CHRISTINE ADAMS, PH.D.

Licensed Psychologist

New Patient Registration Packet

Child(ren) Self-pay

Please keep a copy of this packet for your records.

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New Patient Registration Form

Patient Information

Patient Name: _____Date of Birth: _____

Address: _____
street city state zip

Parent/Guardian Name: _____Relationship to Patient: _____

Address: _____
street city state zip

Telephone: home_____ work_____ cell_____
Please circle the telephone number(s) where it is permissible to leave a message.

Email address: _____ SSN: _____

Parent/Guardian Name: _____Relationship to Patient: _____

Address: _____
street city state zip

Telephone: home_____ work_____ cell_____
Please circle the telephone number(s) where it is permissible to leave a message.

Email address: _____ SSN: _____

Parent/Guardian Marital Status (please circle one): Married Divorced Other (please specify)_____

If divorced, do you have the legal right to contract for psychological services for your child? _____

Emergency Contact: _____ Phone: _____

Child's Pediatrician: _____ Phone: _____

Child's School: _____ Phone: _____

Child's School Address:_____
street city state zip

Who referred you? _____

May we contact him/her to acknowledge the referral only (please circle one)? Yes No

Consent to Use or Disclose Information for Treatment, Payment, and Health Care Operations

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations"). The minimum information necessary is used for health care insurance reimbursement. Insurance companies do not have a right to require progress notes as a condition of reimbursement. I hereby give my explicit consent to the use or disclosure of my Protected Health Information for health care operations as specified above.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____Date: _____

Notice of Privacy Practices

The Notice of Privacy Practices is available to read in the office/reception room. You may ask for a printed copy of the Notice of Privacy Practices for your records at any time.

I acknowledge that I was presented with the HIPPA Notice of Privacy Practices to read prior to beginning treatment or assessment. I further acknowledge that I was given a summary of Privacy Practices to keep for my records.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____Date: _____

Advance Notice for Appointment Cancellation Policy

One standard policy in mental health is to charge patients the **full session fee** for appointments not cancelled with 24 hours advance notice.

This policy has come about because of how income is earned in the mental health field. In mental health, income is earned within a fixed period of time. In other businesses where tangible products are sold, time is not a critical factor in financial solvency. Returned items can be sold again. Once the time is gone, the time cannot be sold.

The policy has a rationale similar to other businesses such as theatrical companies and educational institutions where time is also a critical factor in how income is made. If you missed a theatre production, you would not get a refund on your ticket because the theatrical company can only make money during a set period of time, the night of the production. When you register for a class at an educational institution, you have a certain amount of time for a refund if you cancel your enrollment. If you miss that deadline, you are charged even though you are not taking the class.

This policy is different from most regular medical appointments where there is not a charge for missed appointments. When you go to a regular medical appointment, you are rarely seen at the time you are told your appointment is because they schedule several people for the same time. They overbook to insure adequate income for that business day. You may end up waiting a long time to be seen by your doctor in medical-physical healthcare because several patients are booked into the same time slots to compensate for the patients who are unable to keep their appointment. Although inconvenient for patients, this works for a medical practice where you may only go infrequently.

This is not the case in mental health. Your scheduled time is yours alone. For patients interested in several months of ongoing therapy, a regular time they can count on is essential. They cannot afford to sit around several hours one day a week waiting for their session. Overbooking is not a feasible scheduling policy for mental health. The balance between convenience for patient and financial solvency for the clinician is the charge for sessions not cancelled with 24 hours advance notice.

I have read the above policy on 24-hour advance notice of cancellation. I understand that if I do not cancel my session with **at least 24 hours' notice**, my obligation for that session will be the current rate for my insurance carrier.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____Date: _____

Philosophy, Policies, and Procedures

Practice Philosophy

The decision to engage in psychotherapy is usually made after a great deal of thought and consideration. Selecting a provider who will be a good fit for you is crucial since the process of psychotherapy is intense and a satisfactory outcome is of great importance. I take a strong consumer advocacy position and believe freedom of choice for consumers is critical. I encourage you to feel free to openly discuss your treatment or concerns you may have about the process at any time during the course of therapy.

I seek to conceptualize difficulties individuals and families are experiencing within a model, which fits them uniquely, rather than using one particular method across the board for everyone. As such, my approach is collaborative with patients around finding solutions to problems within their value systems.

I have experience with a wide variety of patient populations, psychological, emotional and behavioral problems, and diagnostic and treatment methods. I provide a broad spectrum of evaluation and psychotherapeutic services to children, adolescents, adults, families and couples. In working with patients, I integrate family-based approaches with psychodynamic and cognitive-behavioral theories.

Texas Board of Examiners of Psychologists Disclosure

The Texas Board of Examiners of Psychologists requires licensed psychologists to clearly specify practice policies especially policies regarding fees. This is for your protection and why I have described these policies in great detail. Please read my policies carefully to be sure you are in agreement with them, especially the charges for services or penalties not covered by insurance prior to initiating psychotherapy with me. It can feel awkward to discuss money matters yet this is essential for a good, collaborative relationship. It can also be confusing what your insurance will actually pay for and what you will be expected to pay when insurance does not cover a particular service. I do not want awkwardness about money to intrude into or otherwise interfere with our work together. Please feel free to discuss financial matters at any point in time should you have concerns. Also, please discuss with me at any point in time any concerns or questions you may have about how therapy is going or questions about the process of therapy or your rights as a patient. It is natural to have questions and it is helpful to talk about such matters in the course of therapy. Please do not hesitate to ask me for clarification at any point in time on any issue.

Financial Policy

Payment for services rendered is due at the time of service. Self-pay patients' fees are discounted on a case-by-case basis.

Fee Schedule

Initial session:	$225
Outpatient session:	$200
Psychological testing:	$275 per hour
Court testimony and forensic services:	$300.00 per hour, including travel time

Potential additional fees

These fees are not covered by mental health insurance. Please initial next to each statement to confirm that you have read the description of each potential fee.

_____ Patient is responsible for the full session charge, not just the co-pay for appointments not cancelled with 24 hours advance notice. This charge may be waived at the discretion of Dr. Adams should there be extenuating circumstances with specific appointments in case of emergencies or circumstances beyond the control of the patient. A waiver for one session does not negate the policy for other sessions.

_____ There is a charge of $50.00 per 15-minute interval for telephone discussions with the patient and/or other party requested by patient (e.g., physician, school, attorney, family member, etc.). There is no charge for administrative calls such as rescheduling, canceling or confirming appointments, insurance issues, etc..

_____ Written reports cost $250.00 per hour.

_____ Legal and/or Court-related fees for expert testimony or documentation for legal matters cost $250.00 per hour, including travel time.

_____ Returned check fees include charges my bank assesses me for returned checks plus penalty fees as allowed by state law. Overdue accounts are turned over to collection agencies after notification to patients of past due accounts.

Payment Methods

All fees are due at the time of service. **I accept cash, mobile transfers directly from online banks, personal checks or bank issued paper checks for payment.** I do not accept credit card, debit card or health savings debit card payments. If you plan to pay by check, please have your check completed prior to the session so that your session time can be devoted to your concerns and not administrative matters. For your convenience, you will find a confidential drop-box for your payment in the waiting room by the receptionist's window.

Cancellation Policy

Advance notice of 24 hours is required to cancel an appointment without charge. You are charged the agreed upon full fee of your sessions for appointments not cancelled within 24 hours. When a legitimate emergency arises, I am open to waiving this requirement. However, I reserve the right to not continue to offer services when appointments are not cancelled within 24 hours or cancellations, even when made within the acceptable time frame, are frequent enough to be disruptive to my ability to schedule other patients. An explanation of the rationale behind this policy is included in your patient registration packet. Please sign and date below to indicate that you have read and understand this important financial policy.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____Date: _____

Time Length of Sessions

Understandably, it can be difficult to stick with the time limitations of psychotherapy because of the importance of the issues being addressed. However, it is essential to start and stop on time, so that everyone's time is respected. If there does not seem to be enough time with one session per week, talk with me about other options such as having two sessions per week or paying out of pocket for additional time added on to your session but paid for by you and not by your insurer.

Telephone Calls

I do not charge for administrative calls (e.g., scheduling, insurance issues, and billing). Fees for clinical telephone consults will be charged at $50.00 per 15-minute intervals. If telephone consultation with another professional or institution is needed, the charges for this service are billed at $50.00 per 15-minute interval. You will be contacted for prior approval for any telephone consultation for which there would be a charge. You have the right to decline this service.

Psychological Testing Services

I do provide psychological testing for patients who choose to pay directly for the cost of this service without going through insurance. Let me know if you are interested in this service and we can discuss which tests and services make sense and what your total costs would be.

Court Testimony

Court Testimony and/or release of patient records for the court are distinct services, which are subject to state laws and Texas State Board of Examiners of Psychologists regulations. It is highly recommended that any possibility of court involvement be discussed as soon as possible to avoid misunderstandings about fees and release of confidential information. Without sufficient notice, it is difficult for me as your provider to adequately prepare for testimony, which could then jeopardize a positive resolution of the issues. In the event of a request by you or your attorney for your personal health records for a civil legal action, there may be additional charges for the compilation of your personal health information to be in compliance with a subpoena or affidavit.

Scheduling

It is important that sessions are scheduled at times convenient to you in order to make it possible for you to have regular sessions. It may be that when you begin therapy, there may not be times that are most convenient with your schedule because established patients may have already taken these times. This is especially true for high demand times such as after school and after work. If you are able to start therapy at a time I have available, you will become an established patient who will be given priority for your preferred time when that time slot becomes available. Progress in therapy is uneven therefore it is not predictable when time slots will open up. If you are already in my practice, I can offer you these times as soon as they arise.

How to Contact Me

When you want to contact me for non-urgent matters, call or text my office voicemail at **713-850-0553** or email me **dr.ckadams@gmail.com**. If you text, include your name in the body of the text so I know who is sending the text. To protect your privacy, I do not set up your full name and telephone number in my contact list. If you must speak with me the same day or get a message to me within a few hours (i.e., running significantly late for an appointment, same day cancellation, urgent scheduling needs, etc.), please text me but also email me if possible. If you have a true **life-threatening** emergency, call 911 or go to the nearest emergency room.

Consent to Treatment

If you have questions or concerns about the policies described above, please discuss them with me. Please sign below if you have read and understand these policies and are in agreement with them.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____Date: _____

Goals for Treatment

If you need more space to write, please include additional pages.

1. What are the current problems/concerns/issues you want to address in counseling?

_____
_____
_____
_____

2. What are the symptoms of your current problems/concerns/issues? (i.e., anxious, depressed, irritability, difficulty sleeping or eating problems, etc.)

_____
_____
_____
_____

3. What do you see as the obstacles or challenges you face in trying to change your problems/concerns (i.e., low energy, lack of support/cooperation from others, etc.)

_____
_____
_____
_____

4. What stressors are you now under that may play a role in your concerns? (i.e., financial pressure, unhappy with work, loss of family member, health issues, etc.)

_____
_____
_____

5. What are your goals? What do you hope will be different when therapy is finished? (i.e., less sad, better interpersonal relationships, higher self-esteem, more assertive, etc.)

_____
_____
_____
_____

6. List any health problems/conditions that you have. (asthma, diabetes, etc.)

_____
_____
_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____Date: _____

Medication

Please list all current prescription medications and dosage and the health issues/problems each medication is intended to address.

Medication Name	Dosage	Health Issue/Problem	Date Started

Please provide the names, addresses and telephone numbers of prescribing physicians.

Name	Address	Phone