ERICK GONZALEZ, PsyD

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NEW PATIENT FORM

GENERAL INFORMATION

Today's Date	
Name of Patient	
Age	
Date of Birth	
Address	
Cell Number	
Marital Status	
Referred By	

FOR CHILD AND ADOLESCENT PATIENTS

Mother's Name	
Mother's Cell	
Mother's Work Number	
Mother's Employer	
Father's Name	
Father's Cell	
Father's Work Number	
Father's Employer	
Gaurdian's Name	
Guardian's Cell	
Guardian's Work Number	
Guardian's Employer	

INSURANCE

Name of Insured	
Date of Birth of Insured	
Insurance Company	
Insurance Phone Number	
Identification Number	

CONSENT FORM

Please read and sign the following sections. There are 6 sections. Each section requires a signature.

1. CONSENT FOR TREATMENT AND PSYCHOLOGICAL TESTING
I give consent for Dr. Erick Gonzalez to perform cognitive, psychological and neuropsychological testing.

Signature of Patient/Guardian	
Date	

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2. CONSENT FOR FILING INSURANCE
I give consent for Dr. Erick Gonzalez and his billing company to contact my insurance company and file insurance claims. Our billing company is called: Area Physician's Billing, Debbie Bain. I also authorize insurance benefits to be paid directly to the provider: 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	

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3. INSURANCE COMPANIES
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.

I have read and understand the policies regarding insurance companies:

Signature of Patient/Guardian	
Date	

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4. 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.

Psychological Testing

- Standard Battery (includes administering, scoring, interpretation and written report $650.00 to $1200.00

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.
- Late Cancellation Fee (less than 24 hours notice) $50.00
- No Show Fee $150.00

Your testing 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.

I have read and understand the policies regarding professional fees:

Signature of Patient/Guardian	
Date	

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5. 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 psychologist'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.

I have read and understand the policies regarding confidentiality:

Signature of Patient/Guardian	
Date	

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6. RELEASE OF CONFIDENTIAL INFORMATION

Today's Date	
Name of Patient	
Parent/Guardian (If patient is a minor)	

Please choose one of the two options:

☐ **I do not wish for my confidential psychological records to be released to any other provider. (If you check this option, please go to the end of this section and sign consent.)**

OR

☐ **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 (Please check):

☐ **Psychological Evaluation**
☐ **Phone Contact, texting and Email or other forms of communication**
☐ **Other professional or person. (Please include full name below):**

Recipient of the information:
Family Doctor, Primary Care Physician or Pediatrician

Name of Doctor	
Phone Number	
Fax Number	

Psychiatrist

Name of Doctor	
Phone Number	
Fax Number	

Other

Name	
Phone Number	
Fax Number	

This information is being requested for the following purpose(s):
☐ **Consultation** ☐ **Coordination of Services** ☐ **Educational Purposes** ☐ **Other:**
This authorization shall remain in effect for a period of 6 months from the date signed below
I understand that:

- **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/Guardian	
Date	