Dudley B. (Chip) Pillow, Psy.D.

Clinical Psychologist

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Germantown, TN. 38138

 Office (901) 756-5730

# Registration and Patient Information

Client’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred daytime phone number where you wish to be reached regarding appointments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Calls will be discreet, but please indicate any restrictions regarding calls \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to notify in case of an emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact’s Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about me \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Church Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date(s) of Previous Therapy and Therapist­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications currently/previously taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Note \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Client is under 18 years of age, please complete this section:**

Parent’s marital status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If divorced/separated, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If divorced, parents remarried? Mother\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father \_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names of Step-parents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the custodial/primary residential party? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Welcome to my practice. I am excited you are interested in psychotherapy and I am honored you are considering therapy with me. I sincerely believe the relationship we develop in therapy can potentially have a profound and lasting impact on your life. Because therapy is an important investment of time, money, and energy, carefully choosing a therapist is very important. **Please read this document carefully** as it contains important information about my professional services and business policies. Make a note of any questions you have so we can discuss them during the first session. You signature indicates you fully understand the information, have given your consent, and constitutes a binding agreement between us to begin counseling/therapy.

## PSYCHOLOGICAL SERVICES

I am a licensed Clinical Psychologist in the state of Tennessee. I offer services including psychotherapy for individuals (adults and adolescents), couples, and consultation. The type of psychotherapy I offer is from a Christian Perspective. It is important for you to understand that I operate from this value system. If you have any questions about my approach (or what this means), values, or worldview, please ask them during our first meeting.

As a clinical psychologist, I do not provide any medication or perform any medical treatments. If medication seems indicated, I maintain close working relationships with a number of physicians, and will be glad to refer you to these practitioners. Additionally, if you are currently taking medication related to mental health, I will be happy to work with your physician to provide the greatest degree of continuity of care I am able. Furthermore, I am not able to give you qualified advice in law, medicine, financial planning, or any other professional viewpoints.

“Therapy” or “counseling” is often difficult to describe. One potential benefit to counseling/therapy is the ability to detect, challenge, and change those beliefs and experiences that create, maintain, and worsen feelings such as depression, anxiety, fear, panic, etc. Additionally, as a Christian, I believe therapy can also help us gain new understanding about our problems and learn new ways of applying God’s Truth to our lives.

Sometimes there are potential risks involved in counseling/therapy. Some people may experience some degree of discomfort and feelings of sadness, anxiety, fear, frustration, anger, etc. when working through difficult issues. Some may recall some unpleasant aspects of their life. Also, some people report feeling worse before they feel better. My desire is for you to be strengthened individually and relationally.

It is important that you and I have a healthy working relationship. If this is not the case, I encouraged you to discuss your concerns with me so that we may work towards resolution of any problem that might arise. I will regularly discuss/review your goals and progress with you, and I want you to be open and honest in providing input, feedback, and suggestions. At any time during our work together, you have the right to decide to end treatment, and there is not a moral, legal, or financial obligation other than to pay for services already rendered. If you are thinking about terminating counseling/therapy before our mutually agreed upon time, I encourage you to discuss this with me, and if you wish, I will provide you with the names of other mental health providers.

## MEETINGS

During our first meeting I will conduct an evaluation. This is similar to a “fact finding mission.” During this session, I will want to get to know you, get an idea of the problem areas in your life (lives), and will want you to get a “flavor” for how I interact with clients. Together we will develop a “game plan” to meet the treatment objectives. At the end of the first meeting, both parties should have a general idea if I am the best “fit” for you, and if the type of psychotherapy I practice could be beneficial for you. Please feel free to ask me any questions that might help you in your decision. My desire is that your decision to work with me be as informed as is reasonably possible.

My sessions are 45 minutes, although extended/double sessions are available. I begin each session on the hour. Please be prompt to our session in order to take advantage of the full 45 minutes. **Unless 24 hours notice is given, you will be expected to pay for the missed appointment** unless I excuse payment due to circumstances beyond your control. I need this notice in order to fill any vacant appointment times with other clients. In the event of bad weather, such as snow or ice, I usually follow the Germantown Municipal School District closing/opening during inclement weather. However, it is strongly recommended that you call to make sure my office is open/closed.

For their own protection, and as a courtesy to others, please do not leave your children unattended in the waiting area.

I am usually in my office Monday through Thursday. I usually begin my first appointment at 8:00 A.M. The last appointment will vary depending on the day of the week.

## TELEPHONE CALLS

 I strive to return calls as soon as possible. I am not interrupted during sessions for incoming calls. **The telephone is not the best means with which to deal with counseling/therapy issues**. Telephone calls that exceed five minutes will be charged for a session. However, in certain situations you may feel a phone consultation is necessary. If so, I will charge my normal hourly rate for a counseling/therapy session. In the event of an emergency, please call 911 or go to the nearest emergency room.

 **I DO NOT take emergency calls and I do not have an answering service to reach me after hours.** I am not a clinician that performs emergency/crisis consultations. If you are in an emergency that requires critical care, **please call 911 or go immediately to the nearest emergency room.** Again, I do not provide emergency services as I am not the most qualified person to address these issues.

 I do not text or email clients. While I understand that most of the world uses text and email messages, I am overly cautious about your confidentiality. Therefore, I use my office phone as I believe it to be the most secure and confidential means in which to communicate.

 Given the changing environment, I do provide some Telehealth. However, please consult with me prior to beginning therapy if this is a viable option.

## PROFESSIONAL FEES

My professional fee is $210.00 for individual, marital or couple sessions. These sessions last **45 minutes**. If testing is warranted, I will refer you to another clinician. Since I am a psychologist trained predominantly in outpatient psychotherapy, I do not provide inpatient treatment or “home visits” as I am not the most qualified person to provide this type of treatment. However, I will work with your inpatient treatment team once you are discharged in order to provide you with continuity of care. If you need me to provide any material in writing (e.g. a written statement to your insurance company, or a letter) I will charge my normal rate of $210.00 per 45 minutes, with a minimum of ½ hour.

I accept checks, cash (the exact amount), credit, and debit (all major credit cards) as means of payment. There is a $30.00 service charge on all returned checks.

All fees are subject to change. In the event of fee changes, you will be notified at least 30 days prior to such changes.

## BILLING AND PAYMENTS

You will be expected to pay for each counseling/therapy session at the time it is held. If prior agreement between us is reached, I will be happy to bill you on a monthly basis. Payment schedules for other professional services will be agreed upon at the time these services are requested. Balances may not exceed $400.00 after a 30-day billing cycle, unless arrangements have been made in advance.

Please remember, I have a professional relationship with you and not your insurance company. Fees are charged to the client, and I **do not accept responsibility for billing, collecting, negotiating, or disputing an insurance claim.** In short, I do not file insurance. I will be happy to provide you with a receipt that shows fees charged, services provided, diagnosis (if one is warranted), billing code, etc. so that you might file your insurance claim if you so choose. However, I encourage you to contact your insurance company to discuss the requirements for reimbursements prior to initiating counseling/therapy. Again, unless previous arrangements have been made, you are expected to pay for each session at the time it is held.

If you are interested, **please ask me why I do not accept responsibility for filing insurance claims.**

If your account is more than 60-days in arrears and suitable arrangements for payments have not been agreed upon, I have the option to exercise legal means to secure payment for services rendered; these include collection agencies, small claims court, mediation, or arbitration. Further, upon nonpayment, I reserve the right to report the “bad debt” to relevant credit bureaus. If such actions are necessary, the costs of bringing that proceeding will be included in the claim, and the client or the responsible party will be responsible for all costs of collection, etc. In such cases, the only information that will be released about the client’s treatment would be the client’s name, nature of the services provided (e.g. individual therapy), dates of service, and the amount due.

**SOCIAL MEDIA**

It is my practice that I **DO NOT** connect with my clients on social media. Due to the lack of confidentiality, I will **not** follow you on Twitter, friend you on Facebook, or connect on any form of social media. I do this as a way to best protect your confidentiality. If you have any questions about this please ask me.

**CONFIDENTIALITY**

Within the limitations discussed below, the information you reveal to me during our professional relationship will be kept confidential and will not be released to anyone without your written consent. However, certain conditions do require that confidentiality and privileged communication be breached, including:

1. if you present a danger to yourself;
2. if you present an imminent danger to another person, which can include a communicable disease that can be life-threatening to others;
3. if there is reason to believe that child abuse or neglect is present a report must be filed with a state child protection agency;
4. if a legitimate court order is issued;
5. if the treatment is ordered or is under the supervision of the court.

No clinical/psychological information is revealed to my staff other than information that you provide when calling or presenting for appointments. I have discussed the legal and professional necessity of confidentiality with my staff.

Information revealed in marital/couples therapy is protected by privileged communication in Tennessee and requires written permission of **both parties** in order to waive. When working with couples, I adopt a **“no secrets” policy**; that is, should I speak with either party (e.g. via telephone), I reserve the right to disclose any information to the other party if I believe this information is relevant to the counseling/therapy process.

**SPECIAL NOTE ON LEGAL PROCEEDINGS**: Because of my Christian perspective, I encourage reconciliation when relationships are damaged. When a family is confronted by parental divorce or separation, it is very hard on everyone. It is important when working as a couple, that each person feels safe to speak openly and honestly, without fear that material revealed in counseling/therapy will be revealed in court and used in a negative fashion. In order to provide a safe environment for couples to work, it is important that you agree **not to call me as a witness or attempt to subpoena records** in the event that you choose to pursue a divorce. Your signature(s) below reflect your agreement not to call me as a witness nor attempt to subpoena any psychological/counseling/therapy records. You should hire a different psychologist for any evaluations or testimony you require. I base this position on two reasons: 1) the testimony I would be asked to provide might adversely affect our therapy relationship, and I shall always make our therapy relationship my highest priority, and 2) I am not a forensic psychologist and am not trained in this field. Should I become involved in any legal matter, such as giving testimony, depositions, etc., my fee is $800.00 per hour for preparation, review of materials, travel time, court time, and any other time involved. I charge a retainer fee that is to be paid in advance of any work and is based on the estimated time involved, and there is a minimum charge of $4800.00.

In order to provide clinical coverage for me when I am out of town, it may be necessary for me to release general information to the licensed psychologist who may be covering for me. If an emergency requires me to be out of the office suddenly, I will be guided by the American Psychological Association’s *Ethical Principles of Psychologists and Code of Conduct* regarding the type of information disclosed.

As previously noted, if because of nonpayment of your bill I pursue legal remedies, certain information will not be considered confidential and will be released, but this would be limited to the minimum that is necessary to achieve the purpose.

### AGREEMENT

I have read this information fully and completely, have discussed any questions I have about the information, and understand the information. I understand that there are no guarantees, stated or implied, and accept the risk inherent in the course of counseling/therapy. I have familiarized myself with the fees and charges for services provided by Dudley B. “Chip” Pillow, Psy.D., and I understand and agree that the psychological services rendered will be charged to me and not any third-party payer. I acknowledge responsibility of payment for services, and I understand that I am responsible for all cost of collection and litigation together with attorney’s fees if the charges for services must be collected by an action of law. I understand the limitations of confidentiality.

Client(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This form is based in part on one developed by Charles Hannaford, Ph.D. Permission was granted to use all materials contained herein

**PATIENT NOTIFICATION OF PRIVACY RIGHTS**

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”); the keeping and use of patient records (“privacy rules”); and, storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care. Providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. The information regarding HIPAA was taken directly from the Tennessee Department of Health Website. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; and, as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification. Since I do not file insurance, much of the information will not pertain to you. However, by law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

I understand and have been provided a copy of Patient Notification of Privacy Rights document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement

form.

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Print Name of Patient/Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Client *or* Parent if Minor *or* Legal Charge Date

Relationship to Patient/Client of Person Signing Notification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Legal Charge, describe representative authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional information on HIPAA in Tennessee can be found at:

<http://health.state.tn.us/HIPAA/index.htm>

If you do not have access to a computer, please let me know and I will provide a copy for you.