Philip R. Budd, Psy.D.

Address: 2216 Shadowlake Dr
Oklahoma City, OK 73159

Phone: 405-990-8204

Client Information Form

Date: _____If you have been a client here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.:_____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell Phone: _____

Calls will be discreet, but please indicate any restrictions:_____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

How did this person explain how I might be of help to you? _____

_____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

Current medications: _____

D. Your current employer

Employer: _____ Address: _____

Work phone: _____Calls will be discreet, but please indicate any restrictions: _____

E. Your education and training

Dates					
From	To	Schools	Special Classes?	Adjustment to school	Did you graduate?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

F. Employment and military experiences

Dates From	To	Name of military/employers	Job title or duties	Reason for leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

G. Family-of-origin history

Family Member	Living? (Y/N)	**Age**	Health Good	Fair	Poor	If deceased, cause of death
Father						
Mother						
Brothers						
Sisters						

-

Check condition and relationship of any blood relative who has or or has had any of the conditions listed below	Mom	Dad	Paternal GF	Paternal GM	Maternal GF	Maternal GM	Siblings	Other ____
Alcoholism/Substance Abuse								
Allergies								
Birth Defects								
Cancer								
Colitis								
Depression								
Heart Attack								
High Blood Pressure								
Migraine								
Mental Illness								
Seizure Disorder								
Mental Retardation								
Learning/Attention Problems								
Suicide/Suicide Attempt								
Other (Specify)								

H. Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____

Date of current marriage: _____ Spouse's name: _____ Spouse's age: _____

I. Significant nonmarital relationships

Name of person	Person's age when started	Person's age when ended	Your age when started	Your age when ended	Reasons for ending
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

J. Children (Indicate which are from a previous marriage/relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?
_____	_____	_____	_____	____	_____	___
_____	_____	_____	_____	____	_____	___
_____	_____	_____	_____	____	_____	___
_____	_____	_____	_____	____	_____	___
_____	_____	_____	_____	____	_____	___

K. Spiritual Life

Signature: _____ **Date:** _____

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GENERAL CONSENT FOR TREATMENT FOR ADULTS

_____ _____
Client's Name Therapist's Name

1. All clinic files are confidential and my written consent is required for any release of information by the clinic to any other persons outside the clinic except in the following circumstances: (a) court orders and subpoenas, (b) to defend legal action against the provider, (c) need to prevent clients from harming him/herself or others, and (d) suspected child abuse/neglect. If I request that the provider submit reimbursement forms for your insurance, complete confidentiality cannot be assured. If I file a lawsuit related to mental health issues, provider records may also be accessed by the court.

2. While I have the right to access my file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my therapist about any questions I have concerning the content of my file or sessions.

3. I may be asked to sign consent forms for the release of social, medical, and/or psychological information from other agencies or individuals for the use by the staff of this clinic in my assessment or treatment. I may request restrictions on the use/disclosure of information in my file for treatment, payment and health care operations purposes, but the therapist is not bound to agree with my request.

4. I understand that it is impossible to assure privacy of any communication by electronic means (email, faxes, text messages). Email or text messages should never be used to communicate any urgent matter to the provider.

5. Information from clients' files may be compiled to study various issues such as treatment outcomes and client satisfaction. My name or any identifying information will not be used in such research.

6. The provider is available at his practice Monday and Wednesday. Emergency and 24 hour services are not available. In the event of an emergency, patients must call 911 or go to an emergency room at a hospital. My therapist and I will set appointments.

7. The practice of psychology and related disciplines is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatments, assessments, and consultations. I understand that I am responsible for working with my therapist to help ensure better treatment outcomes.

8. Dr. Budd is not a medical doctor; therefore I do not prescribe medications and am not authorized to practice medicine. If Dr. Budd thinks that I should consider medication as a part of treatment, and I want to try this, Dr. Budd will refer me to a physician with whom they would work to provide coordinated services. I understand that psychological problems can have medical or biological origins and I should have regular physical exams and speak with the doctor about all my symptoms.

9. I consent to undergo all testing and treatment procedures necessary to address the problems for which I am seeking help. I understand that I have the right to be informed of the nature and purpose of any procedure and that I can refuse or discontinue testing or treatment at any time.

10. I understand I am responsible for any fees for services to which I consent, and that failing to pay such fees may result in termination of any further services to me. Payment is due at the beginning of my appointment. I must cancel at least 24 hours before my session, unless my therapist and I both agree my cancellation was due to an emergency, or I am responsible for the session fee before I can schedule a new session. Continued non-payment of fees may result in action including being referred to a collection agency.

11. I understand that special arrangements may need to be made regarding payment and reporting of assessment and treatment results in cases of divorce and court-mandated services. No child custody evaluation is conducted by Dr. Budd. Any litigation that requires deposition, testimony or reports, will result in additional fees that must be paid in advance.

Philip R. Budd, Psy.D.

CONSENT FOR TREATMENT SIGNATURE PAGE FOR ADULTS

Client's Initials

Therapy sessions and file information are confidential.
Except in cases of: (a) court orders/subpoenas, (b) to defend legal action against Dr. Budd, (c) need to prevent harm to self or others, and (d) suspected child abuse/neglect. Third party billing and lawsuits I bring related to mental health issues may also limit the confidentiality of my file. _____

There are some limitations to my access of my file.
While I have the right to access my file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my therapist about any questions I have concerning the content of my file or sessions. _____

I must sign release forms before information can be exchanged with other agencies.
The privacy of any electronic communication cannot be assured. Do not use email or text message for urgent matters. I may request restrictions on the use/disclosure of information in my file for treatment, payment and health care operations, but the therapist is not bound to agree with my request. _____

Some information from my file may be used in research.
I understand that names or any other identifying information will not be used in research. _____

Dr. Budd does not provide after-hours or emergency services (use 911 for after-hours crises). _____

The practice of psychology and related disciplines is not an exact science.
No guarantees have been made to me regarding the results of Dr. Budd's services. I am responsible for working with my therapist to help ensure better treatment outcomes. _____

Dr. Budd is not a medical doctor and cannot prescribe medications. _____

I consent to undergo all recommended testing and treatment procedures.
I can refuse or discontinue testing or treatment at any time. _____

I agree to pay my clinic bill. Payment is due at the beginning of sessions and I must cancel at least 24 hours before my session or I am responsible for the cost of the session. _____
Consequences of non-payment may include termination of services or being referred to a collection agency.

Special payment/reporting arrangements may be made in cases of divorce, litigation and court-mandated services. _____

I acknowledge that my therapist has reviewed the General Consent for Treatment with me and I have been given a copy to keep for my own records.

_____	_____	_____
Signature of Therapist or Witness	Signature of Client	Printed name of Client
Date: _____	Date: _____	

Revised 8/16/16

Philip R. Budd, Psy.D.

Agreement to Pay for Professional Services

I, the client (or guardian/legal representative), request that Dr. Budd provide professional services to me or to _____ , who is my _____, and I agree to pay his fee of $ 150 per 45/50 minute session and $160 for the initial evaluation. This fee may be determined by insurance contract. This same fee will be applied per each hour of consultation, assessment, or other therapeutic activity unless otherwise negotiated in writing.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I understand that if I do not pay for services that the services provided may be terminated by the therapist. Continued non-payment of fees may result in further consequences such as my case being referred to a collection agency.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. If any part of my fees is being paid by an insurance company or other third party payer, I understand that this may result in limitations to my confidentiality.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

____Copy accepted by client

___ Copy kept by therapist

CONFIDENTIAL

Philip R. Budd, Psy.D.
Notice of Privacy Practices

This notice talks about **privacy information**. This is nothing new. We've always taken great care to safeguard your privacy. What is new is a government regulation requiring us to explain your rights. This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. In the event that the notice is changed, a new notice will be sent to you by mail or at the time of your next appointment. You may request a copy of our Notice at any time.

This notice takes effect April 14, 2003, and will remain in effect until we replace it.

Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment by signing the consent form, this agency will use or disclose your protected health information as described below.

Treatment: We may use and disclose, as needed, your protected health information to provide, coordinate, or manage your health care and any related services.

Health Operations: We may use and disclose, as needed, your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluating practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Other permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to the Department of Human Services which is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse or neglect to the Department of Human Services. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose your protected health information in the course of any judicial, or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

Client Rights

Access: You have the right to inspect and copy your protected health information. We will use the format your request unless we cannot practicably do so. You must submit your request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If your request copies, we will charge you $1.00 for the first page, and $.25 each page thereafter to locate and copy your health information plus postage if you want the copies mailed to you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You have the right to request a restriction of your protected health information. You may also request that any part of your protected health information not be disclosed by family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restrictions we will be able to abide by our agreement (except in an emergency). We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted.

Alternative Communication: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must make your request in writing.

Amendment Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for you amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment or healthcare operations as described in this Notice of Privacy Practices.

Notice: You have the right to obtain a paper copy of this notice from us upon request.

Questions and Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. You may contact our Privacy Officer below for further information about the complaint process.

Attn: Philip R. Budd, Psy.D.

I have read and received a copy of the Notice of Privacy

_____

Client's signature

_____

Date

Philip R. Budd, Psy.D.
ADULT CHECKLIST OF CONCERNS

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

___ I have no problem or concern bringing me here
___ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
___ Aggression, violence
___ Alcohol use
___ Anger, hostility, arguing, irritability
___ Anxiety, nervousness
___ Attention, concentration, distractibility
___ Career concerns, goals, and choices
___ Childhood issues (your own childhood)
___ Children, child management, child care, parenting
___ Codependence
___ Confusion
___ Compulsions
___ Custody of children
___ Decision making, indecision, mixed feelings, putting off decisions
___ Delusions (false ideas)
___ Dependence
___ Depression, low mood, sadness, crying
___ Divorce, separation
___ Drug use—prescription medications, over-the-counter medications, street drugs
___ Eating problems—overeating, undereating, appetite, vomiting (see "Weight and diet issues")
___ Emptiness
___ Failure
___ Fatigue, tiredness, low energy
___ Fears, phobias
___ Financial or money troubles, debt, impulsive spending, low income
___ Friendships
___ Gambling
___ Grieving, mourning, deaths, losses, divorce
___ Guilt
___ Headaches, other kinds of pains

(cont.)

Adult Checklist of Concerns (p. 2 of 2)

___ Health, illness, medical concerns, physical problems
___ Inferiority feelings
___ Interpersonal conflicts
___ Impulsiveness, loss of control, outbursts
___ Irresponsibility
___ Judgment problems, risk taking
___ Legal matters, charges, suits
___ Loneliness
___ Marital conflict, distance/coldness, infidelity/affairs, remarriage
___ Memory problems
___ Menstrual problems, PMS, menopause
___ Mood swings
___ Motivation, laziness
___ Nervousness, tension
___ Obsessions, compulsions (thoughts or actions that repeat themselves)
___ Oversensitivity to rejection
___ Panic or anxiety attacks
___ Perfectionism
___ Pessimism
___ Procrastination, work inhibitions, laziness
___ Relationship problems
___ School problems (see also "Career concerns . . .")
___ Self-centeredness
___ Self-esteem
___ Self-neglect, poor self-care
___ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
___ Shyness, oversensitivity to criticism
___ Sleep problems—too much, too little, insomnia, nightmares
___ Smoking and tobacco use
___ Spiritual or religious concerns
___ Stress, relaxation, stress management, stress disorders, tension
___ Suspiciousness
___ Suicidal thoughts
___ Temper problems, self-control, low frustration tolerance
___ Thought disorganization and confusion
___ Threats, violence
___ Weight and diet issues
___ Withdrawal, isolating
___ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

___ _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: _____