Stefanie A. Gray, Ph.D., PLLC
11107 Wurzbach Rd., #403
San Antonio, TX 78230
(210) 570-2454

Information and Consent

We are pleased that you have selected us as your mental health providers. This document is designed to inform you about our practice, your rights as a patient, and to ensure that you understand our professional relationship. The terms "patient" and "client" are synonymous in this document.

Services Offered: Dr. Gray's specialty is in the treatment of trauma, eating disorders, mood and anxiety disorders for adolescents and adults. She also conducts psychological assessments for patients ages six years through adult. Anna Marie Somera, Licensed Professional Counselor (LPC), uses principles of body-mind integration to support clients as they develop skills to regulate their nervous systems. She uses a holistic approach with the intention of striving for balance and wholeness. We believe that all people have an innate ability to move towards wellness, and that our role is to assist people on that journey.

Confidentiality: Information that is shared between the psychologist/therapist and the patient in the professional setting is confidential. This means that we will protect any information gathered during treatment and/or assessment. All identifying information regarding you and/or your child's treatment and assessment is kept confidential except in the cases listed below.

Exceptions to Confidentiality Agreement:

1. According to state and local laws, psychologists and LPCs 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 and LPCs must report to the appropriate agencies all cases in which there exists a danger to self or others.
3. Occasionally, it is necessary to disclose personal information in order to process medical insurance claims and authorize payment of benefits.
4. To assure coordination of care, occasionally the psychologist or LPC will speak with other medical professionals related to the therapeutic issue (e.g. psychiatrists, registered dieticians). A release of information form will be required in these cases.
5. In assessment cases, consent may be given to share assessment reports with other healthcare professionals and/or schools or businesses.
6. If you become involved in specific kinds of legal proceedings, the courts may subpoena information concerning your treatment.

I have read and agree to the above section:

Patient Initials: ___________ Date: ___________

Parent/Legal Guardian Initials: ____________ Date: ___________

Notice of Privacy Practices Acknowledgement (HIPAA): Under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), patients have certain rights to privacy regarding protected health information. This information can and will be used to:

1. Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from payers such as Medicare/Medicaid and private insurances.

3. Conduct normal healthcare operations such as quality assessments and physician certifications.

Patients or parents/legal guardians may request, in writing, restrictions regarding how private information is used and disclosed to carry out treatment, payment, and health care operations.

I have read and agree to the above section:

Patient Signature: ____ Date: _____________

Parent/Legal Guardian Signature: ____________________________ Date: _____________

What to Expect: Please bring all completed intake paperwork with you to your first appointment. 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. 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.

I have read and agree to the above section:

Patient Initials: ________________ Parent/Guardian Initials: _________________

Payment Arrangements: The hourly session fee will be discussed during your initial session. Costs and payment arrangements for psychotherapy will be agreed upon on an individual basis depending on insurance contributions. Assessment fees vary based on the reason for assessment. Insurance companies do not always cover the full cost, and assessment must often be preauthorized. Assessment fees will be discussed during the initial assessment appointment. Payments and co-payments are expected at each visit. Cash, credit cards, and personal checks are accepted.

I have read and agree to the above section:

Patient Initials: ________________ Parent/Guardian Initials: _________________

No-Show/Late Cancellation Policy: Psychselect.com gives a text reminder 48 hours in advance of each appointment. In the event you are unable to keep an appointment, notification is required 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 for Dr. Gray's clients and $100 for Anna Marie Somera's clients.* Co-payments will be collected at each visit.

I have read and agree to the above section:

Patient Initials: ________________ Parent/Guardian Initials: _________________

Eating Disorder Cases: When we work with clients who are in recovery from eating disorders, we 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. If you do not already have a registered dietitian and psychiatrist on your outpatient treatment team, we will help provide referrals. Each patient is unique in their recovery process, but in most cases, a registered dietician will be required to assist with the food/dietary aspects of eating disorder recovery.

I have read and agree to the above section:

Patient Initials: ________________ Parent/Guardian Initials: _________________

Treatment of Minors: We accept patients for psychological assessment starting at age six. We conduct psychotherapy for adolescents ages 13-17 who are referred for eating disorder treatment and some other psychological concerns such as anxiety. Treatment for children younger than 13 for eating disorders will be decided on a case by case basis. Assessment for intellectual disabilities, learning disabilities, autism spectrum disorder, and other emotional and psychological disorders is provided for children ages six and up.

I have read and agree to the above section:

Patient Initials: ________________ Parent/Guardian Initials: _________________

Legal and Court Proceedings: We do not conduct forensic psychology assessments, including assessments for custody and competency cases. We do not conduct court mandated therapy. In the event that one of us is subpoenaed, we require two weeks' notice prior to any court appearance or deposition hearing. We charge $250 per hour for time spent in court, phone, online (i.e. Skype) or in-person meetings with lawyers, or time spent related to the subpoena. Payment of fees for this time is expected at the time of the appearance.

I have read and agree to the above section:

Patient Initials: ________________ Parent/Guardian Initials: _________________

In case of psychiatric emergency, please contact the nearest hospital emergency room. If you need to reach out to cancel an appointment at the last minute, please contact your therapist directly. Dr. Gray's cell phone number is 210-570-2454 and Anna Marie Somera's cel phone number is 210-660-4748. Because privacy laws and the fact that texts and emails are not compliant with privacy law standards, we will limit use of email or text to discuss making or changing appointment times. In the event that we are away from the office for an extended period of time, another psychologist or mental health professional will be available.

We will provide services in a professional manner consistent with ethical guidelines. While it is impossible to guarantee specific results regarding your psychotherapy/assessment goals, we 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., or Anna Marie Somera, with the knowledge of the above conditions.

Name of Patient: ______________________________________ ***Date:*** ______________

Signature of Patient or Guardian: ____

Stefanie A. Gray, Ph.D., PLLC
Licensed Psychologist
Anna Marie Somera, MA
Licensed Professional Counselor

11107 Wurzbach Rd., #403
San Antonio, TX 78230
(210)570-2454
(210)966-8959 (fax)

Client Information

(Please Print)

Date: ___________________
Client Name: ____
Home Address: ____
City: ________________________________ State: ____________ Zip Code: ____________
Home Phone: ____________________________
Cell Phone: ______________________________
Date of Birth: __________________________ Age: _________ Sex: ___________
Marital Status: _________________________ Education Level: ______________________
Social Security Number: ____-____-______

Occupation: ___________________________ Employer: ____________________________
Work Address: ____
City: ________________________________ State: ____________ Zip Code: ____________
Work Phone: ________________________

Primary Insurance Company: ____
Address: ____________________________________ City: ___________________________
State: ________________ Zip: __________ Phone: _________________________________
Insured's ID#: ____________________________ Group #: ____________________________
Group Name: ______________________________

Secondary Insurance Company: ____
Address: ____________________________________ City: ___________________________
State: ________________ Zip: __________ Phone: _________________________________
Insured's ID#: ____________________________ Group #: ____________________________
Group Name: ______________________________

Responsible Party Information (Person to be billed/Insured family member):
Name: ________________________________ Relationship to Client: __________________
Home Address: ____
City: ________________________________ State: ____________ Zip Code: ____________
Home Phone: ____________________________ Work Phone: ________________________
Cell Phone: ______________________________
Date of Birth: __________________________ Sex: ______

Primary Care Physician: _____________________________ Phone: ___________________
Referring Physician: ______________________________ Phone: _____________________

Stefanie A. Gray, Ph.D.
Anna Marie Somera, LPC
11107 Wurzbach Rd., #403
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Authorization to Secure Credit Card/Debit Card Payment

I, ___________________________________ authorize Stefanie A. Gray, Ph.D., PLLC to process payment on my Visa, MasterCard, Discover Card, or American Express for the purposes of:

1) My payment responsibilities as designated by our agreement.
2) Any outstanding balance that has not been received after 30 days of the service that was provided to me by Stefanie A. Gray, Ph.D., PLLC (i.e. individual or group psychotherapy, telephone consultation, assessment, etc.).

_______I understand that I have given Stefanie A. Gray, Ph.D., PLLC my credit card information. I further understand that if I miss a scheduled appointment or fail to provide 24 hours notice, my credit card will be charged the agreed-upon fees (see consent form).

_______I understand that if my card is declined, Stefanie A. Gray, Ph.D., PLLC may put my credit card payment through on another day when funds become available.

I have read and understand this form. I attest that the information below is true and accurate.

____
Signature of Card Holder

____
Cardholder's name

____
Client's name

____ ____________ ____________
Credit Card Account Number Expiration date Security Code

____
Address on Credit Card Account

____
City, State and Zip Code

______________________ ____
Today's date Email address (for receipts)

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Authorization to Release Information

I, _________________________________, authorize _________Stefanie A. Gray, Ph.D. or ________Anna Marie Somera, LPC, to disclose, release, and/or obtain records or information re: __________________________ to/from:

(Check if yes)		Name	Phone	Fax
	My primary care physician			
	My family member(s)			
	My lawyer			
	My child's school			
	The person who referred me			
	My previous therapist			
	Psychiatrist			
	Dietician			
	Hospital Medical Records			
	Other			

Specific purpose/Information concerning: ____.

Such records or information may include (but are not limited to) test results and/or reports, diagnostic impressions, medical treatment records, academic records, and all other information available. I authorize this to be in either written form or relayed verbally for the purposes of evaluation and/or treatment for a period of one year from the date of my signature. I further understand that this authorization may be revoked by me at any time. A copy of this release is further authorized to be valid as original.

Signature: ______________________________ Date: _______________
Relationship to Patient: ____________________________