GEORGE P. GLASER, LCSW
Austin TX 78748

Video-based Behavioral Medicine

512-371-9418…(voice) • 512-637-8889 (fax) • 512-791-7075…(mobile/text) • george@georgeglaser.com

PRACTICE INFORMATION AND POLICIES

I appreciate the trust you have shown in making this appointment with me. It is my intention to provide you with personalized and effective mental health services. Below is information about my virtual practice policies.

- I want our online sessions to be a place where you can comfortably and safely work on resolving your problems. Please let me know if there is anything about the virtual sessions or our relationship that interferes with that process.
- Notify me as soon as possible, preferably no later than 24 hours in advance if you need to cancel or reschedule an appointment. You have contracted for a portion of my time, and if we do not meet that slot is likely to be empty. This has become especially important as my schedule is full and clients are frequently waiting a couple of weeks or longer for an opening. Missed appointments and late cancellations (i.e. less than 24-hour notice) incur a $60 charge for the first event, and $90 if it occurs again. *No portion of that charge is covered by your insurance.*
- I understand that unusual circumstances occur that might keep you from being able to keep an appointment. Let me know as soon as possible if such a situation occurs.
- Please review the sheet entitled *Payment Methods for Telehealth Services* for information on how I am accepting payments with virtual services.
- If I am contracted with your insurance company, the total ‘allowable’ fee for each session is set by that contract. Your services and fees may exceed the benefits provided by your insurance or managed care benefits package due to factors like annual deductible amounts and copayments. Managed care and insurance plans are often complicated, and I will do what I can to help guide you, interpret the contracts, and track your services and costs. However, as my client you are ultimately responsible for payment of any fees not covered under the insurance plan.
- Text messaging to 512-791-7075 and emailing to george@georgeglaser.com are usually the most efficient ways to reach me. I check my voice mail messages during the day and try to return calls within 24 hours. If you have an emergency outside of daytime hours, call or text me at (512) 791-7075. In a life-threatening situation, call 911, your physician, or go to the nearest emergency room.
- If you are seeing a psychiatrist or other physician for medication, you will need to speak with your doctor or their representative about all questions related to your medication. If a problem occurs, contact your physician(s) or pharmacist immediately.
- Please let me know directly and promptly if you have concerns related to my services with you. It is most constructive to work out concerns sooner than later.
- If you have unresolved concerns about my professional social work services, you can contact the Texas State Board of Social Worker Examiners in Austin at https://www.bhec.texas.gov/texas-state-board-of-social-worker-examiners/index.html, contact by email at licensing@bhec.texas.gov, or call 512-305-7700.

SIGNATURE: ________________________________ DATE: ______________________

Keep a copy for your records

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CLIENT INFORMATION–ADULT

Please complete all pages.

Today's Date __________ Referred by __________

Referrer's Address __________ Referrer's Phone __________

First Name __________ Middle Name __________ Last Name __________

DOB __________ Sex __________ Gender Identity __________ Relationship Status __________

Address __________

City __________ State __________ Zip __________ Mobile Phone __________

Home Phone __________ Ofc Phone __________ E-mail* __________

* ☐ *Check here to confirm your approval to communicate by unencrypted email or text.*

Employer __________ Occupation __________

Emergency contact __________ Relation to You __________ Mobile # __________

Spouse/Partner's Name __________ Spouse/Partner's Occupation __________

Spouse/Partner's DOB __________ Spouse/Partner's Employer __________

Spouse's Mobile # __________

Children	DOB	Siblings	DOB

INSURANCE INFORMATION (*Please scan or photograph your insurance cards if you want me to file claims for our services*)

Primary Insurance

Insured Person __________ Insured's SS# __________ Employer __________

Insurance Co __________ Account ID # __________ Group # __________

Claims Address __________ Effective Date __________ Insured's DOB __________

City __________ State __________ Zip __________ Claims Phone # __________

Secondary Insurance

Insured Person __________ Insured's SS# __________ Employer __________

Insurance Co __________ Account ID # __________ Group # __________

Claims Address __________ Effective Date __________ Insured's DOB __________

City __________ State __________ Zip __________ Claims Phone # __________

ADULT INTAKE FORM
Problem Description and History

NAME: ____ DATE: ________________________

PROBLEM DESCRIPTION AND HISTORY

1. What is/are the problem(s) for which you are seeking help?

2. Why do you think these problem(s) exist?

3. Have you sought help before with this problem(s)? Where, when, and how?

4. What results did you have? *(if applicable)*

5. Are you currently working with any other mental health provider(s)? Yes ❑ No ❑
   If yes, please give names, addresses, and phone numbers

6. Who is your primary care physician? (include their address and phone number)

7. Are you taking any prescribed medications? Yes ❑ No ❑
   If yes, list types, dosage, and the prescribing physician(s):

8. Do you currently use...

Alcohol	Yes ❑	No ❑	Frequency of use __________	Amount _____________
Drugs	Yes ❑	No ❑	Frequency of use __________	Amount _____________
Tobacco	Yes ❑	No ❑	Frequency of use __________	Amount _____________
Caffeine	Yes ❑	No ❑	Frequency of use __________	Amount _____________

9. Have you ever been addicted to, or told you were addicted to...

Alcohol	Yes ❑	No ❑
Drugs	Yes ❑	No ❑

   Add additional comments if needed about drug and alcohol use current or past:

10. Describe your expectations of how therapy will help you.

11. What do you need to learn and accomplish to change the problem(s) for the better?

12. Describe any physical problems you have been experiencing during the past month.

13. What methods do you use for relaxation?

14. Describe any spiritual practices and beliefs in your life?

15. Describe your current intimate relationship(s).

16. Describe, if applicable, any history of physical or sexual abuse/assault as a child or adult.

17. Do you use pornography? If "yes", describe the frequency and type of pornography, and does anyone (including you) believe it affects your current or past relationships?

18. What are some ideas and beliefs you hold about yourself? What do you think about yourself?

19. How do other people in your life relate to you? How do you think other people describe you?

ADULT INTAKE FORM

Problem List

NAME:

DATE:

Mark the severity of these symptoms to the extent they apply to you by clicking the appropriate checkmark.	**None**	**Mild**	**Moderate**	**Severe**
Depressed Mood	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Suicidal Thinking	☐	☐	☐	☐
Disturbed Sleep (increase / decrease)	☐	☐	☐	☐
Appetite Changes (increase / decrease)	☐	☐	☐	☐
Slowed Activity	☐	☐	☐	☐
Significant Weight Loss	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐
Poor Grooming	☐	☐	☐	☐
Agitation	☐	☐	☐	☐
Elated Mood	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Emotions Are Hard to Control	☐	☐	☐	☐
Obsessive Thinking	☐	☐	☐	☐
Tense/Anxious	☐	☐	☐	☐
Fearful (Phobic)	☐	☐	☐	☐
Physical Problems	☐	☐	☐	☐
Hard to Keep Train of Thought	☐	☐	☐	☐
Makes Inappropriate Speech or Sounds	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Impaired Intellectual Functions	☐	☐	☐	☐
Impaired Judgment	☐	☐	☐	☐
Long-term Memory Problems	☐	☐	☐	☐
Short-term Memory Problems	☐	☐	☐	☐
Paranoia	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Hostile Feelings Toward Self or Others	☐	☐	☐	☐
Violence Toward Self or Others	☐	☐	☐	☐
Illegal Behavior	☐	☐	☐	☐
Conflict with Authority	☐	☐	☐	☐
Disruptive Behavior	☐	☐	☐	☐
Social Isolation	☐	☐	☐	☐
Dissociative Episodes (amnesia, losing consciousness)	☐	☐	☐	☐
	None	Mild	Moderate	Severe

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FEE INFORMATION AND CONTRACT

The following list shows my fees for professional services as of January 1, 2023.

Initial Evaluation (Individual) $150

Initial Evaluation (Couples and Families) $180

Psychotherapy (Individual)

25 minutes $80

50 minutes $130

80 minutes $175

Couples Therapy

50 minutes $150

80 minutes $180

Family Therapy

80 minutes $180

Clinical Hypnosis

25 minutes $70

50 minutes $140

80 minutes $180

Reports, letters, and other documents

Copy and send chart documents.......... $40

Report preparation per page up to 2 pages.......... $40

(*Fees for reports longer than 2 pages will be discussed on an individual basis)*

Court and Deposition Services per hour $250

These fees do not reflect any contracted discounts with managed care plans or individuals. The total fee, or the agreed upon copayments, are due at time of service unless alternative arrangements have been made with Mr. Glaser.

* *

I have read the *Practice Information and Policies, HIPAA Notice of Privacy, and Fee Information and Contract* forms. I agree to participate in assessment and agreed-upon treatment services with Mr. Glaser. I understand the fees and payment policies and agree to pay all professional fees in a timely manner as discussed with Mr. Glaser and as outlined on the above-mentioned forms.

Type your name and date below to affix your signature.

Signature: ____ Date: __________________

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HIPAA NOTICE OF PRIVACY

Client Name: ___________________________________ Date of Birth: _____________________

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully and ask Mr. Glaser for clarification if needed.

Private Health Information (PHI) may be used and disclosed in the following circumstances:

1. Information that is necessary to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman's compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits by managed care companies.

As a client, you have rights to your Private Health Information, including,

1. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored as soon as possible and within 30 days.
2. The right to request information of any party that has requested information pertaining to your private health information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

As a private practitioner, I have the responsibility to:

1. Make each client aware of the Privacy Notice.
2. At any time make the necessary changes to the Privacy Notice that are required by law.

If you think your privacy has been violated you have the right to complain by filing a written complaint with the Secretary of Health and Human Services in Washington, D.C.

Choose one option below using the checkbox: (*You must use the first option when using your insurance*)

☐ I, (print name) _________________________________, understand the above statements and hereby authorize George P. Glaser, LCSW to release PHI on my behalf to the following parties (*including but not limited to insurance companies, physicians, therapists*):

____

☐ Do not release any of my Private Health Information to any outside parties. (*this option is not available when using your insurance benefits*)

Type your name and date below to affix your signature.

Client/Legal Guardian Signature: ___________________________________ Date: ________________

Sign and date this sheet.

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TELEHEALTH INFORMED CONSENT

I __________________________________, (*name of client*) hereby consent to participate in telemental health services with George Glaser, LCSW as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telemental health services:

1. I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. That there are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. That there will be no recording of any of the online sessions by either party unless recording is requested by the client. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. That the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. That if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. That during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 512-371-9418 to discuss the issue as we may have to re-schedule.
7. That my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocol

As the therapist, I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on

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on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to a treatment center in the event of an emergency.

In case of an emergency during the video session, my (the client) location is:

____

and my emergency contact person's name, address, phone is:

____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all my questions have been answered to my satisfaction. *Enter your name and date below to affix your signature.*

________________________________	________________
Signature of client/parent/legal guardian	*Date*
________________________________	________________
Signature of therapist	*Date*

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Payment Methods for Telehealth Services

Zelle®*

Zelle allows you to easily send payments directly from your bank with your computer or device. Many banks offer the option of sending funds by Zelle with no service fee to the sender or recipient. Set me as the payment recipient by using my name, George Glaser, and my mobile number, 512-791-7075.

Apple Cash*

I accept payments via Apple Cash. Use the Apple Cash button in a text message to me at 512-791-7075. These payments are sent and received immediately, and payment confirmation appears in your Apple Wallet. This is an easy and secure way to send payments.

Google Pay*

Payments can be sent using Google Pay by finding me at 512-791-7075 using the Google Pay app. Confirmation of the payment will appear in the app. This is an easy and secure way to send payments.

Venmo

Venmo is a social media app and associated financial service that allows you to send payments directly from your bank with your computer or device. Your financial institution may offer the option of sending money by Venmo with no service fee to the sender or recipient. Use **@George-Glaser-6** as the Venmo username. Because of the social media aspect of the service, I recommend as a confidentiality safeguard that your Venmo preferences are set to "Private" to avoid others seeing your payment.

Check*

I accept personal checks, or one sent from your bank. For security reasons, I recommend you confirm with me by text, phone, or email when planning to send a payment by check. Checks should be sent to me at the address at top.

Cash App**

Cash App is like Zelle in some ways, but it is more like a credit card in the way it charges the recipient. Download the Cash App on your IOS or Android device and link it to a debit card, then send payment to me at $GlaserTherapy plus a 3% surcharge added to the fee. (*payment for a $100 fee totals $103*).

Credit Card**

I accept credit card payments with a 4% surcharge. To use this method, I need your credit card account number, expiration date, security code, and zip code of the account. You can call and leave that information confidentially on my office line at 512-371-9418 or provide it during a session.
(*payment for a $100 fee totals $104*)

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* Preferred Methods

** Involves a surcharge to the base fee

Updated 10-15-2022