PATIENT INFORMATION RECORD

NAME:_____ DOB:___/___/___ AGE: _____ ___M ___ F

SSN:_____ DRIVER'S LIC#:_____ MARITAL STATUS: __S __M __D __OTHER

STREET ADDRESS:_____ CELLULAR PHONE:_____

CITY:_____ STATE:_____ ZIP:_____

EMAIL:_____

EMERGENCY CONTACT:

NAME:_____ STREET ADDRESS:_____

CITY & STATE:_____ PHONE:_____ RELATIONSHIP TO PATIENT:_____

PATIENT EMPLOYER/SCHOOL ADDRESS: _____

PATIENT EMPLOYER/SCHOOL TELEPHONE:_____

PARENT/SPOUSE:_____ DOB:__/__/__ SSN: _____

PARENT/SPOUSE ADDRESS:_____

PARENT/SPOUSE TELEPHONE:_____

PLEASE CIRCLE **(YES OR NO)**

MAY I LEAVE A MESSAGE FOR YOU VIA VOICEMAIL IN REGARDS TO APPOINTMENTS? **Y N**

MAY I EMAIL YOU IN REGARDS TO APPOINTMENTS? **Y N**

MAY I SEND TEXT MESSAGES TO YOUR TELEPHONE IN REGARDS TO APPOINTMENTS? **Y N**

I HEREBY AUTHORIZE EMMA J. WOOD, PSYD, TO PROVIDE TREATMENT FOR ME AND/OR MY DEPENDENTS.

DATE:_____ SIGNATURE:_____

PLEASE INITIAL UNDER EACH SECTION:

Confidentiality:

I understand that my information and things I discuss with Dr. Wood will be kept confidential. I understand that there are exceptions to confidentiality, and confidentiality may be broken under any of the following circumstances:

1. If a court of law orders my records.
2. If Dr. Wood believes I am a danger to myself or someone else.
3. If I disclose sexual misconduct by a mental health therapist.
4. If Dr. Wood suspects child abuse or abuse of the elderly or disabled.
5. I will be responsible for the confidentiality of the documentation/receipt from my appointment that contains information about my diagnosis and treatment.

If you have any questions about the above information, or if you have questions about a specific situation, please feel free to discuss your questions with Dr. Wood.

****INITIALS**: _____

Fees for services:

Fees for services are as follows:

Intake Session: $180
Therapy hour: $160.00
Late cancelation (less than 24 hours) fee: $50
No show fee is equivalent to the services scheduled to be rendered

All fees are due after each session. Fees are assessed for each 50-minute session.

**INITIALS: _____

Court:

I understand that Dr. Wood does not testify in court as an expert witness. In rare and unusual situations where Dr. Wood might be required to testify in civil court, she will require payment of her standard fee of $160.00 per hour. Fees will be assessed for any time that Dr. Wood spends in court related activities. These include, but are not limited to, paperwork, consultation, travel, and time spent in court.

****INITIALS**: _____

Crisis Intervention:

I understand that Dr. Wood does ***not*** provide 24-hour crisis counseling. If I experience a crisis that requires immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance. If I need to be seen prior to my next scheduled appointment, I understand that I may contact Dr. Wood and ask for an earlier appointment. I understand that Dr. Wood will make an effort but does not guarantee to provide me with an earlier appointment.

****INITIALS**: _____

I acknowledge that I have read and understand the above information. I certify that the information I provided above is true and accurate, to the best of my knowledge. By signing below, I consent to receive psychological services from Dr. Wood. My signature also acknowledges that I have received a copy of Dr. Wood's Notice of Privacy Practices.

Printed Name _____

Signature:_____ Date:_____

CONSENT TO USE OR DISCLOSE INFORMATION FOR
TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

(TPO)

Patient Name:_____

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 I provide, and for other professional activities (known as “healthcare operations”). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise my Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time. You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or healthcare operations: however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked. I hereby consent to the use or disclosure of my protected Health Information as specified above.

Signature of Patient:_____ Date:_____