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, your rights as a patient, and to ensure that you understand our professional relationship.

Services Offered: My specialty is in the treatment of eating disorders, as well as trauma, mood and anxiety disorders for adolescents and adults. I also conduct psychological assessments for patients ages six years through adult.

Confidentiality: Information that is shared between the psychologist and the patient in the professional setting is confidential. This means that I 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 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. 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 will speak with other medical professionals related to the therapeutic issue (e.g. psychiatrists, registered dieticians).
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 is $150. 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.* 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 I work with patients who are in recovery from eating disorders, 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. If you do not already have a registered dietitian and psychiatrist on your outpatient treatment team, I 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: I accept patients for assessment starting at age six. I conduct psychotherapy for adolescents ages 13-17 who are referred for eating disorder treatment. 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: I do not conduct forensic psychology assessments, including assessments for custody and competency cases. I do not conduct court mandated therapy. In the event that I am subpoenaed, I require two weeks' notice prior to any court appearance or deposition hearing. I 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 me to cancel an appointment at the last minute, you may call or text 210-570-2454 or email drgray@drstefaniegray.com. Because privacy laws and the fact that texts and emails are not compliant with privacy law standards, I will limit use email or text to discuss making or changing appointment times. 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 psychotherapy/assessment 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 Patient: _____ ***Date:*** _____

Signature of Patient or Guardian: _____