Cynthia J. Turner
Licensed Psychologist
7505 Waters Ave., Suite E-2
Savannah, GA 31406
Office (912) 352-8658 Fax (912) 356-5492

We extend a warm welcome to you, our new patient. The quality of care we provide to our patients is important to us.

It is our policy to collect the total charge of $350.00 for the evaluation and report at the time of service excepting cases in which some managed care insurance policies apply. When you call for scheduling, these issues will be further discussed with you. Please note fees are subject to change.

WE GLADLY ACCEPT MASTERCARD, VISA, CASH, CASHIERS CHECK, OR MONEY ORDER (NO PERSONAL CHECKS, AMERICAN EXPRESS OR DISCOVER). Included in the fee: Administration of the MMPI-2 or MBMD test, clinical interview and evaluation, and a written psychosocial evaluation report.

We are located at 7505 Waters Ave. Suite E-2, in the business complex Park South. Park South is located between Eisenhower Drive and Mall Blvd. across the street from the Enmark gas station. Directions and a map to our office is attached.

We have an alarm entry system set up for patient confidentiality; therefore you will need to knock on the office door for admittance upon your arrival.

PLEASE NOTE: ANY CANCELLATIONS OR CHANGE IN THE SCHEDULING OF YOUR APPOINTMENT WILL REQUIRE A 24 HOUR NOTICE. YOUR TIME IS RESERVED FOR YOU AND YOU ONLY. WE DO NOT DOUBLE-BOOK OR OVERBOOK APPOINTMENTS. CANCELLATIONS PROBABLY WILL RESULT IN A SUBSTANTIAL DELAY WITH REGARD TO YOUR EVALUATION AND SUBSEQUENTLY TO THE SCHEDULING OF YOUR SURGERY.

Please feel free to call the office at any time if you have questions, concerns or issues regarding the evaluation process and/or recommendations. Dr. Turner or Hyacinth Townsend will be glad to assist you.

Sincerely,

Cynthia J. Turner, Ph.D.

DIRECTIONS TO DR. CYNTHIA TURNER'S OFFICE
PARK SOUTH OFFICE COMPLEX
7505 WATERS AVE., SUITE E-2
SAVANNAH, GA 31406

FROM INTERSTATE 16 AND LYNES PARKWAY (516), MERGES INTO DERENNE AVE.

TURNER RIGHT ON WATERS AVE.

DRIVE APPROXIMATELY TWO MILES

AFTER CROSSING THE EISENHOWER INTERSECTION, LOOK FOR PARK SOUTH OFFICE COMPLEX, 7505 WATERS AVE. ACROSS FROM THE ENMARK GAS STATION.

TURN RIGHT INTO THE PARKING LOT, THEN LEFT TOWARDS BUILDING E.

THE OFFICE IS UPSTAIRS TO THE LEFT, SUITE E-2

FROM INTERSTATE 95, TAKE 204 TOWARDS SAVANNAH, WHICH MERGES INTO ABERCORN STREET.

TURN RIGHT ONTO MALL BLVD.

AT THE THIRD RED LIGHT, TURN LEFT ONTO WATERS AVE.

DRIVE APPROXIMATELY ONE QUARTER MILE.

PARK SOUTH OFFICE COMPLEX ON THE LEFT, DIRECTLY ACROSS FROM THE ENMARK GAS STATION.

PATIENT INFORMATION

Name of Patient: ____
(First) (MI) (Last)

Address: ____

City: _____________________________ State: _____________ Zip Code: _____________

Telephone(s): ____________________ _____________________ ___________________
(Home) (Work) (Cell)

May we leave messages for you at home? Y or N Answering Machine? Y or N

May we contact you at work? Y or N Voice Mail? Y or N

Marital Status: _________________ Age: ______________ DOB: ___________________

Did you complete High School, Technical School or College? Please Circle

List any Degrees: _________________________ Total # of Educational Years: ________

SS# __________________________ Employer: ___________________________________

Occupation: _______________________________ How Long:_______________________

Primary Care Physician: ____

Telephone: ______________________________ Fax: _____________________________

Insurance Co:___________________________ Subscriber ID # ______________________

Group #_______________________ Insurance Telephone # _________________________

Policy Holders Name: _________________________Policy Holders DOB#:____________

Policy Holders SS#: _________________________ Is a preauthorization required? Y or N

Are you currently receiving Medicare Benefits or Medicare Disability? Y or N

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Self-pay patients are responsible for payment of the total charges for the initial evaluation. We cannot guarantee payment by the insurance company. Patients offering health insurance as complete or partial payment of their fees may do so by assigning anticipated insurance payments to Dr. Cynthia Turner. However, your deductible, co-payment or co-insurance are due at the time of service. **Payment is expected at the time of your visit.**

I hereby assign all medical benefits to Cynthia J. Turner, Ph.D. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL THE CHARGES WHETHER OR NOT PAID BY THE SAID INSURANCE COMPANY. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

_______________________________________ _____________________

SIGNATURE OF PATIENT **DATE**

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<u>Statement of Client Rights and Responsibilities</u>

1. My goal is to always treat you competently, ethically, and respectfully.

2. You can stop seeing me without any obligation other than to pay for services you have received or appointments not cancelled 24 hours in advance.

3. Feel free to ask questions about my approach and methods or to decline any recommendations I make.

4. You can see you records.

5. Our discussions are confidential. This means that, except as noted below, I won't release information that identifies you to anyone without your written permission.

6. In certain situations, by law, I must reveal information about you to others **even without your permission:**

   (a) In emergencies, including the risk that you may harm yourself or others, I'll share information necessary to keep you and others healthy and safe.

   (b) I am obligated to release to a court of law any information specifically described by a court order.

   (c) I will report to the Department of Family and Children Services any reasonable suspicion I have that a minor is being abused or neglected.

   (d) I will release any information necessary to collect any outstanding bill for services rendered to you.

Please show your understanding of the above by signing the above by signing the below.

________________________________ ____________________
Signature of Patient Date

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HIPAA CONSENT FORM

I HAVE READ AND UNDERSTOOD THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WHICH HAS BEEN PRESENTED TO ME BY DR. TURNER.

SIGNATURE: ______________________________

PRINT: ____________________________________

DATE: _____________________________________

I HAVE BEEN OFFERED BUT DO NOT WANT A COPY OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

SIGNATURE: ______________________________

PRINT: ____________________________________

DATE: _____________________________________

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AUTHORIZATON FOR COMMUNICATION

I hereby authorize communication between **CYNTHIA J. TURNER, Ph.D., and**

Name: **Memorial Health Bariatrics including all Team Members**

Address or Agency: **4600 Waters Avenue, Savannah, GA 31404**

Phone or Fax #: **912-350-3438 or 912-350-9037**

As agreed below. Unless revocation is received, this consent will expire one year after the date indicated. I understand that I have the right to revoke this consent at any time.

Patient Name: ____

Date of Birth: ____

I. **RELEASE AND OBTAIN INFORMATION:** For the purpose of psychosocial evaluation and referral for treatment.

INFORMATION TO BE RELEASED: Psychosocial report, MMPI-2 or MBMD, clinical interview data, and other test materials.

Patient Signature: ______________________________ Date: _________

Printed Name: ____

Witness Signature: _____________________________ Date: _________

AUTHORIZATON FOR COMMUNICATION

I hereby authorize communication between CYNTHIA J. TURNER, Ph.D., and

Name: ____

Address or Agency: ____

Phone or Fax #: ____

As agreed below. Unless revocation is received, this consent will expire one year after the date indicated. I understand that I have the right to revoke this consent at any time.

Patient Name: ____

Date of Birth: ____

I. **RELEASE AND OBTAIN INFORMATION:** For the purpose of: Psychosocial evaluation and referral for treatment.

INFORMATION TO BE RELEASED: Psychosocial report, phone consultation, MMPI-2 OR MBMD, clinical interview data, and other test materials.

Patient Signature: ______________________________ **Date**: ________

Witness Signature: ______________________________ Date: _________

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AUTHORIZATON FOR COMMUNICATION

I hereby authorize communication between CYNTHIA J. TURNER, Ph.D., and

Name: Anisa Grantham, LPC, NCAC_(Instructor for Success Habits Workshop)

Address or Agency: 613 Towne Park Drive West, Suite 103 Rincon, GA 31326_______

Phone #: 912-826-0918 Fax #: 912-826-0959

As agreed below. Unless revocation is received, this consent will expire one year after the date indicated. I understand that I have the right to revoke this consent at any time.

Patient Name: ____

Date of Birth: ____

I. RELEASE AND OBTAIN INFORMATION for the purpose of: Psychosocial evaluation and referral for treatment.

Information to be released: Psychosocial report, phone consultation, and other test materials.

Patient Signature: _______________________________ Date: _________

Witness Signature: ______________________________ Date: _________

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AUTHORIZATION FOR COMMUNICATION

I HEREBY AUTHORIZE **CYNTHIA J. TURNER, PH.D**. TO MAIL A COPY OF THE SUMMARY SECTION OF MY PSYCHOSOCIAL EVALUATION TO MY HOME ADDRESS.

Patient Name:____

Date of Birth:____

Cynthia J. Turner, Ph.D.

CLINICAL INTERVIEW & EVALAUTION

Welcome! Thank you for taking the time to answer the following questions prior to our interview. This will give us more time to discuss issues and test results in-depth. I'm looking forward to speaking with you soon.

Date ________ Name______________________________ DOB _________ Age _______

Gender ______ Race________ Surgery: Lap-Band ____ Roux-en-Y ____ Sleeve ______

Surgeon: ____ Dr. Whipple _____ Current height is: _____ ft. _____ inch

Current BMI: _____ Current weight: ______ Highest weight/BMI: ________ Year _____

When did your problem with obesity begin? _______________________________________

Were there specific issues such as: stopping smoking, pregnancy, illness, divorce, stress, shift work, with a surge of weight gain? YES or NO If yes, please circle.

Were you adopted? ______________________ If so at what age? ____________________

Please list your mother's / father's / brother's / sister's (half & full) and their ages. Indicate approximately their weight, and if they are living or deceased.

How many brothers do you have? _____ How many sisters do you have? _____

Mother's Age ______ Wt._______ Living/Deceased Cause of death _________________

Father's Age ______ Wt.________ Living/Deceased Cause of death _________________

Brother's/Sister's Age ___Wt. ____ Living/Deceased Cause of death _________________

Brother's/Sister's Age ___Wt. ____ Living/Deceased Cause of death _________________

Brother's/Sister's Age ___Wt. ____ Living/Deceased Cause of death _________________

Brother's/Sister's Age ___Wt. ____ Living/Deceased Cause of death _________________

Brother's/Sister's Age ___Wt. ____ Living/Deceased Cause of death _________________

Brother's/Sister's Age ___Wt. ____ Living/Deceased Cause of death _________________

Brother's/Sister's Age ___Wt. ____ Living/Deceased Cause of death _________________

Brother's/Sister's Age ___Wt. ____ Living/Deceased Cause of death _________________

Brother's/Sister's Age ___Wt. ____ Living/Deceased Cause of death _________________

Any extended family members with morbid obesity issues such as grandmother, grandfather, aunts, uncles, cousins on either side? **(CIRCLE ANSWERS)**

<u>CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:</u>

Heart Attack

High Blood Pressure

Congestive Heart Failure

Stroke

Clots

Snoring/Sleep Apnea/CPAP

Swelling/Edema

Fatty Liver Disease

Diabetes/Any stage

Elevated Cholesterol/Triglycerides

GERD

Osteoarthritis

Joint Pain

Gout

Back Pain

Constant Fatigue

Bladder Incontinence

Polycystic Ovarian Syndrome

Asthma

Gallstones

Infertility

Endocrine/Metabolism

Depression

Anxiety

Pseudotumor

Quality of Life Issues

Cancer

List other significant medical problems not listed above: ____________________________

Are you currently up-to-date with routine visits with your physician including: colonoscopy, mammograms, physicals, pap smears, and blood work? Y / N

Do you take medications as directed? Y / N

List all major surgeries, including Lap-Band or Roux-en-Y bypass, liposuction or other weight loss surgeries: ____

____

Morbid obesity has many causes, including genetics, medical issues, your schedule and access to different foods. Eating patterns and food choices are part of the equation. Please describe in general what you think your biggest problem is with food and eating behaviors and in your opinion, what has caused your obesity? ____________________

____

How many major diets have you tried? Please list them: _________________________

____

What was the most weight you lost, on which diet, what year, and how long did you maintain the weight loss?

Most Weight __________ Diet ______________________________________

Year ________________ How Long ______________________________

Do you know others who have had weight loss surgery? Y / N

<u>CIRCLE ANY BEHAVIORS YOU HAVE HAD *** IN THE PAST FIVE YEARS ***** AND INDICATE THE FREQUENCY IN TIMES PER WEEK WHICH THEY MAY OCCUR.</u>**

Addiction to Any Specific Food Y / N Times per week __________

List foods: ____

Bingeing (eating extremely/ unusually large amounts of food in a short time span, such as 2-3 hours, and feeling out of control)
Y / N Times per week ___________

Buffets Y / N Times per week __________

Fast food restaurants Y / N Times per week __________

Sweetened Beverages Y / N Times per week __________

Sodas, tea, coffee or ____

Craving Specific Foods Y / N Times per week __________

List Foods ____

Grazing Y / N Times per week __________

Snacking Y / N Times per week __________

Picking or tasting Y / N Times per week __________

Night Eating Y / N Times per week __________

Skipping Meals Y / N Times per week __________

Hiding Foods Y / N Times per week __________

Eating Secretly Y / N Times per week __________

Do experience a fullness sensation after eating? Y / N

Eating when upset, sad, anxious bored, angry, emotional, when driving, stressed, watching TV? **(CIRCLE ANSWERS)** Y / N Times per week __________

Purging (vomiting or laxatives) Y / N Times per week __________

Unusually large intake amounts of: Fats, carbohydrates, or sweets.
(CIRCLE ANSWERS)

If no then, do you eat less than, about same, more than, or much more than an average person? **(CIRCLE ANSWERS)**

What is your estimated daily calorie intake? ____________________________________

Have you ever been diagnosed with anorexia, bulimia, binge eating disorder, exercise bulimia, sugar addiction, or purging/laxatives? Y / N

Please list: ____

What is your goal weight or desired weight? ____________________________________

What are your goals, expectations, and hopes for yourself following your weight loss?

____

____

PERSONAL, SOCIAL AND FAMILY HISTORY:

Where did you grow up? City ___________________________ State ______________

Did you grow up in a family with one or both parents, single, or married? **(Circle)**

Biological Parent's occupations: Father's _____________________________________

Mother's _____________________________________

Step-Parent (s) occupations: Father's _____________________________________

Mother's _____________________________________

Describe any divorce or step parenting experiences you may have had as a child:

____

____

Describe your most painful childhood memories: ________________________________

____

____

Described what role food played in your home growing up: ________________________

____

Was there alcohol abuse, substance abuse or family violence in your home during your childhood? **If yes, please circle your answers.**

Have you ever been a victim of physical abuse, sexual abuse, verbal abuse, neglect, poverty, assault, victim of a violent crime? **If yes, please circle your answers.**

Have you served in the military? **If yes, please explain:** __________________________

Have you ever been diagnosed with Post-Traumatic Stress Disorder? Y / N

If so, when _______________Who made the diagnosis: __________________________

Were you prescribed medication? If so, please list: ______________________________

Number of marriages you have had and how long: _______________________________

____

Number of divorces and issues related to divorce: ______________________________

____

Current marriage/spouse's age _______ spouse's occupation ______________________

Spouse's weight issues: ____

Does your spouse support your efforts to lose weight? Y / N

Does your spouse tease you about your weight, make painful remarks, or try to control it? Y /N

Is your spouse abusive in any way past or present? Y/N

Explain: ____

Describe your greatest marital challenge: _____________________________________

____

Do you have children? **If yes, please complete:**

Male / Female Age: ______ Weight: ___________ General Health ____________

Male / Female Age: ______ Weight: ___________ General Health ____________

Male / Female Age: ______ Weight: ___________ General Health ____________

Male / Female Age: ______ Weight: ___________ General Health ____________

Please describe your current home environment: _________________________________

____

Do you currently own your home; rent, live with parents or roommate? (**CIRCLE**)

List others who live in your home: ____

____

List family members who have any of the following:

Psychiatric disorders, bipolar, schizophrenia, depression, anxiety, institutionalization:

____

____

Substance abuse/alcoholism: ____

____

Suicides/homicides: ____

____

Describe any structured exercise program last year: ______________________________

____

CIRCLE any that apply: **recent legal problems / lawsuits / bankruptcy / major financial problems / DUI**

Describe your stress management strategies, including hobbies, recreational activities, and leisure activities: ____

____

CIRCLE any that apply: Outpatient psychotherapy, inpatient psychiatric hospitalization, intensive pastoral counseling, marital counseling, drug or alcohol rehab. Past or current, in childhood or as an adult.

Describe: ____

____

List any psychoactive medications you have ever used or are currently using, including antidepressants, anxiety meds, mood stabilizers, pain pills, meds for ADD or ADHD, sleeping pills or other:

____

Have you ever abused or been addicted to alcohol, drugs, gambling, spending, shopping, or sex? **If yes, please circle.**

YOU ARE REQUIRED TO BRING A LIST OF ALL MEDICATIONS CURRENTLY BEING TAKEN. INCLUDING FREQUENCY AND DOSAGE AMOUNTS.

LIST BELOW:

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

10. ______________________________

On a scale of 0 - 10, **(10 being the highest)** how would you rate your stress level:

____

On a scale of 0 - 10, **(10 being the highest)** how would you rate your level of coping and functioning, in daily responsibilities, activities, and work performance:

____

Describe your current moods, day to day: ______________________________________

CIRCLE if you have or have had any of the following symptoms:

GENERALIZED ANXIETY

ANXIETY/PANIC ATTACKS

AGORAPHOBIA (unable to leave your home due to anxiety)

SOCIAL ANXIETY

OBSESSIVE COMPULSIVE DISORDER

PHOBIAS

PTSD (nightmares, flashbacks, or vivid recalls)

RECURRENT OR SEVERE INSOMNIA

SLEEP APNEA/SNORING

DEPRESSION

HOPELESSNESS

IRRITABILITY

CHRONIC STRESS

FRUSTRATION

WITHDRAWAL OR ISOLATION

ANGER MANAGEMENT PROBLEM

BOTTLING ANGER

HOLDING MY FEELINGS IN "PEOPLE-PLEASING"

EXPLOSIVE EPISODES

BIPOLAR DISORDER

MANIC EPISODE

BORDERLINE PERSONALITY DISORDER

BODY DYSMORPHIC DISORDER **(severe anxiety around a feature of the body)**

DISABILITY OF ANY KIND

IMPAIRED ACTIVITIES OF DAILY LIVING

PSYCHOSIS - HALLUCINATIONS/ HEARING VOICES

MENTAL OR PSYCHIATRIC BREAKDOWN **(more than a few days)**

SELF INJURIOUS BEHAVIOR **(cutting when upset)**

SUICIDE ATTEMPT / OVERDOSE

THOUGHTS OF SUICIDE **(past or present)**

SHOCK THERAPY **(ECT)**

ATTENTION DEFICIT DISORDER

SEXUAL PROBLEMS

Check any of the following statements that apply to you:

_____ Thoughts of food occupy much of my time.

_____ Sometimes I eat huge amounts of food, feel sick and out of control.

_____ I have sometimes purged myself by inducing vomiting or using a laxative or enema after overeating.

_____ I overeat by snacking or grazing continuously during the day.

_____ I hide food for future bingeing or eating.

_____ I consider food to be my friend.

_____ I use food frequently to manage emotions, stress, or boredom.

_____ I have specific ways to eat when I am emotionally upset, sad, angry, afraid, anxious, or ashamed.

_____ I prefer to eat alone or I am uncomfortable eating with others.

_____ Sometimes when eating, I am afraid I will lose control and not be able to stop.

_____ I frequently eat large amounts of high calorie, sugary foods.

_____ I frequently eat desserts, candies, pastries or other sweets.

_____ I feel addicted to chocolate / ice cream / cokes or sodas. **(CIRCLE)**

_____ I feel addicted to ____**(fill in the food).**

_____ Following ingestion of a very large amount of food, I feel "hung over," bloated, or fatigued the next day.

_____ I feel depressed and guilty after eating a large amount of food.

_____ In the past, I have been told that I have an eating disorder such as binge eating disorder, anorexia, bulimia, or exercise bulimia.

_____ I drink very large amounts of sugar sweetened beverages such as: regular Cokes, Starbucks, Kool-Aid, fruit juices, or sweet tea. **(CIRCLE)**

Explain:____

_____ I am a big stress eater.