PRE-INTAKE INFORMATION

NAME:_____
First Middle Last

AGE: _____ DATE OF BIRTH_____

(IF PATIENT IS A MINOR)

GUARDIAN OR PARENT'S NAME _____
GUARDIAN OR PARENTS'S NAME _____
PARENTS ARE _____.
Married, separated, divorced, unmarried
==========

OCCUPATION (OR GRADE) _____

HOW LONG EMPLOYED_____

CHILDREN'S NAMES AND AGES _____

_____

MARITAL STATUS _____LENGTH OF MARRIAGE_____

SPOUSE'S NAME _____

BRIEF REASON FOR SEEKING THERAPY
_____
_____
_____

MEDICATIONS, DOSAGES, PRESCRIBING DR.'S NAME:
_____
_____
_____

PREVIOUS TREATMENT, DATES AND THERAPIST'S NAME(S)
_____
_____
_____

INFORMATION

HOME ADDRESS:_____

_____

CITY/STATE/ZIP _____

HOME PHONE: _____ WORK PHONE_____

CELL PHONE: _____SOC. SEC. # _____-_____-_____

DRIVER'S LICENSE NUMBER: _____

EMPLOYER: _____

ADDRESS: _____

OCCUPATION: _____

PRIMARY INSURANCE CARRIER INFORMATION

NAME OF INSURED: _____

DATE OF BIRTH: _____/_____/_____ RELATIONSHIP _____

HOME PHONE: _____

CELL PHONE: _____

EMPLOYER: _____

SOC. SEC. #: _____-_____-_____DL #_____

Emergency Contact: _____

Who is financially responsible for the account? _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I_____, authorize my therapist, Dr. Debra Dayton to release information as to my diagnosis and treatment to my insurance company for the sole purpose of validating my claim. I also

assign my insurance benefits to my provider and I authorize payment to be made directly to her office by my insurance company.

Signature: _____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

ID # ON CARD: _____ GROUP: _____

CUSTOMER SERVICE OR MENTAL HEALTH NUMBER ON CARD:
_____

THE FOLLOWING SECTION TO BE COMPLETED ONLY IF PATIENT IS A MINOR

GUARDIANS' NAME: _____
ADDRESS _____
CITY/STATE/ZIP _____
HOME/WORK CELL _____
PLACE OF EMPLOYMENT _____
SECOND GUARDIAN'S NAME: _____
ADDRESS
(IF DIFFERENT) _____
HOME/WORK/CELL _____
PLACE OF EMPLOYMENT_____
IF PARENTS ARE DIVORCED PLEASE EXPLAIN THE CUSTODY ARRANGEMENT:
_____
_____
_____

Phone Consults

Your Psychologist understands that you may have questions or concerns after appointment times. Please understand we see clients by hourly appointments and are unable to do phone consults. If you have therapy questions that are not an emergency (life or death nature) please wait until your next appointment, or call to schedule an appointment to discuss your concerns.

If you have any questions have regarding medication please call your physician.

RETURN CHECKS
Returned checks have a fee of 10.00 for the first returned check that is received
and any charges that may be assessed by the providers Bank.

The second returned check that is received will be discussed in therapy with the provider as well as a 25.00 charge plus any fees the provider is assessed from the Bank.
The third returned check the Client will be referred to a new Therapist as well as a 25.00 charge and any fees the Provider is assessed from the Bank.
An insufficient fund receipt will be provided every time a notice is given by your Provider.

PATIENT SIGNATURE (or parent/legal guardian)

_____

OFFICE PROCEDURES AND PATIENT CONTRACT

Please be aware that Dr. Dayton maintains a separate and independent practice from Dr. Gifford or any associates. No partnership exists between these individuals and each assume liability solely and only for their own psychological practice. As a client I acknowledge and agree that I will not hold these providers accountable or liable for the actions of the other.

Initial_____

1) Clients are seen by appointment only. Appointments may be made by calling Dr. Dayton Monday-Friday between the hours of 9:00 am and 5:00 pm, or on therapyappointment.com link. It is policy to change, confirm, add or cancel appointments ONLY with the identified adult client or, if the client is a minor, with the legal guardian. Sessions are generally 45-50 minutes in length.

Initial_____

2) If you cancel an appointment with fewer than **24** hours notice, you will be responsible for full session fee of (70.00), which insurance does not cover. Your provider retains the right to cancel or reschedule appointments due to client needs and/or emergencies, and will make every effort to contact you as promptly as possible, should such an occasion arise.

Initial_____

3) Dr. Dayton is a psychologist and can not admit clients to any hospital. Therefore, in case of emergency, contact your psychiatrist or go directly to the nearest hospital ER or contact 911 for help. Please be advised that phone consultations over 15 minutes are billed at the same rate as office visits, and may not be covered by the insurance.

Initial_____

4) All communications that occur between therapist and patient are kept in the strictest confidence. No information will be discussed with anyone without prior written authorization from the patient/legal guardian. Under most circumstances, evaluation reports and therapy session notes will remain completely confidential; however, under Texas law, there are several exceptions to this rule. The most common are:

a. Suspected abuse of a child, elderly, or disabled person.

b. You indicate an intention to harm yourself or any other person

c. Sexual exploitation by a former or current therapist

d. Cases, before a court of law, in which your mental health is an issue

e. Collection of past-due charges of fees.

f. All patients using third parties to provide partial or complete payment of fees should be aware that any and all of the information provided to the paying organization could be made available by that organization to: employers providing the insurance benefits, other insurance companies/agencies requesting the information, and other health-care providers that have contact with the insurance company.

Initial_____

5) If you want us to file insurance claims for you, you must supply the appropriate information and claim forms (if your insurance company requires special billing forms). If you do not supply us with accurate information to file your insurance claims, all charges become your responsibility. I **do not file claims for secondary insurance.** I require at least 24-hours' notice of any change in insurance in order to obtain the proper authorization for treatment and to file your claim. If you fail to give us at least 24-hours' notice of a change in insurance, all charges become your responsibility. Please be advised that this office utilizes a billing service/therapyappointment.com & Office Ally to process claims. All client information is handled with utmost confidentiality and HIPAA compliance.

Initial_____

6) I hereby give written permission to fax clinical data to managed-care companies, other third party payers, and/or other mental health care professionals.

Initial_____

7) I hereby give permission for treatment.

Initial_____

8) You have a right to withdraw from treatment at any time, unless treatment is court-ordered. If you would like a referral to a different therapist, your provider will gladly assist you in finding one.

Initial_____

9) The ethical codes of therapists/psychologists prohibit dual relationships between clinician and patient. This means that if you ever are a patient, your therapist cannot meet with you for social occasions or be involved in any business activities with you other than providing psychological services.

Initial_____

10) Often, patients seek psychological services because they wish to change some aspect of their lives, behavior, or environment. Changes in the patient frequently produce changes in personal relationships, work relationships, and other areas of the patient's life. It is important that you recognize the potential impact of any changes that may occur before you begin treatment.

Initial_____

11) In the event that my therapist reasonably believes that I am a danger, to myself or another person, I specifically consent for the therapist to warn the person in danger and my emergency contact person

Initial_____

12) Dr. Dayton, due to confidentiality and reasons of ethics, cannot connect or communicate with clients on social media such as Linkedin or Facebook.

Initial_____

13) You should be aware that I share the cost of office rent with other psychologists. Each psychologist, including myself, maintains a separate practice. The providers are not a part of a group practice, and each provider is responsible for his/her own business policies and practice activities. All independent practitioners in the office are bound by the same rules of confidentiality.

Initial_____

14) You should be aware that I contract with administrative staff as needed. In some case, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. These employees are given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Initial_____

I HAVE READ AND UNDERSTAND THE CURRENT PROCEDURES STATED ABOVE, AND AGREE TO ABIDE BY THEM REQUISITE TO TREATMENT;

Signature of patient/legal guardian_____

Date_____

NOTICE OF PRIVACY PRACTICES

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

1) The privacy of your medical information is important. I understand that your medical information is personal, and am committed to protecting it. I create a record of the care and services you receive at this office. This record is needed to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways a therapist may use and share this information about you. It describes your rights and certain duties psychologists have regarding the use and disclosure of medical information.

2) Psychologists Legal Duty:

The Law Requires Psychologists To:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

Psychologists Have the Right To:

1. Change privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in privacy practices and the new terms of the notice effective for all medical information that is kept, including information previously created or received before the changes.
3. Before making an important change in privacy practices, the notice will be changed and a new notice will be available upon request.

3) Use and Disclosure of Your Medical Information:

The following section describes different ways that psychologists use and discuss medical information. Not every use of disclosure will be listed. Therapists will not use or disclose you medical information for any purpose not listed below, without your specific written permission. Any specific written authorization you provide may be revoked at any time in a written statement to your therapist.

1. For Treatment: Psychologists may use medical information about you to provide you with treatment or services. Psychologists may disclose medical information about you to doctors, nurses, technicians, or other people who are taking care of you.
2. For Payment: Psychologists may use and disclose your medical information for payment purposes.

Initial_____

3. Court-Ordered, Judicial, and Administrative Proceedings: Your therapist may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful

process under certain circumstances. These circumstances include a court order, warrant, or grand jury subpoena. Your therapist may share your medical information with law enforcement officials. Your therapist may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person.

4. Victims of Abuse, Neglect: Your therapist may disclose information if she/he reasonably believes that a minor, disabled or elderly individual is a possible victim of abuse or neglect. Your therapist may inform an intended victim if there is a threat to their life or inform the authorities.

5. According to the Patriot Act: Your therapist may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law your therapist cannot reveal when she/he has disclosed such information to the government, according to the Patriot Act.

4) Your Individual Rights:

You have a right to:

1. Look at or get copies of your medical information. You may request that your therapist provide copies in a format other than photocopies. Your therapist will use the format you request unless it is not practical to do so. You must make your request in writing. You may request the form from a member of our staff. If you request copies, the charge is $10.00 for 1-5 pages, and $2.00 per page thereafter. If you request that the copies be mailed, you may be charged postage.

2. Request that your therapist place additional restrictions on the use of disclosure of your medical information. Your therapist is not required to agree to these additional restrictions, but if so, he/she will abide by the agreement, except in case of emergency.

3. Request that your therapist change your medical information. Your requests may be denied. If your therapist denies your request, your therapist will, upon request, provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information that you want changed. If your request is accepted to change the information, a reasonable effort will be made to tell others, including people you name, of the change, and to include the changes in any future sharing of that information.

Initial _____

FINANCIAL POLICY

Thank you for choosing me as your mental health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of the FINANCIAL POLICY, which *you are required to read and sign prior to the receipt of any treatment.*

CO-PAYMENTS AND/OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH AND CHECKS ONLY.

Insurance: We will gladly discuss your insurance, and will answer any questions to the best of our ability. You must realize, however, that:

1) Fees for services are as follows:

- Initial Evaluation 150.00
- Individual 125.00
- Group fees vary depending on the group. (separate group fee contracts will be signed)

Payment is due at the beginning of each appointment. Nonpayment of services which are thirty (30) days past due will result in termination of therapy. If termination is necessary, you will be given notice, and supplied with a list of alternative therapists or agencies in your area and/or referred back to your insurance company for further resources.

2) Your insurance is a contract between you, your employer, and your insurance company. We are not party to that legal contract.

3) The above fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of "usual and customary" fees. Current fees are considered usual, customary, and reasonable by most insurance companies.

4) Not all services are covered benefits in all contracts. Some insurance companies select certain services they will NOT cover. It is YOUR RESPONSIBILITY to determine if the services provided you are a covered benefit under your plan.

I must emphasize that, as a mental health care provider, my relationship is with YOU, and NOT YOUR INSURANCE COMPANY. While this office does file claims with your insurance company, **all charges are your responsibility from the date services are rendered.** If payment is not received, or if the payment that is received from the insurance company is incorrect, a reasonable effort will be made to contact your insurance company, you may then be billed directly for the amount not received. It will then be **your responsibility** to contact your insurance carrier to resolve the issue. If such problems do arise, you are encouraged to contact your insurance company promptly, as any balance unpaid within 60 days of the date of service may be turned over to a collection agency.

MINOR PATIENTS: The adult accompanying the minor patient shall be responsible for making a co-payment at the time of service. For minors not accompanied by an adult, non-emergency treatment will not be provided unless arrangements for co-payment have been made in advance.

Signature_____

FORENSIC SERVICES

(Professional Services related to Court appearances as an expert witness, and/or reports to be used in Court, or related legal areas.)

1. Hourly Rate $ 150.00

Includes:

A. Preparation Time
B. Travel Time
C. Consultation with attorneys, both in person and by phone
D. Time spent testifying as an expert witness
E. Review of documentation related to Court, Forensic Areas
F. Testing and/or report/letter preparation

2. Fees are not covered by insurance and are to be pre-paid. For Court appearances, a minimum of $450.00 (3 hours at $150.00 per hour) is required to be paid in advance.

3. In the event that a court appearance is canceled within two (2) days of the date scheduled, the fee is non-refundable, with the exception of $150.00, which will be applied to subsequent Forensic Services. If none are required, that amount ($150.00) will be refunded.

4. A subpoena will not negate fees generated.

I have read the information related for Forensic fees and agree to the terms.

_____ _____

Patient or Authorized Representative Signature Date

The Client agrees and understands that Dr. Dayton will not communicate with the client through social media sites such as LinkedIn or Facebook for ethical reasons, as this would be a conflict of interests.

The Client agrees that if they do not Schedule an appointment or communicates with their therapist for three months, their therapist will assume they have terminated. If a client has not been seen in therapy for one year, they will be treated as a new client.

Patient Name_____

Signature of Patient/Guardian_____

Date_____

I acknowledge that, in the event of Dr. Debra Dayton's death or incapacity it will be necessary for another person to take possession and control of my file and my records. By my signature below I give my consent to allow another person, **selected by my psychologist** to take possession and control of my file and records and to provide me with copies or to deliver to a mental health provider of my choice, upon my written request and payment for reasonable administrative costs.

Name of Patient (Printed)_____

Signature of Patient/Guardian_____

Date_____

QUESTIONS AND COMPLAINTS

If you have any questions or would like to discuss any of the policies or procedures please contact your therapist:

Debra Dayton PhD.
3508 Hwy 121
Bedford, TX 76021-3125
682-704-1063

Additionally, if you feel that any of your rights have been violated, please contact the person above. You may also submit a written complaint to the U.S. Department of Health and Human Services or the Texas State Board of Examiners of Psychologists. Your therapist will provide you with the address to file your complaint, and no retaliatory action will be taken.

ACKNOWLEDGEMENT:

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

PATIENT NAME
(please print)_____

SIGNATURE OF
PATIENT/GUARDIAN_____

DATE_____