Ψ ERICK GONZALEZ, PsyD Ψ

100 Allentown Pkwy, Suite 204 Allen, Texas 75002 (972) 727-3627 (VM) 469-247-8637 (Cell)

Date:_____ Referred by:_____

Name of Identified Patient:_____ Age: _____

(If you are here to discuss your child, they are the identified patient)

Street: _____ City:_____ State:_____ Zip:_____

SS#_____ D.O.B._____ Marital Status:_____

Physician:_____Medications:_____

Contact Information: (For identified patient)

Home Phone:_____ Work#:_____ Cell#:_____

Email address:_____Teenager's Cell Phone:_____

I give my permission to be contacted at: (circle appropriate) Home Work Cell Email

Child/Adolescent Patients: Name of school_____ Grade_____

Mother's Name:_____ Employer:_____

Mother's Home Phone:_____ Work:_____ Cell:_____

Father's Name:_____ Employer:_____

Father's Home Phone:_____ Work:_____ Cell:_____

Adult Patients: Employer:_____

Spouse's Name: _____ Spouse's Work #:_____

Spouse's Employer:_____

Responsible Party: _____ Phone:_____

Street:_____ City:_____ State:_____ Zip:_____

Person to Call in an Emergency:_____

Relationship:_____ Phone #:_____

Insurance Information (If we are filing for you):

Name of Insured:_____ Insurance Co Phone #: _____

Insurance Company:_____ ID/Group #:_____

I give consent to receive treatment and authorize insurance benefits to be paid directly to the provider: Susan Blandino, Psy.D. or Erick Gonzalez, Psy.D., and consent given to the release of any medical records needed by my insurance company to certify benefits or process claims.

_____ _____

Signature of Patient/Guardian Date

Office Policies

Erick Gonzalez, Psy.D.

Welcome. I assure you that services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. I am pleased that you have chosen me as your psychologist. I want to be certain that you understand what to expect. Please take a few minutes to review our office policies.

The Psychotherapy Relationship:
Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Psychotherapy calls for a very active effort on your part. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. But there are no guarantees of what you will experience. If you have questions about procedures, we should discuss them whenever they arise.

Fee Schedule: It is your responsibility to pay any deductible amount, copay, co-insurance amount or any other balance not paid by your insurance on the day that the service is provided. Payment may be made by cash, check, Visa, or Mastercard.

Office Visits

• Initial Consultation/Diagnostic Interview	$150.00
• 45-50 Minute Individual, Couples, or Family Therapy Session	$125.00

Testing

• Psychological Testing Rate	$125.00/unit
• Standard Battery is 5-7 units and includes administering, scoring, interpretation and written report	$625.00 to $875.00
• Psychoeducational Testing (Achievement testing is not part of the standard battery)	$125.00/unit

Office Fees

• Letter Writing	$50.00
• Phone Consultations (exceeding 15 minutes duration)	$50.00
• Photocopying of records (exceeding 15 pages)	$30.00
• Court Testimony/Written/Oral Correspondence for Legal Matters:	$350.00/hr.

Your session time is reserved for you. We do not make courtesy calls reminding you of appointment dates/times. If you are unable to keep your appointment, please notify us at least 24 hours in advance. In the absence of notification, you will be billed for the missed session. Insurance companies do not reimburse for missed appointments.

Late Cancellation Fee (less than 24 hours notice)	$50.00
No Show Fee	$125.00

Insurance Companies/Managed Care:
You are responsible for knowing your benefits, deductibles, copays and whether your provider is in or out of network. We are willing to do the extra work it routinely takes to work with such organizations. We will be responsible for filing insurance visits and recertification. We cannot accept responsibility for insurance company's decisions when paying claims. Filing of insurance is a courtesy provided at this office. Please note that we use a billing service. They have the same policies as this office with regard to patient confidentiality and privacy. Our billing company is called: Area Physician's Billing, Debbie Bain. Their contact number is 1-972-366-9969.

Contacting Us:
We use a voice mail system for all incoming calls (7 days, 24 hours). In the case of an emergency, we can be reached by calling the office number, pressing our voicemail box #, then pressing 0, and leaving call back information in that voicemail box. If your call is regarding appointment issues or other non-emergency related topics, please leave a message on our voice mail system and it will be returned promptly. Please note that if you do not contact me to schedule an appointment within a month of your last appointment, I will assume that you are no longer interested in receiving services and your case will be considered inactive.

Limits of Confidentiality:
The law and ethical codes protect the privacy of all information shared between a patient and psychologist. Only with your written permission can material from our sessions be shared with others. However, there are limits to confidentiality, some required by law and others are required by ethics. Please be aware of the following exceptions to privileged communications:

1. Any evidence or reason to believe that a situation of child/elderly abuse and/or neglect exists. By law, this information must be reported to the Texas Department of Human Services.
2. Any probability of physical harm to self or others. Protection from physical injury takes precedence over confidentiality and the therapist's primary responsibility is his/her "duty to warn" if he/she believed someone to be in imminent physical danger. Therefore, if an individual intends to take harmful, dangerous, or criminal action against self or another, it may be the therapist's duty to report such action or intent.
3. If subpoenaed by a court. This may involve providing the court with verbal testimony and/or records.
4. Clinical information may be shared with your insurance company, if that is your desired method of paying for sessions.

If your child is participating in therapy, parents will be informed if the child appears dangerous to self or others. However, the child's confidentiality will be observed with parents while allowing for periodic updates concerning progress, completed goals, and recommended parenting interventions based on the child's presenting problems.

Coordination of Care
Your insurance company requests that we communicate with your primary care physician to coordinate your care. Please complete the attached release of information (and supply your physician's name) so that we can inform them about diagnosis, treatment, and assessment. If you are uncomfortable with us communicating with your physician, please discuss this during the meeting with your psychologist.

I affirm that I have read and concur with the policies outlined above.
I have read and understand the limits of confidentiality and the therapist's responsibility to take action where necessary.
I have received a copy of HIPPA Notice of Privacy Practices.
I give my consent for releasing minimum necessary information to insurance carrier so that they can be billed.
I consent to treatment for myself (or my minor child).

Signature of Patient/Guardian:_____Date: _____

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Release of Confidential Information

Name:_____ Parent (if under 18):_____

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

☐ Treatment Plan ☐ Psychological Evaluation ☐ Telephone Contact

☐ Other_____

Recipient of the information:

☐ Family doctor: _____ phone #: _____ fax #: _____

☐ Psychiatrist: _____ phone #: _____ fax #: _____

☐ Other: _____ phone #: _____ fax #: _____

☐ Other: _____ phone #: _____ fax #: _____

☐ Other: _____ phone #: _____ fax #: _____

This information is being requested for the following purpose(s):

☐ Coordinate treatment

☐ Educational planning

☐ Other _____

This authorization shall remain in effect from the date signed below until

_____(expiration date or until the discontinuation of treatment.)

I understand that:

- **I may inspect or copy the protected health information to be used or disclosed**
- **I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.**
- **Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA.**
- **I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.)**

Signature of Patient: _____ Date:_____

Signature of Parent/Guardian:_____ Date:_____