CLIENT INFORMATION

Client name _____

Mailing address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

Sex (M) (F) Date of birth _____ Marital status _____

Referred by _____

I received a copy of the "Office Policies and Procedures"

_____ _____

Signature of Client or Responsible party Date

CLIENT INFORMATION

Client name _____

Mailing address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

Sex (M) (F) Date of birth _____ Marital status _____

Referred by _____

I received a copy of the "Office Policies and Procedures"

_____ _____

Signature of Client or Responsible party Date

Office Use Only

Therapist _____ _ DX _____ Feeinfo_____

HEALTH CARE ASSESSMENT

Please complete this form for yourself as thoroughly as you can. If you do not want to answer a question, just leave it blank.

Client name _____

What is the main reason you are seeking counseling at this time? _____

_____

Please list any medications you are currently taking _____

_____

Do you have any current concerns about your physical health? □ Yes □ No If yes, please describe your

concerns _____

Do you get 3 balanced meals each day? □ Yes □ No Do you get regular physical exercise? □ Yes □ No

Are you currently having suicidal thoughts? □ Yes □ No

Do you have any sleep problems? □ Yes □ No

If yes, please describe_____

How many alcoholic drinks do you have? ____ per day ____ per week

Do you currently use drugs? □ Yes □ No

Name of primary care doctor _____ Dr.'s phone _____

Doctor's address_____

By signing below I authorize Robert Hay, Ph.D. to release or receive my treatment records (or the records of my child) with the primary care physician.

I understand that the specific information to be disclosed may include history of substance abuse or mental health treatment, information concerning communicable diseases such as HIV and AIDS, lab test results, treatment progress, and any related information.

I understand that I may refuse to sign this authorization, and that I may revoke it at any time except to the extent that action has been taken in reliance on it. I may revoke this authorization by informing Dr. Hay in writing. This authorization will expire in 180 days.

_____ _____

Signature of client or responsible party Date

NAME_____ DATE_____

Below is a list of problems that people sometimes have. Please read each one carefully. Put an "X" in the column that best describes HOW MUCH DISCOMFORT THAT PROBLEM CAUSED YOU DURING THE PAST WEEK, INCLUDING TODAY.

0-Not at all
1-A little bit
2-Moderately
3-Quite a bit
4-Extremely

IN THE PREVIOUS WEEK HOW MUCH WERE YOU BOTHERED BY:

		0	1	2	3	4
1.	Headaches	☐	☐	☐	☐	☐
2.	Nervous or shakiness inside	☐	☐	☐	☐	☐
3.	Repeated unpleasant thoughts that won't leave your mind	☐	☐	☐	☐	☐
4.	Faintness or dizziness	☐	☐	☐	☐	☐
5.	Loss of sexual interest or pleasure	☐	☐	☐	☐	☐
6.	Feeling critical of others	☐	☐	☐	☐	☐
7.	The idea that someone else can control your thoughts	☐	☐	☐	☐	☐
8.	Feeling others are to blame for your problems	☐	☐	☐	☐	☐
9.	Trouble remembering things	☐	☐	☐	☐	☐
10.	Worried about sloppiness or carelessness	☐	☐	☐	☐	☐
11.	Feeling easily annoyed or irritated	☐	☐	☐	☐	☐
12.	Pains in heart or chest	☐	☐	☐	☐	☐
13.	Feeling afraid in open spaces or on the street	☐	☐	☐	☐	☐
14.	Feeling low energy or slowed down	☐	☐	☐	☐	☐
15.	Thoughts of ending your life	☐	☐	☐	☐	☐
16.	Hearing voices other people do not hear	☐	☐	☐	☐	☐
17.	Trembling	☐	☐	☐	☐	☐
18.	Feeling that most people cannot be trusted	☐	☐	☐	☐	☐
19.	Poor appetite	☐	☐	☐	☐	☐
20.	Crying easily	☐	☐	☐	☐	☐
21.	Feeling shy or uneasy with the opposite sex	☐	☐	☐	☐	☐
22.	Feelings of being trapped or caught	☐	☐	☐	☐	☐
23.	Suddenly scared for no reason	☐	☐	☐	☐	☐
24.	Temper outbursts that you could not control	☐	☐	☐	☐	☐
25.	Feeling afraid to go out of your house	☐	☐	☐	☐	☐
26.	Blaming yourself for things	☐	☐	☐	☐	☐
27.	Pains in lower back	☐	☐	☐	☐	☐
28.	Feeling blocked in getting things done	☐	☐	☐	☐	☐
29.	Feeling lonely	☐	☐	☐	☐	☐
30.	Feeling blue	☐	☐	☐	☐	☐
31.	Worrying too much about things	☐	☐	☐	☐	☐
32.	Feeling no interest in things	☐	☐	☐	☐	☐
33.	Feeling fearful	☐	☐	☐	☐	☐
34.	Your feelings easily being hurt	☐	☐	☐	☐	☐
35.	Other people being aware of your private thoughts	☐	☐	☐	☐	☐
36.	Feeling others do not understand you or are not sympathetic	☐	☐	☐	☐	☐
37.	Feeling that people are unfriendly or dislike you	☐	☐	☐	☐	☐
38.	Having to do things very slowly to insure correctness	☐	☐	☐	☐	☐

TURN OVER TO NEXT PAGE

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		0	1	2	3	4
39.	Heart pounding or racing	☐	☐	☐	☐	☐
40.	Nausea or upset stomach	☐	☐	☐	☐	☐
41.	Feeling inferior to others	☐	☐	☐	☐	☐
42.	Soreness of your muscles	☐	☐	☐	☐	☐
43.	Feeling that you are watched or talked about by others	☐	☐	☐	☐	☐
44.	Trouble falling asleep	☐	☐	☐	☐	☐
45.	Having to check and double-check what you do	☐	☐	☐	☐	☐
46.	Difficulty making decisions	☐	☐	☐	☐	☐
47.	Feeling afraid to travel on buses, subways, or trains	☐	☐	☐	☐	☐
48.	Trouble getting your breath	☐	☐	☐	☐	☐
49.	Hot or cold spells	☐	☐	☐	☐	☐
50.	Avoiding things, places or activities because they frighten you	☐	☐	☐	☐	☐
51.	Your mind going blank	☐	☐	☐	☐	☐
52.	Numbness or tingling in parts of your body	☐	☐	☐	☐	☐
53.	A lump in your throat	☐	☐	☐	☐	☐
54.	Feeling hopeless about the future	☐	☐	☐	☐	☐
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57.	Feeling tense or keyed up	☐	☐	☐	☐	☐
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59.	Thoughts of death or dying	☐	☐	☐	☐	☐
60.	Overeating	☐	☐	☐	☐	☐
61.	Feeling uneasy when people are watching or talking about you	☐	☐	☐	☐	☐
62.	Having thoughts that are not your own	☐	☐	☐	☐	☐
63.	Having urges to hurt, injure, or harm someone	☐	☐	☐	☐	☐
64.	Awakening in the early morning	☐	☐	☐	☐	☐
65.	Repeating the same actions such as touching, counting, washing	☐	☐	☐	☐	☐
66.	Sleep that is restless or disturbed	☐	☐	☐	☐	☐
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68.	Feeling very self-conscious with others	☐	☐	☐	☐	☐
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72.	Feeling uncomfortable about eating or drinking in public	☐	☐	☐	☐	☐
73.	Getting into frequent arguments	☐	☐	☐	☐	☐
74.	Feeling nervous when you are left alone	☐	☐	☐	☐	☐
75.	Others not giving you credit for your achievements	☐	☐	☐	☐	☐
76.	Feeling lonely even when you are with people	☐	☐	☐	☐	☐
77.	Feeling so restless you couldn't sit still	☐	☐	☐	☐	☐
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84.	The idea that you should be punished for your sins	☐	☐	☐	☐	☐
85.	Thoughts and images of a frightening nature	☐	☐	☐	☐	☐
86.	The idea that something is wrong with your body	☐	☐	☐	☐	☐
87.	Never feeling close to another person	☐	☐	☐	☐	☐
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HEALTH CARE ASSESSMENT

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ROBERT HAY, Ph.D., PSYCHOLOGIST

303 N. Carroll, #120
Denton, TX 76201

Voice 940 243-8000
Fax 940 381-0481

OFFICE POLICIES AND PROCEDURES (rev. 10-10-2014)

This document (the Agreement) contains important information about my professional services and business policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some impressions of what our work will include if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

If you miss an appointment and do not call to reschedule within 10 days, I will assume that you have discontinued your counseling. Of course, you can call to resume your counseling at a later time.

PROFESSIONAL FEES

For individual counseling my fee is $145 for the initial evaluation and $100 for subsequent meetings. The typical therapy session is 45 to 50 minutes. My fee for couple or family counseling is $120. Your fee may be less (or even zero) if other arrangements have been made with your insurance company. Limited appointments are available evenings and weekends for self pay only ($150 for individual therapy, and $180 for marital therapy).

Other services such as report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me will be charged at the same rate.

Although testifying in legal proceedings is not a professional service I offer, if you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation of records and transportation, even if I am called to

participate by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation, travel, and attendance at any legal proceeding. A minimum payment of $500 is due prior to any such involvement.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. My telephone is answered by voicemail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I need to share information for administrative purposes, such as scheduling, or billing. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient.
- The mental health professionals who work in this office share certain expenses and administrative functions. Because they are completely independent in providing you with clinical services, I am fully responsible for those services. Your clinical records are separately maintained and no other provider in this office will access your records without your permission.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency, usually the Department of Protective and Regulatory Services. Once such report is filed, I may be required to provide additional information.

- If I determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon your request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For children between 16 and 18, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from the patient and his/her parents that the parents consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. In circumstances of financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible

for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

Your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE, AND THAT YOU AGREE TO RECIEVE PROFESSIONAL PSYCHOLOGICAL SERVICES FROM ME, INCLUDING COUNSELING AND PSYCHOLOGICAL ASSESSMENT.

_____ _____

Name Date

_____ _____

Name Date