avalit Client Registration Information

(PLEASE PRINT CLEARLY AND COMPLETE ALL AREAS)

CLIENT: (if client is not the responsible party: also fill out **responsible party information** below)

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

TELEPHONE: HOME (____)_____ WORK: (____)_____ CELL: (____)_____

EMAIL: _____

AGE: _____ DATE OF BIRTH: _____ SEX: _____ SOCIAL SECURITY NO. : ____-____-_____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED

STUDENT STATUS: (CIRCLE ONE) FULL-TIME PART-TIME NONSTUDENT

EMPLOYMENT STATUS: (CIRCLE ONE) FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME: _____

EMPLOYERS ADDRESS: _____ CITY, STATE, ZIP: _____

In Case of an emergency notify: _____

Relationship: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (Only fill out if client is **NOT** the responsible party)

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

RELATIONSHIP TO CLIENT: (CIRCLE ONE) PARENT LEGAL GUARDIAN SPOUSE OTHER

AGE: _____ DATE OF BIRTH: _____ SEX: _____ SOCIAL SECURITY NO. : ____-____-_____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

TELEPHONE: HOME (____)_____ WORK: (____)_____ CELL: (____)_____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED

STUDENT STATUS: (CIRCLE ONE) FULL-TIME PART-TIME NONSTUDENT

EMPLOYMENT STATUS: (CIRCLE ONE) FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME: _____

If the client's parents are separated or divorced, or you have legal guardianship and are not the child's biological parent please provide documentation of guardianship to the front desk.

Was this appointment court ordered or recommended by an attorney? Y or N

If yes, what is your attorney's name? _____

Attorney Phone Number: _____ **Case #** _____

Other parties involved: _____

Donaldson Wellness Center
Kerry Donaldson, PhD #39407
508 Grace Street
Waxahachie, Texas 75165
972-923-0730
www.donaldsonwellnesscenter.com

INFORMED CONSENT
SOME THINGS YOU SHOULD KNOW ABOUT THERAPY

Before we start therapy together there are some things you should know about the therapeutic process and about our office. In legal terms, this is called "Informed Consent." This information will help you understand better what to expect, and it will explain some limitations about what you and your therapist will be doing.

Your Privacy and Confidentiality

Of course, all of our work together – our conversations, your treatment record, and any information that you give us – are protected by something called legal *privilege*. That means that in most cases the law protects you from having information about you given to anyone without your knowledge and permission. Our office respects your privacy, and we intend to honor your *privilege*. However, the law also makes some important exceptions to your privacy.

If we believe there is a risk you might harm yourself or someone else, we may be called upon to contact the authorities to give them the opportunity to protect you. If you are abusing children, an elderly person, or a disabled adult, we are required to notify the authorities, so they can protect others from harm. Also, if you become involved in any lawsuit in which your mental health is an issue – for example, a child custody dispute or a personal injury lawsuit in which you claim compensation for emotional pain and suffering – then the court or the lawyers may insist upon, and may obtain your information from us. That concern is especially important to understand if you are here for marriage therapy, and later find yourself in divorce litigation. Similarly, you would lose the protection of your privilege if you sue us or if you file a complaint against us with a state licensing board.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third-party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company involved, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. By your signature, below, you authorize our office to provide information to your insurance and managed care companies to the extent necessary to enable them to pay for your services. If we find ourselves in a dispute with you over billing, our office reserves the right to employ a collection service and to provide them with any information necessary to clarify and to collect an outstanding balance.

Side effects of therapy and other potential unpleasantness

You should know that therapy is not always easy. You may find yourself having to discuss personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, coworkers, and family members. It is possible that you might become somewhat depressed. Therapy is intended to alleviate those problems, but sometimes at first, as you get below the surface of some things, you may feel them even more acutely than in the past. We may also ask you to do some things that might, at first, make you feel uncomfortable or awkward. Sometimes therapy requires trying new and unfamiliar ways of doing things. You will always be free to move at your own pace, however. We will work with you to make changes, but we cannot promise anything about the results you will obtain. The outcome you achieve will depend on many things.

Our office specializes in the treatment of specific issues and clients. If we believe that your problem requires knowledge that we do not have, we may refer you for a consultation with someone with training or experience different from our own. We will discuss any such referral with you before we act. At the very beginning we will create a treatment plan with you. That is, we will look at what you would like to change, what we will do to change it, how we will know you are succeeding, and we will estimate how long it will take to achieve your goals. Every now and again, we will review that plan with you to see if it needs to be updated.

The Internet and Electronic Communication

You may, at your discretion, use email to communicate with your therapist. If you choose to communicate via email, remember that email communications are not private. Email is, by its nature, subject to pass through a variety of email servers and thus subject to interception by unknown parties. Email communication with our office should be limited to administrative and logistical matters; your therapist will NOT use email to discuss important personal and therapy matters. If you wish to communicate via email, please provide your preferred email address:

By my signature, below, I acknowledge and I accept the limited privacy of email communications, and I authorize your office to communicate with me at the following email address:

Signature:_____

Email: _____

Fees and Policies Regarding Litigation Services

Ordinarily, our office does not conduct evaluations in court- or litigation-related matters, nor do we customarily offer testimony in depositions or in court hearings. We believe that your interactions with your therapist should remain private, and the success of your work depends, in some part, on protecting you and your information from disclosure. Our office will do all that we can to avoid offering information or testimony about you and your mental health in the context of litigation, although the courts or lawyer may be able to require participation and disclosure. In the event we are required to respond to litigation-related requests there are some additional, specific considerations.

If our office, or your therapist, becomes involved in litigation related to your treatment, you will be required to pay, in advance, your therapist's litigation fees and for the cost of any appearance in court or for a deposition. By your signature below, you agree to the following conditions and payment terms:

1. For any deposition or court appearance regarding your therapy, whether commanded by you and your lawyer, or by an adversarial lawyer or party, you agree to pay your therapist $750 for a ½ day and $1500.00 for a whole day for court appearances.
2. You agree to pay at least two additional hours for your therapist to review documents and to prepare for her appearance.
3. By your signature you agree to pay an advance retainer of $2,000. That amount will cover six hours' appearance and two hours' preparation. The retainer is fully refundable until five days before the scheduled appearance. Half of the retainer will be refunded if the appearance is cancelled fewer than five days but more than forty-eight hours in advance of the scheduled appearance. With less than forty-eight hours' notice, any retainer balance is non-refundable.
4. Payment of these fees is due in advance as a retainer, due and payable at least ten days prior to any appearance. Our office will not schedule a deposition or court appearance until the retainer has been paid to our office.
5. In addition to the contracted fees for your therapist's time and appearance, if your therapist believes it is necessary to retain an attorney to represent her interests, you agree, by your signature, below, to reimburse our office you're your therapist's attorney fees, up to a maximum of one thousand five hundred dollars ($1,500).

Agreement for Private Psychological Testing and Evaluation Services

If you are seeking services from our office for a psychological evaluation or for psychological testing rather than, or in addition to counseling/psychotherapy services, you should be aware of the following considerations.

I understand that the assessment services may include face-to-face interviewing and administration of tests, questionnaires, checklists, and other assessment methods. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, constructing a report about the results and findings, and other activities to support these services. If you have questions or concerns about this assessment, the psychologist will answer your questions, although some answers may be deferred until after completion of the testing and interview.

Referral Source:

_____

I understand that the purpose of this evaluation is to provide information regarding the following question(s):

_____

I request that a report of the findings of this assessment will be sent to

Name:_____
Address:_____
Phone:_____
Fax:_____

Signature of Patient or Authorized Representative: _____

Printed Name: _____

I understand that if a diagnosis is assigned, the diagnosis is not made based on the results of any single assessment instrument alone. Rather a diagnosis is made while considering all test results, the clinical interview, historical information obtained, review of collateral documents, and observations made during the assessment.

I agree to cooperate and to participate as diligently I can by supplying full and accurate answers and making a sincere effort to do my best on all of the tests and interviews. I understand that I may refuse to answer any question or terminate the evaluation whenever I wish. I understand that the evaluator is required to notify authorities if the evaluator believes or suspects that a child is abused, or if the evaluator has reason to believe that I may harm others or myself. I have discussed the issues above with the psychologist who has answered any questions I have raised. I assert that I am fully competent to give informed and willing consent to this assessment.

By your signature below you consent to the treatment offered by our office, you agree to pay for the services you receive as indicated and at the time of service, and if you are using a third party (e.g. insurance) payer, you agree that our office may provide any information to your insurance carrier and managed care company necessary to consider, process, and approve payment of services. Further, you agree that all charges for services are reasonable and that all fees are your responsibility. In the event your insurance carrier refuses payment, you agree to pay all amounts due. Your therapist may refuse to schedule an appointment until you have paid any outstanding balance you have with our office. If you are unable to pay for your services in the future, you understand and agree that your therapist will be unable to continue to work with you. In that event, your therapist will provide you with a referral to another provider or providers more readily able to work within your budget.

_____ Date: _____

Client Signature

_____

Client Printed name

I, the psychologist, have discussed the issues above with the client (and/or his or her parent or guardian) and answered any questions raised. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____ Date ___/___/___

Signature of psychologist/Therapist

Consent for Telepsychology and Teleneuropsychological/ Telepsychological Assessment

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.For communication between sessions, I use email, TSecure portal, and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods should not be used if there is an emergency.

If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent [use whatever title you have for your informed consent document] still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, [include any local hotlines or other resources], or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive communication back within a reasonable amount of time, then call me on the phone number I provided you (972.975.2007) or email us.

If there is a technological failure and we are unable to resume the connection, you will only be charged the pro-rated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____ _____

Signature Date

DONALDSON WELLNESS CENTER

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www.donaldsonwellnesscenter.com

ADULT CLIENT HISTORY

Name: _____ **Date of Birth:**_____ **Age:**_____

Race/Ethnicity: _____ **Sex: M — F — Other:** _____
Referred by: _____
Reason for Referral:_____
_____
_____

Family Members/Others Residing in Home	**Age**	**Relationship to Client**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Marital Status: Single Married Widowed Separated Divorced Common Law

Family of Origin

FATHER: _____ Age (current, if living): _____
Occupation: _____Highest Level of Education: _____
Describe your father/child relationship: _____
_____
_____
_____

MOTHER: _____ Age (current, if living): _____
Occupation: _____Highest Level of Education: _____
Describe your mother/child relationship: _____
_____
_____
_____

Other Important Family Members	Age	Relationship to Client
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

With whom did you live during your childhood? _____

How many siblings do you have?_____

Where did you grow up? _____

Describe your childhood: _____

Describe your adolescence: _____

Have there been any significant deaths or losses in your family? Y or N If Yes, please explain: _____

Maternal Family Psychiatric History (If so, who?)

Depression/Sadness_____
Suicidal Ideation/Attempt_____
Anxiety/Excessive Worry_____
Panic Attacks_____
Bipolar Disorder_____
Obsessive-Compulsive Tendencies_____
Schizophrenia_____
Attention Problems/ADHD_____
Learning Problems _____
Alcohol/Drug Use_____
Problems with the Law_____
Seizures_____

Paternal Family Psychiatric History (If so, who?)

Depression/Sadness_____
Suicidal Ideation/Attempt_____
Anxiety/Excessive Worry_____
Panic Attacks_____
Bipolar Disorder_____
Obsessive-Compulsive Tendencies_____
Schizophrenia_____
Attention Problems/ADHD_____
Learning Problems _____
Alcohol/Drug Use_____
Problems with the Law_____
Seizures_____

Medical History

Have you had any history of, difficulty with, or diagnosis of any of the following:

□ Allergies	□ Arthritis	□ Asthma	□Broken Bones
□ Cancer	□ Diabetes	□Eating Disorder	□ Emotional
□ Epilepsy/Seizures	□ Fainting	□ Head injury/concussion	
□ Hearing Problem	□ Hepatitis	□ Headaches/Migraines	□ Heart Problems
□ Liver problems	□ HIV+/AIDS	□ Liver problems	□ Lung problems
□ Organ transplant	□ Osteoporosis	□ Shortness of breath	□ STD
□ Stroke	□Tobacco use	□ Substance/Alcohol abuse	□ Thyroid problems

□ Other:_____

Please list all medications you are currently prescribed and/or are using and for what reason:_____

Please list all medications you have been prescribed and/or have used in the past and for what reason:_____

Mental and Emotional History

Please check any of the following problems that pertain to you:

□Alcohol Use	□Anger	□Anxiety/nervousness	□Appetite	□Body image
□Children	□Depression	□Difficulty making decisions	□Divorce	□Educational problems
□Fatigue	□Feelings of inferiority	□Financial problems	□Health problems	□Illicit Drug Use
□Insomnia	□Lack of energy	□Loneliness	□Legal matters	□Marital problems
□Nightmares	□Memory problems	□Occupational problems	□Parenting	□Post-traumatic stress
□Self-Control	□Separation	□Prescription drug abuse	□Sexual problems	□Sleep
□Stress	□Social problems	□Stomach trouble	□Suicidal thoughts	□Suicide attempt
□Temper	□Thoughts			

Have you ever been abused? Y or N (circle one and all that may apply)
Sexually Verbally Physically Mentally Emotionally Other:_____
If Yes, who was the abuser? _____
Have you ever been diagnosed with a mental health disorder?_____
Have you ever participated in therapy?_____Psychological testing?_____
With whom?_____Diagnosis Assigned?_____
Was the previous treatment beneficial? Y or N (circle one) Please explain:_____
_____
_____

Educational and Employment History

What is your highest level of education? _____
Where did you attend school? Include high school, college, trade schools, etc. _____
_____

Did you have difficulty in school? Yes or No (circle one)
If yes, please explain: _____
_____

Describe your employment history for the past five years beginning with your current position:
Employer Position Time in Job Reason for leaving
_____
_____
_____
_____
_____

Have you ever served in the military service? Yes or No (circle one) If yes where? when? _____
_____
_____
Which branch? _____Rank? _____
Did you ever serve in combat? Yes or No (circle one) If yes, please describe your experience. _____
_____
_____
_____

Legal History

Have you ever been arrested? Yes or No (circle one) If yes, please explain:

Have you ever been incarcerated? Yes or No (circle one) If yes, please explain:

Are problems with the law currently a concern for you? Yes or No (circle one) If yes, please explain:

Recreational and Leisure Activities

Do you have any hobbies? Yes or No (circle one) Explain:

Do you socialize with others? Yes or No (circle one) Explain:

Do you attend church? Yes or No (circle one) Are spiritual issues important to you? Yes or No (circle one) Explain:

Strengths and Weaknesses

What do you think are your biggest personal strengths?

1.

2.

3.

What do you think are your biggest personal weaknesses/limitations?

1.

2. _____

3. _____

_____

Signature

CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

PATIENT'S NAME: _____

NAME, AS IT APPEARS ON CREDIT CARD:

_____

BILLING ADDRESS: _____

_____

EMAIL ADDRESS: _____

AMEX/DISC/MC/VISA CARD #_____

EXPIRATION DATE_____/_____ CVV CODE: _____

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize The Donaldson Wellness Center to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be charged in the event payment is not received. I agree to receive billing statements, invoices and receipts to my email. If I am an uninsured patient, I authorize payment at time of service. I agree to update any information regarding this credit card account as applicable.

_____ _____

Cardholder Signature Date

Email _____

No show/Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our clients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another client.

A "no-show" is missing a scheduled appointment. A "late-cancellation" is canceling an appointment without calling us to cancel within 24 hours of an office appointment or 72 hours in advance of psychological testing.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case-by-case basis.

A charge of $75 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours' notice is given.

A charge of $250 will be assessed for each no show or late cancellation psychological testing appointment if less than 72 hours' notice is given.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

For your convenience, you can cancel or reschedule an appointment 24/7 by leaving a voicemail or emailing donaldsonwellness@gmail.com. This policy is in effect to ensure that all of our clients have the opportunity to be seen in a timely manner.

_____ Date_____

Patient Acknowledgement (Please sign)