0	1	2	3	4
11. I exaggerate or magnify the importance of weight.	0	1	2	3	4
12. I have gone on eating bingers where I felt that I could not stop.	0	1	2	3	4
13. I like the shape of my buttocks.	0	1	2	3	4
14. I am preoccupied with the desire to be thinner.	0	1	2	3	4
15. I think about binging (overeating).	0	1	2	3	4
16. I think my hips are too big.	0	1	2	3	4
17. I feel bloated after eating a normal size meal.	0	1	2	3	4
18. I eat moderately in front of others and stuff myself when they're gone.	0	1	2	3	4
19. If I gain a pound, I worry that I will keep gaining.	0	1	2	3	4
20. I have the thought of trying to vomit in order to lose weight.	0	1	2	3	4
21. I think that my thighs are just the right size.	0	1	2	3	4
22. I think my buttocks are too large.	0	1	2	3	4
23. I eat or drink in secrecy.	0	1	2	3	4
24. I think that my hips are just the right size.	0	1	2	3	4
25. When I am upset, I worry that I will start eating.	0	1	2	3	4