Stefanie A. Gray, Ph.D.
14802 Jones Maltsberger Rd., Suite 1201
San Antonio, TX 78247
(210) 570-2454

Information and Consent

I am pleased that you have selected me as your mental health provider. This document is designed to inform you about my practice and to ensure that you understand our professional relationship.

I am a licensed clinical psychologist in the state of Texas. My specialty is in the treatment of eating disorders, as well as trauma, mood and anxiety disorders. I also conduct psychological assessments. I earned a doctorate in Personality Psychology from the University of California at Davis in 2004. I completed a Post-Doctoral Respecialization in Clinical Psychology certification program in 2017. I received psychological associate license to practice in 2014. I have worked in private practice and nonprofit community psychology settings, and in 2016-2017 I completed a clinical psychology internship at the Eating Recovery Centers of San Antonio and Austin and the Insight Behavioral Health Center in Round Rock, TX.

Therapy sessions are 50 minutes in duration with the remaining 10 minutes devoted to maintaining your personal file. This arrangement is standard practice for most therapists. In the event you are unable to keep an appointment, you will need to notify me 24 hours in advance. If I do not receive such notice, you will be responsible for paying for the session you have missed. The no-show or late cancellation (within 24 hours) fee is $150. Payment is expected at each visit. Cash, credit card, and personal checks are accepted. Co-payments are expected at each visit.

Assessment appointments may vary in length. Each assessment includes an initial appointment, time for testing, interpreting and writing the report, and a feedback session to discuss the results. Costs and payment arrangements will be agreed-upon on an individual basis, depending on insurance contributions and the individual's reasons for assessment.

I will keep confidential anything you say to me with the following exceptions: 1) According to state and local laws, psychologists must report to the appropriate agencies all cases of physical or sexual abuse or neglect of minors or the elderly; 2) According to state and local laws, psychologists must report to the appropriate agencies all cases in which there exists a danger to self or others; 3) When authorized in order to process medical insurance claims and authorized payment of benefits; 4) In the event of an emergency and other medical personnel need to be contacted; 5) If you become involved in specific kinds of legal proceedings, the courts may subpoena information concerning your treatment; and 6) If you direct me to tell someone else.

I regularly consult with other medical and clinical personnel concerning all eating disorder cases. A Release of Information form will be provided to you to facilitate this interdisciplinary coordination of treatment. Treatment of children under the age of 18 years will be provided only with the consent of the legal guardian or parent.

In case of psychiatric emergency, please contact the nearest hospital emergency room. If you need to reach me to cancel an appointment at the last minute, you may call or text

210-570-2454 or email drgray@drstefaniegray.com. However, due to privacy laws and the fact that texts and emails are not compliant with privacy law standards, I will not use email or text to discuss your case. In the event that I am away from the office for an extended period of time, another psychologist or mental health professional will be available.

I will provide services in a professional manner consistent with ethical guidelines. While it is impossible to guarantee specific results regarding your counseling goals, I will strive to provide the best treatment for you. Overall, the success of our work together depends much on your own motivation and efforts.

I have read and understand the statement of Information and Consent. I consent to treatment or evaluation (or the treatment or evaluation of a minor under my care) by Stefanie A. Gray, Ph.D., with the knowledge of the above conditions.

Name of Client: _____ ***Date:*** _____

Signature of Client or Guardian: _____