Dr. Desireé Gallagher
413 West Bethel Road, Suite 100
Coppell, Texas 75019
(972) 393-1596 Ext. 40

Hello and welcome to my practice, which focuses on building healthy relationships, families, and quality of life. The following forms may seem overwhelming. Here is a brief description of the forms to help. Please call or email me if you have additional questions or you may bring the forms and questions to the first session. The first two pages are to gather basic information and insurance verification and payment information, if applicable. The next three information pages are for more detailed history and background which will also be reviewed during the first session. The following forms (pages 6-9) review treatment procedures, confidentiality, HIPPA privacy policies, and ask for your signature if you understand these descriptions. THESE WILL BE YOURS TO KEEP. The final form describes different ways you may obtain appointment reminders and contact preferences. **Please bring pages 1-5 and 10-11 to the first session.** Please bring all of these forms to the first session. I look forward to meeting you.

Sincerely,
Dr. G

Today's Date / /

ADULT INTAKE FORM

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Home Phone No. ( )
				Cell Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. ________ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ________

Email Address:	Alternative Email Address:

Emergency Information: Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Cell Phone No.

INSURANCE INFORMATION (PLEASE GIVE A COPY OF YOUR INS. CARD TO DR. GALLAGHER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? ________

Please Select Your Primary Insurance Provider	❑ Blue Cross/Blue Shield ❑ Cigna ❑ Humana ❑ Magellan/Aetna ❑ MHN ❑ TriCare ❑ United Healthcare ❑ Value Options ❑ Other ________

Insured's Name	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

Name of Secondary Insurance (if any) Insured's Name and date of birth	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

PAYMENT INFORMATION

A CREDIT CARD WILL BE KEPT ON FILE FOR CONVENIENCE OF BILLING. Please complete the information for the card you would like to be on file: **Card type**: VISA MASTERCARD AMEX OTHER:____________________
Last 4 digits:_____________ Expiration Date:____/_______

By signing below, you authorize the charge of this credit card for appointments unless you specify otherwise. Charges will also be billed for no show appointments. The fee is $150. Insurance will not pay or reimburse for no shows or late cancellations.

____ ________________________________

Authorized user Date

MEDICAL HISTORY

Name of Primary Care Physician: ____

Physician's Address:_______________________________Physician's Phone: ____________________

Date of last medical evaluation:________________ Date of next appointment:______________________

Current medications being taken:

1)__________________ Dosage/Freq__________ Start Date__________Purpose______________________

2)__________________ Dosage/Freq __________ Start Date__________Purpose______________________

3)__________________ Dosage/Freq __________ Start Date__________Purpose______________________

4)__________________ Dosage/Freq __________ Start Date__________Purpose______________________

Prescribed by: ____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO
If yes, when did you stop? ____________________________

Type of Drug	How much	How often

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO
If yes, please list:

Type of Alcohol	How much	How often

Do you smoke cigarettes/tobacco? (Circle One) YES NO

Describe any important medical history, chronic ailments, or other health problems you experience:_____________________
____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:____
____
____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: ____

OCCUPATIONAL AND FAMILY HISTORY

Current employment ____ How long? ________________________

Describe your current working environment:____
____

Describe employment history: ____
____

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:____
____

What was the last year of school you completed? __________ If you did not complete high school, please explain:
____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)____ Year(s)/degree___________________________

(2) School(s)____ Year(s)/degree___________________________

(3) School(s)____ Year(s)/degree___________________________

Please check all information which applies to your biological parents:

MOTHER
____ living
____ deceased
____ married
____ divorced
____ remarried ____# of times

FATHER
____ living
____ deceased
____ married
____ divorced
____ remarried ____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your “real” parents? If so, whom?
____

Describe your relationship with your mother while growing up:____
____

Currently: ____

Describe your relationship with your father while growing up:____
____

Currently: ____

List first names and ages of brothers & sisters, including you:

Name	Age	Relationship (natural, step, half, etc.)
______________________________	_____	______________________________
______________________________	_____	______________________________

______________________________ ______ ______________________________

______________________________ ______ ______________________________

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse:____

____

Sexual/physical/emotional abuse:____

____

____

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _______________ If living w/someone, how long? ________________

Please list your children:

Name	Age	Relationship (biological/step)	Lives with

CURRENT FUNCTIONING

Please check any of the following that describe how you have been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful
____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless

Describe any other feelings you have had:____

____

What activities or hobbies do you participate in? ___________________________________

____

Do you participate in regular exercise? (Circle One) YES NO Describe:________________________

Have you had any change in sleeping habits? (Circle One) YES NO Describe:__________________

____

Have you had any change in eating habits? (Circle One) YES NO Describe: __________________

____

How would you describe your current support network? (friends, relatives, etc.): _____________

____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:____________________________________

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:____________________________________

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:____________________________________

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain:____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain:____

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): ____

____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior.

Please explain:____

____

____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

____

____

____

____

Please list your therapy goals:

____

____

____

____

____

____

Thank you!

Dr. Desireé Gallagher
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IMPORTANT INFORMATION AND CLIENT CONSENT (Please keep for your records!)
Please sign the form at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and Dr. Desireé Gallagher have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

AVAILABLE SERVICES: Dr. Desireé Gallagher offers a wide array of counseling services, including individual, family, and group services. I also conduct psychological testing and evaluations. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is my intent to convey the policies and procedures used in my practice, and I will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving skills. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

THERAPY: I provide therapy designed to address a variety of the many issues clients and their families go through. Your first visit will be an assessment session in which you and Dr. Desireé Gallagher will determine your concerns, and if both agree that Dr. Gallagher can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you, services to you may be terminated. The goal of Dr. Desireé Gallagher is to provide the most effective therapeutic experience available to you. If at any time you feel that you and Dr. Gallagher are not a good fit, please discuss this matter with me to determine if transferring to a more suitable Psychologist/Therapist who is right for you. If we decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. The therapeutic services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Clients are seen by appointment only. Appointments are typically scheduled on a weekly basis and are approximately **45 minutes** long unless we agree upon more time in advance. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. If you must cancel or reschedule your appointment, I ask that you call my office at 972-393-1596 ext. 40 **at least 24 hours** in advance. This will free your appointment time for another client. **Remember: exceptions are made for emergencies but you may be charged the full session fee for missed appointments.**

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$ 190
	Regular Office Visits (45 minutes) (Individual)	$ 150
	Family Sessions (60 minutes)	$ 175
	Psychological/Educational Testing (per hour)	$ 190
	Outside Office Work (inpatient visits, court, collaborative law services)	$ 300
	Emergency/Crisis/After Hours Phone Calls	$ 50+

A reasonable fee will be charged for copies of any records requested by the Client.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. Payment will be made before your session begins. If you are using insurance benefits, I will file insurance claims for you, and I will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. You are responsible for any authorizations, fees or copays at each appointment. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, I expect full payment at the time of service, and will provide you with a statement for services rendered.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact me at (972) 393-1596 ext. 40. I am available 24-hours per day by phone or voicemail. I will return your call as soon as feasible. I will not answer calls during sessions. At times, there may be another therapist "on-call" to cover my absence. I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, I will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: Dr. Desireé Gallagher follows all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your sessions. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a mental health professional and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of Dr. Gallagher to discuss this matter further. By signing this Information and Consent Form, you are giving consent to Dr. Desireé Gallagher to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless Dr. Gallagher from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If Dr. Desireé Gallagher believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Dr. Gallagher to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I may also give consent to Dr. Gallagher to contact the specific person(s) in addition to any medical or law enforcement personnel deemed appropriate.

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of Dr. Gallagher, it will be necessary to assign my case to another mental health professional and for that professional to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by Dr. Gallagher, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing. Please contact the Coppell Counseling Center for direction of your records.

CONSENT TO TREATMENT: By signing the Notice of Privacy Practices and Consent to Treatment, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Dr. Desireé Gallagher will not render services to your child until I have received and reviewed a copy of the most recent applicable court order.

Dr. Desireé Gallagher
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NOTICE OF PRIVACY PRACTICES (Please keep for your records)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use or disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI.

Required by Law. Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as fitness for military duties, eligibility for VA benefits, and national security and intelligence)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- A health oversight agency (such as HHS or a state department of health), or to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for

Verbal Permission. I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. I will also obtain an authorization from you before using or disclosing· Psychotherapy notes and PHI in a way that is not described in this Notice. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to the Privacy Officer, Dr. Gallagher, at 413 West Bethel Road, Suite 100, Coppell, Texas 75019:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. If you are the parent or legal guardian of a minor, please note that certain portions of the minor's record will not be available to you. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information, although I are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions. .** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised. If there is a breach of unsecured protected health information concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with Dr. Gallagher, or with the Secretary of Health and Human Services (HIPAA complaints) at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. Complaints can also be made to **The Texas Board of Examiners of Psychologists** 333 Guadalupe Tower 2, Room 450, Austin, Texas 78701 or call (512) 305-7700 or 1-800-821-3205 the 24-hour, toll-free complaint system. **I will not retaliate against you for filing a complaint.**

Dr. Desireé Gallagher
413 West Bethel Road, Suite 100
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ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices
Practice Policies/Consent to Treatment

By my signature below, I ____ DOB: ______________, acknowledge that I read, received copies, and understand the **Notice of Privacy Practices and Practice policies/Consent to Treatment** for Dr. Desireé Gallagher, Licensed Psychologist.

I understand that email, cell phone, and text correspondence may not remain confidential and if I agree to communicate through these methods, my protected health information (PHI) could be at risk.

I do seek and consent to take part in the treatment by Dr. Gallagher. I understand that developing a treatment plan with Dr. Gallagher and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as the results of treatment or any other testing or procedures.

I am aware that I may stop services with Dr. Gallagher at any time. The only thing I will be responsible for is paying for services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, than I may have to answer to the court).

I know I must contact Dr. Gallagher at least 24 hours before the time of my appointment. If I do not cancel and do not show up, I will be charged for this missed appointment.

I am aware that an agent with my insurance company or other third party payer may be given information about the type(s), cost(s), and date(s), and providers of these services of any treatment or procedure. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment and seek to collect the fees.

____ ______________________
Signature of Client Date

____ _______________________
Signature or Parent/Guardian Date

I, the psychologist, have discussed the practice policies and issues above with the client or his/her representative. My observation of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

- ❑ Client Refuses to Acknowledge Receipt
- ❑ Other____

____
Signature of Clinician Date

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: ____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Requested password: |__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Your email address: ______________________________________

Your cell phone number: ___________________________________

Your cell phone carrier (circle one):

Alltel AT&T Boost Mobile Nextel Sprint SunCom

T-mobile Verizon VoiceStream Virgin Mobile (Other) ____________

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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Signature Date