SUZI PHELPS, Ph.D.
CLINICAL PSYCHOLOGIST
(713) 779-0351
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6750 WEST LOOP SOUTH #1000
BELLAIRE, TEXAS 77401

P.O. BOX 20134
HOUSTON, TEXAS 77025

CLIENT INFORMATION & INFORMED CONSENT

CLIENT INFORMATION

NAME_____

ADDRESS_____

CITY_____ZIPCODE_____

HOME PHONE_____WORK_____

CELL PHONE_____

EMAIL_____

DATE OF BIRTH_____

MARITAL STATUS_____

EMPLOYER_____

REFERRAL SOURCE_____

LIST ANY SIGNIFICANT HEALTH PRIOBLEMS_____

_____

CURRENT MEDICATIONS_____

_____

FINANCIAL AGREEMENT

Each therapy session is scheduled for 50 minutes. Most insurance companies pay for a portion of psychologist's services. You will receive a receipt with all the information needed for you to get any reimbursement from your insurance company that your plan allows. I do not accept credit cards, only cash or checks.

Once a commitment to begin therapy is made, it should be thought of as an important life priority. Only an emergency will keep me from honoring my commitment to be at your session. Therefore, I expect the same from you. Failure to provide a 24 hour notice of cancellation generally means than another person is not able to use that appointment time. Insurance companies do not reimburse for missed appointments. **Therefore, it is necessary to charge the full fee for appointments which are not cancelled 24 hours in advance, unless a situation arises which we would both define as an emergency.**

Please indicate if a confirmation call or text the day before the appointment would be helpful:

Call_____ Text____ Not Necessary_____ Best Phone#_____

EMERGENCIES

As we work together, you will notice that I do not accept phone calls while I am in session. During those times, and at other times during the day and evening, my calls are answered by voice mail. I check messages frequently during the weekdays. My office phone # is (713) 779-0351. If you have an emergency and need to speak with me after hours, you can text or call me on my cell phone 832-816-9314.

CONFIDENTIALITY

All communication with me is considered privileged to the full extent of the law. This means that what you tell me, the notes I make, and any other records I have cannot be made public or turned over to anyone without your written permission. There are, however, exceptions to this:

*If you are an immediate danger to yourself or others.

*If you are elderly, disabled, or a minor, and I have reason to believe you are CURRENTLY the victim of abuse or if you divulge information about current abuse.

*If the information is subpoenaed by a court.

*If you have been injured on your job and worker's compensation is paying for your treatment. In this case treatment notes are required in order to receive payment.

PHILOSOPHY OF THERAPY

I believe therapy is a collaborative process where we work together to accomplish your goals. It is my desire that you feel as comfortable as possible and that the work we do together be productive and rewarding for you. Therapy usually works best when scheduled once a week. As we meet your goals, it may make sense to then meet twice a month, and then monthly, to make sure your gains have been maintained. The length of treatment depends on what you want to work on and how motivated you are to achieve these goals. While it is a reasonable expectation that you will begin to feel better soon, you will not always leave a therapy session feeling good. It can be painful to examine one's life and make changes in thoughts, emotions, and behavior. The majority of those who persevere through the process, however, report significant positive changes and a better quality of life. Many people leave therapy, for a variety of reasons, before their goals are accomplished. If this is the case, please know that it is always appropriate to resume treatment in the future for the same or different issues.

INFORMED CONSENT FOR TREATMENT

Please indicate with your signature that you have read and understood this form. Thank you.

_____ _____

Signature Date

Consent for the Use or Disclosure of Protected Health Information

Suzi Phelps, Ph.D.
6750 West Loop South, #1000 Bellaire, Texas 77401

As required by the Health Insurance Portability and Accountability Act of 1996 this practice may not use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices, which is available upon request. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

CONSENT SECTION

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

_____ _____

Signature Date