

WILSON PSYCHOLOGICAL ASSOCIATES, PLLC
417 East Silas Street
Bartlesville, Oklahoma 74003
(918) 337-6050 Phone
(918) 337-6061 Fax

Psychotherapy Information, Disclosure, and Contract

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you may have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

While the detail included in this document may seem tedious, I believe it is important that you understand from the beginning how situations will be handled in the typical work encountered in my practice. I believe you have the right to know the parameters of our relationship at the outset of our work together. Please initial each page and sign the signature page if you are in agreement with the terms presented.

PSYCHOLOGICAL SERVICES - PSYCHOTHERAPY

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be the most successful, you will have to work on issues we talk about both during our sessions and at home.

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 benefits for those who go through it. 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 first impressions of what our work will include and a treatment plan to follow, 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. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to set up a meeting with another mental health professional for a second opinion.

My approach to therapy is called Cognitive behavioral therapy (CBT). This is a philosophy of psychotherapy characterized as structured, practical and effective in treating a number of psychological problems encountered in the course of living. This type of therapy is a strong tool that works by identifying and addressing the behaviors and thinking patterns that maintain the problem or problems you are facing and focuses on your here-and-now thoughts and actions. We will look at how actions, or lack of actions, contribute to whether you feel bad or good. We will also look at the negative and unrealistic ways of thinking that may make you feel depressed, anxious, or uncomfortable. Cognitive behavioral therapy can equip you with the tools to think more realistically, to grow and to live and feel better. At times, there are problems we may work through together, examining both the potential rewards and consequences of particular courses of action you may take. While the therapy is typically focused on the here-and-now, it is sometimes helpful to revisit past experiences from which you may have learned lessons about living that may now outlive their usefulness. While traditional therapy focuses on insight and self-knowledge, CBT is more oriented to action and change. It is important to note that you will always guide the work through the goals and objectives you have for therapy.

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I am doing or that I recommend you do, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and you can request that I refer you to someone else if you decide I am not the right therapist for you. You are free to leave therapy at any time, though my preference, if you decide to terminate therapy with me as your therapist, is for us to have one or two sessions to end our work together.

You normally will be the one who decides when therapy will end, with *four exceptions*. 1) If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. 2) If I am not, in my judgment, able to help you because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. 3) If you miss, without cancelling with appropriate notice, three scheduled sessions, I reserve the right to terminate therapy with you. 4) If you do violence to, threaten (verbally or physically), or harass me, the office staff, my family, or family members of the office staff, or damage or destroy property of any of the above mentioned persons, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but I cannot guarantee they will accept you for treatment.

I do not have social relationships with clients or former clients because that would not only be unethical and illegal, it would be an abuse of the power that I have as a therapist. If you have questions about this policy, please bring them with you to your session so we may discuss them.

PSYCHOLOGICAL SERVICES – PSYCHOLOGICAL ASSESSMENT

At times, I may feel that psychological assessment is necessary to assist me in understanding your problem and to facilitate treatment; consequently, I may recommend another provider or I conduct this type of evaluation. Or, you may have been referred for psychological assessment by other professionals (e.g., physicians, teachers, counselors, or attorneys). Psychological assessment

typically consists of a diagnostic interview and various objective and projective instruments measuring characteristics such as intelligence, memory, attention/concentration, personality, neuropsychological status, and/or psychological/emotional symptoms. If I recommend testing, you will be provided with a separate information form regarding the testing process.

MEETINGS

To schedule an initial appointment, I require you to provide me with a valid credit card to be kept on file in your HIPPA compliant and encrypted case file. If you do not provide sufficient notice of cancellation and break an appointment for reasons beyond your control, payment for your broken appointment is your responsibility and will not be billed to your insurance company. Your credit card will automatically be charged for the broken appointment fee. Broken appointment fees are the full session fee (not your copay) and are not covered by your insurance.

With regard to psychotherapy, I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually recommend that you schedule one 53-minute session (one appointment hour of 53 minutes duration) per week as the schedule allows, although some sessions may be longer or more frequent. It is important to note that shorter sessions may be scheduled, but due to the nature of a typical therapy day, they are not routinely scheduled and must receive therapist approval before being scheduled.

As the schedule is done on a first-come, first-served basis, it is important that you make advance preparation with my office manager, Bekah, for scheduling our meetings. I open my schedule for the third succeeding month on the fifteenth of each new month; any new appointments may be scheduled for the third succeeding month beginning that day (e.g., I will open the December schedule on September 15th and you may then schedule any appointments you desire for the month of December; January will be opened on October 15th, and so on). *It is best for you to schedule your time well in advance and cancel if you decide you no longer need to come or have conflicts that arise as the schedule tends to fill up one to two months in advance.* As only you know your schedule, I rely on you to make sure you are scheduled for the frequency of appointments that we agree upon.

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 53 minutes. If you are late, we will end on time and not run over into the next person's session.

Once an appointment hour is scheduled, to avoid a broken appointment fee, I ask you to provide advance notice of your desire to cancel *by 12:00 pm the business day before your scheduled appointment, unless we both agree that you were unable to attend due to circumstances beyond your control.* If it is possible, I will try to find another time to reschedule your appointment. If you do not provide sufficient notice of cancellation, payment for your broken appointment is your responsibility and will not be billed to your insurance company; you will need to pay the broken appointment fee at or before your next session. This cancellation policy applies to meetings scheduled, and to each hour scheduled for psychological assessments. If you break an appointment for reasons that are not situations *beyond your control*, I will require that you have a valid credit card on file with my office for the duration of your future treatment. If you miss another

appointment for reasons not beyond your control, your credit card will automatically be charged the broken appointment fee. If you develop a pattern of missing scheduled appointments, I reserve the right to terminate therapy with you and offer you a list of referrals. This policy pertains to all clients except those covered by *SoonerCare* or Medicaid Insurance due to state limitations on charges to those covered by these programs.

For clients covered by *SoonerCare* or Medicaid through the Oklahoma Health Care Authority, in accordance with state regulations, if a visit is missed without notice, except in emergency situations, you will be asked to ensure that all future visits are cancelled with appropriate notice. If a second visit is missed without notice by the noon deadline the day preceding the appointment, I will assume therapy is no longer a priority and will terminate therapy with you after an appropriate termination session(s), if possible. If you still desire therapy services, a list of referrals will be provided, but I cannot guarantee another therapist will accept you for treatment.

In order to assist you in remembering your scheduled appointments, my office staff makes reminder calls on the day before your appointment at the number you provide and prefer. However, it remains your responsibility to keep track of your appointments and to attend or appropriately cancel the time reserved for you. We do not overbook appointments; therefore, if you reserve an hour, it is yours unless you provide appropriate notification that you no longer desire the time.

Since I schedule my appointments up to three months in advance, there may be times when I must be out of the office unexpectedly, such as in the event of illness, family emergency, or my own healthcare provider appointments. If I must be out of the office at a time you have scheduled, I will let you know at the earliest point possible and will do my best to reschedule your appointment at a time that we both agree upon. Please know, I take my appointments with my clients seriously and do not cancel appointments arbitrarily.

PROFESSIONAL FEES

I have listed a schedule of fees for your information. My hourly fee for the first clinical intake session is \$200 and the fee for each succeeding session is \$165. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly charge if I work for periods of time less than one hour. Other services include telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Phone calls after office hours are considered crisis intervention and are billed at the rate of \$300 per 60 minute hour.

With regard to psychological assessment, my 60 minute hourly fee is \$190.00. Neuropsychological assessment (such as a dementia evaluation) is charged at the rate of \$220.00 per hour. This fee structure includes review of records for assessment purposes, consultations with other persons, scoring, interpretation, and report writing time. I charge \$25.00 for completing simple forms; for more complex forms, I charge a pro-rated rate of my hourly charge.

I do not accept patients who are involved in legal disputes who are seeking expert psychological testimony or psychologist participation without written prior agreement. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$475.00 per 60 minute hour for preparation, attendance, and participation, which includes time spent traveling and waiting; this includes any psychological evaluation/assessment or other report that may be required for legal proceedings. In addition to any in-office preparation time or research time, other time is calculated as "Door-to-door" time. There is a minimum 4 hour charge for any time I must be away from my office. Additionally, any and all travel expenses must be paid (including, but not limited to: airfare, lodging, mileage, meals, etc) in order for me to participate in these proceedings. *A forensic service deposit of \$3000.00 must be paid prior to my participation in any legal work* and from this account your charges will be deducted as time is used; the balance of this account must be kept at or above \$1000.00 during the legal proceedings and until the issue is settled. Any fee not used after the close of the proceeding will be refunded to you. This fee includes any testimony compelled by another party or by you in my role as a treating expert, fact witness, or expert witness and includes charges for both time for your attorney(s) and for your opposing attorney(s).

FEE SCHEDULE

<u>Code</u>	<u>Service Description</u>	<u>Fee</u>
90791	Diagnostic Interview	\$200.00
90832	Individual Psychotherapy (1-20 min)	\$70.00
90834	Individual Psychotherapy (38 min)	\$120.00
90837	Individual Psychotherapy (53 min)	\$165.00
90846	Family Psychotherapy (w/o patient present, 45 min)	\$165.00
90847	Family Psychotherapy (with patient present, 45-50 min)	\$165.00
90853	Group Psychotherapy	\$75.00
90825	Psychological Evaluation of Records (per hour)	\$190.00
90822	Environmental Intervention (per hour)	\$165.00
90900	Biofeedback (45-50 min)	\$165.00
96101	Psychological Assessment (Psychologist)	\$190.00
96102	Psychological Testing (Computer)	\$190.00
96103	Psychological Testing (Technician)	\$190.00
96105	Testing for Aphasia (per hour)	\$220.00
96116	Chart Review, Scoring of Instruments (per hour)	\$190.00
96118	Neuropsychological Testing (Psychologist)	\$220.00
96119	Neuropsychological Testing (Technician)	\$220.00
96120	Neuropsychological Testing (Computer)	\$220.00
97770	Cognitive Rehabilitation (per hour)	\$190.00
90889	Preparation of Report (per hour)	\$190.00
99373	Telephone Consultation (per hour)	\$190.00
99075	Legal Partic, Deposition, Testimony, Preparation, Att. (per hour)	\$475.00
99049	Missed Visit, Not Cancelled with Notice (per scheduled hour)	\$165.00
00000	Crisis Intervention/Critical Incident Stress Debriefing	\$270.00
	Premarital Counseling (per hour)	\$150.00

Document Fee for Record Copy: \$1.00 first page; \$.25 for each additional page.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for treatment. 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. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have become increasingly 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 for me to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients 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.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or in some rare cases copies of the entire record. This information will become part of the insurance company's 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 will 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 to the insurance company, if you request it. Your signature on this document authorizes the above mentioned release.

Once we have all 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 our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless in rare cases this is prohibited by your insurance company policy and/or their contract with me as a provider. My Office Manager, Bekah, will assist you with the preauthorization and interpretation of your benefits.

BILLING AND PAYMENTS

You will be expected to pay for each session on the day of your appointment, unless we firmly agree otherwise in advance or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installation plan. However, I cannot barter for my services.

If you are the parent or guardian of a child and you share medical expenses with the child's other parent/guardian, you will be expected to pay the full fee when you bring the child and work out the portions of payment with your co-parent. At each appointment, the person bringing the child will be responsible for the payment of the fee due at each appointment. Our office does not bill portions (e.g., 60/40) to co-parents.

I am not willing to carry a balance on your account unless we have firmly agreed in advance on a structured payment plan, which is a rare occurrence. In these rare cases, if you do not fulfill your agreed upon payments as scheduled, I reserve the right to stop the payment plan and require full payment of fees at the time of the appointment. There will be a fee associated with a structured payment plan and the plan must include a valid credit card to which the payments are posted each month.

Accounts that are not paid in full within 30 days will be subject to a \$25.00 per month rebilling fee for each month the account remains unpaid. I reserve the right to use a collection agency or other legal means for balances that remain delinquent for more than 120 days. The cost of the collection will be included in the balance.

CONTACTING ME

I am often not immediately available by telephone. My office manager, Bekah, is available Monday through Thursday from 8:30 am to 4:30 pm and Friday from 8:30 am to 12:00 pm. The office is closed daily from 12:00 to 1:00 pm for lunch. If Bekah is not immediately available by phone, you may leave a message on the secure voicemail. Bekah will make every effort to return your call within 24 hours of when you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform her of some times when you will be available. If you require a phone consultation with me lasting longer than 5 minutes, Bekah will ask you to schedule time for us to speak by phone. If you are in the midst of a crisis and need to speak to me promptly, please inform Bekah and she will relay that message to me. As email is neither private nor confidential, I will not communicate with you using this medium. I will do everything in my power to safeguard your privacy and information. I also have a secure voicemail on which you may leave any non-emergency messages.

I am away from the office several times per year for vacations. I will tell you well in advance of any lengthy absences and give you the name and phone number of the therapist who will be covering my practice during my absence. If you experience a crisis when I am out of town, or outside my regular office hours (after 5 pm on weekdays or over the weekend), please call my after-hours urgent-care number at **918-397-1930** to reach the on-call therapist. I cannot guarantee I will be

the therapist on call if you need this service, but each therapist is trained and capable of helping you stabilize or helping you rally the resources needed to help you. The on-call therapist will not contact me until the next business day with a note indicating the nature of your call. While I know it will be your preference to speak to me if you have an urgent situation, I cannot be on call every day, all day, and therefore call is rotated among WPA therapists. (Note: These calls are billed as *Crisis Intervention* and may not be covered by your insurance.) As explained, the urgent care service is staffed by therapists associated with my practice, and on a rotating basis. If you utilize this service and you sign this document, you give authorization for the on-call provider to communicate the information to me when I return to the office to assist in your care.

IF, due to technical or other problems your call is not answered within a reasonable amount of time, please call the (1) Community Outreach Psychiatric Emergency Services – Tulsa (COPES) at **(918) 744-4800** to speak with a crisis counselor, or the (2) National Suicide Prevention Hotline at **1-800-273-8255**, or (3) **1-800-784-2433 (1-800-SUICIDE)**. It is important for you to understand that, while I make every effort to be available to you in case of a crisis, there are unrelated circumstances (such as poor cell phone reception) that may prevent me from being available to you at the time you need assistance. Consequently, I believe it is important that you have these contingency plans in place if the on-call therapist is not immediately available by phone.

In a life-threatening emergency where you believe that you cannot keep yourself safe, please do not call the office or the answering service; rather, please go to the nearest emergency room and ask for the mental health worker on call, or call “911” and report to them that you have a life-threatening emergency and that you need transport to the nearest emergency room. Once your safety is assured, you may then have me contacted through the answering service.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the follow policy. This is because the use of various types of electronic communication is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it

during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for the matter, please discuss this with me during our time together so that we can deal with and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professional cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while you are in treatment together on any of these websites. This is because it has a signification potential to damage our ability to work together.

SOLE PRACTITIONER

While I share office space with other mental health practitioners, I am a sole psychological practitioner. This office is not to be understood as a 'group practice'; each practitioner is solely responsible for his/her professional conduct and practice.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. I keep brief records noting that you have been here, what topics we discussed, your diagnosis, and what interventions happened in each session. You are entitled to receive a copy of your records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I therefore recommend that we review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they consent to relinquish access to your records. You will find this agreement for minor psychotherapy clients immediately following this document in the packet of information. If they agree, I will provide them only with general information about our work together, unless I feel that there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a written summary of your treatment when it is complete. Before giving them any information, I will discuss this matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. Adolescent clients will be asked to review and sign an associated adolescent treatment agreement.

Also, due to the nature of the psychotherapy relationship and the need for the therapist's office to be a "safe zone," I require parents of minor children in therapy to sign an assignment of privilege to the minor child. This waiver is attached to this document and signifies your agreement to not access your child's record without his/her permission. Additional information regarding this waiver may be found on the waiver page attached.

PLEASE NOTE: ANY PARENT/GUARDIAN SEEKING SERVICES FOR A MINOR CHILD MUST HAVE:

1) FULL LEGAL CUSTODY (NOT ONLY FULL PHYSICAL CUSTODY; IF DIVORCED OR SEPARATED, COURT ORDERED DOCUMENTATION OF CUSTODY MUST BE PROVIDED PRIOR TO OR AT THE FIRST VISIT)

Or, 2) CO-SIGNATURE FROM ANY OTHER CUSTODIAL PARENT/GUARDIAN IF THERE IS A JOINT CUSTODY ARRANGEMENT.

If parents are divorced and documentation of FULL CUSTODY or JOINT SIGNATURES on all documents are not provided prior to or at the first appointment, the appointment will be cancelled and a broken appointment fee will be charged.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist or counselor is protected by law, and I can only release information about our work to others with your written authorizations. *But, there are a few exceptions.*

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if s/he determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another person, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I strive to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

Finally, if you drive to my office in an altered state of consciousness, such as intoxication with recreational drugs or alcohol, or are observably over-medicated with prescription medication, I reserve the option of contacting a family member, friend, or the authorities to arrange transportation and to ensure your safety and the safety of those whom you may encounter. This situation has also rarely occurred in my practice.

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 at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

CONSULTATION WITH PRIMARY CARE PHYSICIAN AND/OR PSYCHIATRIST

Many times during the course of psychotherapy, I deem it helpful to consult with my clients' primary care physician and/or psychiatrist in order to best serve their health care needs; with some insurers (e.g., Medicare), this communication is *required*. This information will be limited to the minimum amount necessary to accomplish your best health care. Typically, before I contact your physician, I will discuss my impressions with you and the reasons I think it would be helpful to speak with him/her. If you have questions about this, we should discuss them at our next meeting. ***Your signature on this document serves as your agreement to this disclosure of Protected Health Information for the purpose of healthcare coordination. If you REFUSE THE RELEASE OF THIS INFORMATION UNDER HIPPA, please initial here _____. (If you refuse, it may make it impossible for us to serve you due to insurance regulations.) Your signature on this document, minus any initial on the line above, authorizes us to release information to your healthcare providers for the purpose of healthcare coordination.***

AGREEMENT AND SIGNATURES

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You will be provided with a copy of this agreement if you so desire (please ask at your first appointment) and I will keep the original in your file at my office.

Your signature below indicates that:

1. You have had sufficient opportunity to read and understand this document.
2. You have asked the doctor to clarify anything you did not understand.
3. You agree to abide by the terms of this agreement in their entirety.
4. You understand that this form applies only to the policies and procedures for therapy services with the provider. A separate consent and agreement is needed for testing.
5. You are giving your consent to conduct counseling/treatment with you and/or your child.

Client/Guardian Signature

Date

Relationship to Client (if client is a minor or unable to give legal consent)

Signature of Co-Parent or Co-Guardian if Joint Custody

Relationship to Client (if client is a minor or unable to give legal consent)

Client Printed Name

Client Date of Birth

OFFICE USE ONLY

My signature below indicates that I have answered any questions raised by the client/parent/guardian. I have been told and believe that the person understands all of the issues discussed in this form, and I find no reason to believe that this person is not fully competent to give informed consent to services.

K. SPENCER WILSON, Ph.D., OK HSP PSYCHOLOGIST

DATE

KRISTIN L. WILSON, M.A., LICENSED PROFESSIONAL COUNSELOR

DATE

KRISTA QUIGLEY, M.E.D., LICENSED PROFESSIONAL COUNSELOR

DATE

KEESHA L. KUNTZ, M.A., LICENSED PROFESSIONAL COUNSELOR

DATE

BRITTANY L. FOWLER, M.S., LPC CANDIDATE

DATE

STACY B. LEE, Ph.D., UNDER SUPERVISION FOR LICENSED PSYCH
HEALTH SERVICE PROVIDER

DATE

WILSON PSYCHOLOGICAL ASSOCIATES, PLLC
417 East Silas Street
Bartlesville, Oklahoma 74003
(918) 337-6050 Phone
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CONFIDENTIAL CLIENT INFORMATION
Initial Information Form – Your Life in Review

Please take a few moments to fill out this form as completely as possible. From this history, valuable information may be realized by examining areas such as the Presenting Picture (current symptoms and what precipitated them); the History of Present Problems (current symptoms); the Past History (past issues that may be important now). In brief, this is what your life has been. You are taking an important next step in your work to change it to what you want it to be.

Name: _____ Date: _____

Briefly describe why you are here: _____

Name of Referral Person/Source to the Practice: _____

I. PRESENTING PROBLEM (Current symptoms and what precipitated them) I am a ____ year old ____ [M] or ____ [F] from _____ (city). If I had to describe my one major symptom, it would be ____ Depression ____ Anxiety ____ Obsessive Worries ____ Panic Anxiety
____ Times of Confusion ____ Drug Abuse ____ Inattention/Hyperactivity ____ Mood Swings
____ Loss of Memory ____ Sexual compulsivity ____ Relationship problems
____ Other _____ (name). The major stressor(s) that precipitated my symptom is/are
____ Marital Issues ____ Parent/Child Issues ____ Job Issues ____ Health Issues ____ Relationship Issues
____ Financial Issues ____ Issues of Past (____ Guilt ____ Abuse ____ Family of Origin)
____ Other _____ (name).

My symptom(s) began: _____ (date). My symptom(s) increased:
_____ (date).

My Three biggest worries in life at the present time are:

1. _____ 2. _____
3. _____

I ____ am (or) ____ am not concerned especially now that I have been having ____ suicidal and/or
____ homicidal thoughts or impulses.

II. HISTORY OF PRESENT PROBLEM: (Current symptoms: Check all that apply)

Occ'l Wkly Daily

Depression & Anxiety

- Increased crying
- Sad mood
- Lack of motivation
- Poor concentration
- Sleep Pattern (More) or (Less)
- Appetite changes
- Weight changes
- Lack of interest
- Decreased self-esteem
- Sad affect
- Hopeless/Helpless feeling
- Nightmares
- Other: _____

Other Symptoms

- Inattention
- Hyperactivity
- Delusions/Paranoia
- Hallucinations (hearing voices/music that no one else hears)
- High with racing thoughts, increased speech, decreased sleep, and increased activity
- Energy level
- Chest discomfort
- Abdominal (Stomach) distress
- Feeling dizzy
- Fear of going crazy
- Startled response
- Chills or hot flashes
- Outburst of anger

Occ'l Wkly Daily

- Anxiety in general
- Restlessness, keyed up, fatigued, decreased concentration, irritability, muscle tension, decreased sleep
- Hypervigilance – excessive attention and focus on all internal and external stimuli
- Obsessions/compulsions – constant checking, washing, or counting type behaviors; unrelenting worries
- Avoidance of stimuli associated with a trauma
- Agoraphobia – anxiety of places or inescapable situations
- Specific phobia – marked and persistent fear of certain objects or situations
- Social phobia – marked and persistent fear of social or performance situations where embarrassment may occur
- Post-traumatic stress experiences
- Intense fear
- Rapid heartbeat

- ___ ___ ___ Increased sweating
- ___ ___ ___ Shortness of breath
- ___ ___ ___ Withdrawn
- ___ ___ ___ Isolating self from all contact with others
- ___ ___ ___ Amnesia
- ___ ___ ___ Running away
- ___ ___ ___ Truancy
- ___ ___ ___ Memory impaired with trouble organizing and sequencing
- ___ ___ ___ Somatization – undue health worries with no adequate medical explanation
- ___ ___ ___ Agitated – irritable (easily annoyed and provoked to anger)
- ___ ___ ___ Drugs you've used: _____
- ___ ___ ___ Behavioral problems – Name: _____
- ___ ___ ___ Developmental problems – Name: _____
- ___ ___ ___ Self-mutilation – Name: _____
- ___ ___ ___ Legal Issues – Name: _____
- ___ ___ ___ Sexual Issues – Name: _____
- ___ ___ ___ Eating Issues – Name: _____
- ___ ___ ___ Impulsive
- ___ ___ ___ Aphasia, apraxia, agnosia
- ___ ___ ___ Disturbance of executive functioning
- ___ ___ ___ Suspiciousness

III. PAST HISTORY: (Past issues that may be important now)

- A. Have you had similar and significant symptoms(s) in the past? Yes No
 If yes, when: _____
 Did they recently increase? Yes No
 If yes, what caused the increase? _____
- B. Name three past stressful events in your life that precipitated the original symptom(s):

- C. Prior psychiatric hospitalization? Yes No If yes, where: _____
 Reason hospitalized: _____
 Prior outpatient counseling? Yes No
 If yes, therapist(s)/date(s): _____
- D. Substance abuse history. Yes No If yes, when did it begin? _____
 Substances _____
 Drug(s) of choice: _____
 Any treatment Yes No Date(s): _____
- E. Brief medical history _____

My Primary Care Physician is: _____ Phone: _____

I think my primary care physician _____ is _____ is not meeting my medical needs. If not, please explain why:

E.1. Current General Medication and Dosage

Current Medicine &	Date Began	Side Effects	Results
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Dosage			

F. Any known drug allergies _____

G. *Past* psychiatric medications _____

Current Psychiatric Medicine & Dosage	Date Began	Side Effects	Results

H. Family of origin:

1. Father – what was he like? _____

2. Mother – what was she like? _____

3. Brothers/Sisters – how many of each? _____

4. Where did you fit in birth order? _____

5. What type of relationship did you have with your sibling(s)? _____

6. School history – what type of grades? _____

How far did you go in formal education? _____

7. Marriages – how many? _____ Please list beginning and ending date(s) (if applicable):

8. Children – how many? _____

Ages and sex of

each? _____

I. My childhood overall was: ___Painful ___Uneventful ___Good

Birth and early development was ___Normal ___Abnormal (Please Explain):

J. I have an history of: ___Abuse ___School problems ___Abandonment ___Relationship problems

___Disability ___Job problems ___Legal ___Other (Name) _____

K. I presently live: ___Alone ___With Spouse ___With parents ___Other _____

My current support system is ___Good ___Fair ___Poor

L. Psychiatric history – Name(s) of past psychiatrist(s) and/or therapist(s) and dates seen and if the treatment was or was not successful:

M. Job history and current job _____

N. Religious history _____

O. I ___ have ___ have not been hospitalized due to psychiatric reasons. The hospitalization ___ was ___ was not with my consent. Dates/Facilities: _____

P. I _____ have _____ have not attempted suicide in the past. If yes, please list each attempt with approximate date(s) and method used:

Q. I _____ have _____ have not had a psychological evaluation in the past. (If yes, please have copies sent to the office as soon as possible.)

R. Past and current history summary:

I grew up in _____ (state). I grew up in the _____ country _____ a small town _____ a large city. Both parents _____ were (or) _____ were not in the home. I was one of _____ children and was _____ in the birth order. My childhood was _____ good _____ difficult _____ very difficult in the sense of _____. In high school my life revolved around _____ sports _____ work _____ church _____ social _____ academics _____ other _____ (name). After high school I _____ did _____ did not attend college.

After high school, life has been _____ good _____ difficult _____ very difficult in the sense of _____. I am currently _____ single _____ married for _____ years. I presently live _____ alone _____ with spouse _____ with parents _____ other _____. My current support system is _____ good _____ fair _____ poor. I have been married _____ time(s). I _____ do not have _____ do have _____ (number of) children. I _____ do not have _____ do have health problems. Life now centers around _____ family _____ work _____ friends _____ other _____. Recently, life has been _____ good _____ difficult _____ very difficult in the sense of _____.

_____. (If you work

outside the home:) I _____ enjoy (or) _____ tolerate (or) _____ hate my job because

_____.

Please use the space on the backs of these sheets to include any other information you believe may be helpful in gaining an understanding of you and/or your problem(s). I am glad you are taking this step toward a better you.

INSURANCE/PAYMENT INFORMATION

Responsible Party

Last Name _____ First Name _____ M.I. _____
Address _____
City _____ State _____ Zip _____ Home Phone (____) _____
Date of Birth _____ SSN _____ Relationship to Patient _____
Employer _____ Address _____
Occupation _____ Business Phone (____) _____
Spouse Name _____ Spouse's SSN _____

Primary Insurance Co _____ Effective Date _____
Insured's Name _____ DOB _____ SSN _____
Address (if different) _____
Policy No. _____ Group No _____ Relationship to Patient _____

Secondary Insurance Co _____ Effective Date _____
Insured's Name _____ DOB _____ SSN _____
Address (if different) _____
Policy No. _____ Group No _____ Relationship to Patient _____

I (we) authorize payment of medical benefits to the provider herein for all medical/psychological services rendered. I (we) authorize the provider or Wilson Psychological Associates to release any information required to process my insurance claims. I (we) authorize my insurance benefits to be paid directly to Wilson Psychological Associates. I (we) understand that I (we) am (are) financially responsible for payment of any insurance deductible, copayments, and non-covered charges or services. A photocopy of this signature is valid as the original.

Signature of Responsible Party _____ Date _____
Signature of Spouse _____ Date _____
(required if marital therapy)

Please provide us with your insurance card so that we may have a copy on file. Please notify us of any changes to your insurance. We reserve the right to require you to file your own insurance if we are not made aware of insurance changes within two visits of the policy change. Thank you for your consideration in this matter.

WILSON PSYCHOLOGICAL ASSOCIATES, PLLC
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**Acknowledgement of Receipt of Notice of Mental
Health Providers Policies and Privacy Practices and
Client Rights Information (HIPPA Notice)**

By signing this form below, I acknowledge that I have been offered and taken for my records (or, refused) a copy of Wilson Psychological Associates, PLLC's Privacy Policies and Practices (HIPPA Notice).

Please check the appropriate statement below.

____ I received this notice.

____ I have been offered and refused a copy of this notice.

Patient Printed Name

Patient or Parent/Guardian Signature

Date

Staff Signature/Witness

Date

Patient Health Questionnaire – PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total Score = _____ + _____ + _____ + _____ + _____

If you have been bothered by any of the 9 problems listed above, please answer the following:
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Please circle the answer)

Not difficult at all Somewhat Difficult Very Difficult Extremely Difficult

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Add the score for each column

+ + +

Total Score (add your column scores) =

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____