Jason S Berman, PhD, PLLC; Licensed Psychologist; 12830 Hillcrest Rd, Suite D-111 Dallas, TX 75230

NEW PATIENT INTAKE FORM

Note: This information is confidential. Pages 10 (informed consent)**, 12** (privacy policy) **and 13** (release of information for insurance claims, other doctor, family member, etc) **require your signature.**
Please complete the final page with your insurance company info (for the ones I accept) as well as any other clinician, family member or friend with whom you would want me to communicate.
Thank you. JB

Today's Date: _____________________

A. Identification

Your name: __________________________________ Your Date of birth: ______________ Age: ______

Preferred Name: _____________________________

Name of person with the insurance policy: ____

BIRTHDATE of the person who has the insurance policy:_____________________________________

Relationship to you: _____________________________

Your Home street address: ____

City: ____ State: ________Zip: ________________

Home/evening phone: ________________________e-mail: ______________________________

Cell phone: ___________________________I prefer to get calls ❑ at home ❑ at work ❑ on my cell phone

Calls or e-mail will be discreet, but please indicate any restrictions: ____________________________

B. Referral: Who gave you my name?

Name: ____Phone: _____________________

If a healthcare professional, may I have your permission to thank this person for the referral?

❑ Yes _______(please initial) ❑ No

How did this person explain how I might be of help to you? _________________________________

____

C. Emergency information:

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: ____________________________

Phone: ___________________________ Relationship: _______________________

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: ______________________________________

Date of last physical/medical exam: __________________________

E. Alcohol and Recreational drugs:

I drink ___ alcoholic drinks per week; I become intoxicated ____ times per week OR per month (please circle)

I have been drinking at this amount since ___________________ Recreational drug use _______________;

Other info on your use of drugs/alcohol: ____

Have you ever been in treatment for drugs or alcohol? ______ If so, please explain:

____

Has anyone ever had a problem with your drinking/ drug use or other addictive behaviors?

____

F. Psychiatric medications you currently take (please include dose, purpose, etc):

____

Who prescribes these meds? _____________________ phone: ____________________________

G. Your current employer:

Employer: ___________________________________Occupation: ___________________________________

H. Educational History (if applicable): (please include graduation years)

High School (Name and City): ____

Vocational Training:____

College: ____

Graduate School: ____

Did you have any academic or social problems during your education? If yes, please explain.

____

I. Important **relationships** in your life (past/or present)**:**

____

____

J. Faith Identity and racial/ethnic identification

Current denomination/ faith/religious affiliation: ❑ Evangelical Christian ❑ Other Protestant

❑ Catholic ❑ Jewish ❑ Islamic ❑ Other: _______________

❑ None/Unsure ❑ Atheist/Agnostic ❑ Former/Ex believer

Involvement/Devotion: ❑ None ❑ Some/Irregular ❑ Active ❑ In the past only

How important are spiritual concerns (e.g. prayer, worship, service, faith, knowing God) in your life?

____

____

Ethnicity/national origin: ___________________Race: ____________________

Other ways you identify yourself and consider important: ______________________________

____

K. Chief concern:

Please describe the main difficulty that brings you in:

____

____

____

L. What is going well in your life? What are your strengths?

____

____

Checklist of Concerns

Name: ____Date: ___________________________

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

❑ I have no problem or concern bringing me here
❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
❑ Aggression, violence
❑ Alcohol use
❑ Anger, hostility, arguing, irritability
❑ Anxiety, nervousness
❑ Attention, concentration, distractibility
❑ Career concerns, goals, and choices
❑ Childhood issues (your own childhood)
❑ Codependence
❑ Confusion
❑ Compulsions
❑ Custody of children
❑ Decision making, indecision, mixed feelings, putting off decisions
❑ Delusions (false ideas)
❑ Dependence
❑ Depression, low mood, sadness, crying
❑ Divorce, separation
❑ Drug use—prescription medications, over-the-counter medications, street drugs
❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
❑ Emptiness
❑ Failure
❑ Fatigue, tiredness, low energy
❑ Fears, phobias
❑ Financial or money troubles, debt, impulsive spending, low income
❑ Friendships
❑ Gambling
❑ Grieving, mourning, deaths, losses, divorce
❑ Guilt
❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems
❑ Housework/chores—quality, schedules, sharing duties
❑ Inferiority feelings
❑ Interpersonal conflicts
❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility
❑ Judgment problems, risk taking
❑ Legal matters, charges, suits
❑ Loneliness
❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings
❑ Motivation, laziness

❑ Nervousness, tension
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, sex addiction, dysfunctions, conflicts, desire differences, other (see also “Abuse”) (please circle)
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholic /overworking, can’t keep a job, dissatisfaction, ambition

❑ Which of these is primary or most pressing?:

____

____

____

____

PROFESSIONAL SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for an active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience—*and it's important to express*-- uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees ahead of time about what you will experience.

EVALUATION:

I normally conduct an evaluation that will last from **4 to 6 sessions**. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one session per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide *at least* **24 hours advance notice** of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment within the same week. If you do not cancel within 24 hours and I cannot reschedule you within the same week, I will charge you a **$100** fee**.** The reason is that I cannot fill an appointment time that I reserve for you in less than 24 hours certainly and most often in less than several days.

On a separate issue, if you do not show up for a scheduled appointment and you have not called to cancel and/or explain within 24 hours, I will consider this a termination of services, your case will be closed and you will be charged **$100** for that missed appointment. If you want to quit, it is almost always better to meet one more time to talk about what you didn't like and so that I can help you find someone who might be able to help you. I make referrals to other psychologists, therapists, physicians frequently.

As part of the initial evaluation, I like for all new clients to take a personality exam called the **MMPI-II** for a fee of $85 which is not charged through insurance. This exam is a long paper/pencil test that needs to be taken in my office suite but it can provide a helpful baseline for our work together. I encourage you to take the MMPI-II but it is not required.

PROFESSIONAL FEES

My hourly fee is **$165** for the service of psychotherapy except for the diagnostic interview which is $170. The cost for the service of psychotherapy includes many things. First and foremost you are paying for the time and skill of a licensed psychologist, who has many years of education, training, and experience. The cost of psychotherapy also includes the time I spend on administrative tasks, as well as studying to improve my ability to intervene therapeutically and competently with whatever is troubling you. I also include in my fee responding to e-mail messages and time spent on the telephone. In addition, I at periodically spend time consulting with your other health care providers (with written permission) to coordinate car (with your primary care doctor or psychiatrist, for example), and may also seek supervision/consultation from colleagues to improve the quality of care I provide. So, you are paying for more than the psychotherapy hour itself. In addition to weekly individual appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Cost of individual counseling and group are subject to gradual increases. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge **$300** per hour for preparation and attendance at any legal proceeding.]

I also offer **psychoanalysis** which is the most intensive type of treatment involving lying on the couch multiple times per week. Another service I provide is **group therapy** which costs **$225** per month (subject to increase) as a place in a group is uniquely yours and cannot be filled by another person unless you leave the group entirely. Payment for all scheduled group sessions for the month ahead is due on the 1st of each month.

BILLING AND PAYMENTS

You will be expected to pay me directly for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.] I may need to consult a collection agency for any fees unpaid after 90 days.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will often

provide some coverage for mental health treatment. Please find out your co-pay or deductible from your insurance company and bring that information to our first appointment. As in life, there are advantages and disadvantages to using your health insurance to help pay for the service of psychotherapy. I am an in-network provider for Blue Cross Blue Shield of Texas and Medicare. You (not your insurance company) are responsible for full payment for services you receive from me.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 9 AM and 6 PM, Monday through Thursday and until 3pm on Fridays, I will very rarely answer the phone when I am with a patient. When I am unavailable, my telephone is answered by a voicemail I monitor frequently and supported by an answering service who knows where to reach me. I will make every effort to return your call within 24-48 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to cover for me.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records upon written request unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. I am sometimes willing to conduct a review meeting without charge. Patients will be charged an appropriate fee for any time spent in preparing information requests.

TREATMENT WITH MINORS

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible and it is good treatment to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise. One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should

end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records to preserve the confidentiality of your teenager. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent unless it is something of serious concern. I will tell you if your child does not attend sessions. At the end of your child's treatment, upon request, I will provide you with a verbal or written treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

LEGAL SITUATIONS WITH MINORS:

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision.

Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $300 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly or disabled person] is being abused or neglected, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

Your signature below indicates that you have read and understood the information in the Professional Services Contract document above and agree to abide by its terms throughout our professional relationship.

1) ____ ________________
Signature of Client(s) & Printed Name Please Date Signed

Please list your ***credit card number***, expiration date, billing address here. I keep this on file in strict confidentiality—as befitting a psychologist—and security. I charge your card at the time I register your clinical meeting. Thank you. JB

Credit Card # ___________________________ Exp# ________

Billing Address__________________________ Code on the back: _________

Notice of Privacy Rights and Policies

Effective March 1, 2009

As required by the privacy regulations created as a result of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).** If you agree**,** *please sign and date on page 3 and bring the document with you to your first appointment.*

This notice describes how health information about you may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

My practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *Protected* Health Information, or PHI). In conducting my business, I will create records regarding you and the treatment and services I provide to you. I am required by law to maintain the confidentiality of health information that identifies you. I am also required by law to provide you with this notice of my legal duties and the privacy practices that I maintain in my practice concerning your PHI. By federal and state law, I must follow the terms of the Notice of Privacy Practices that I have in effect at the time.

I realize that these laws are complicated, but I must provide you with the following important information:

• How I may use and disclose your PHI,
• Your privacy rights in your PHI,
• My obligations concerning the use and disclosure of your PHI.

A. The terms of this notice apply to all records containing your PHI that are created or retained by my practice. I reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that my practice has created or maintained in the past, and for any of your records that I may create or maintain in the future. My practice will post a copy of my current Notice on my website (www.talkitoutdallas.com) in a visible location at all times, and you may request a copy of my most current Notice at any time.

B. If you have questions about this information, please discuss it further with me. If you feel your privacy rights have been violated, please contact:

Office for Civil Rights U.S. Department of Health & Human Services 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX

C. I may use and disclose your PHI in the following ways:

The following categories describe the different ways in which I may use and disclose your PHI.

1. Treatment. Treatment refers to the provision, coordination, or management of healthcare including mental health related to one or more providers. The information provided to insurance and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

2. Payment. My practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, I may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and I may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, I may use your PHI to bill you directly for services and items. I may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts. **3. Contacting the Client.** I may contact you to remind you of appointments and to tell you about treatments or other services which may be of benefit to you.

4. Health Care Operations. My practice may use and disclose your PHI to operate my business. As examples of the ways in which I may use and disclose your information for my operations, my practice may use your PHI to evaluate the quality of care you received from me, or to conduct cost-management and business planning activities for my practice. I may disclose your PHI to other health care providers and entities to assist in their health care operations.

5. Disclosures required by law. My practice will use and disclose your PHI when I am required to do so by federal, state or local law. This includes but is not limited to: reporting child abuse or neglect, when court ordered to release information, when there is a legal duty to warn or take action regarding imminent to danger to others, when the client is a danger to self or others or is gravely disabled, when required to report certain communicable diseases and certain injuries; and when a Coroner is investigating a client's death.

6. Health Oversight Activities. My practice may disclose your PHI to a health oversight agency for activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, and regulatory programs or determining compliance with program standards. **7. Crimes on the Premises or Observed by me:** Crimes that are observed by me or directed at me or occur at my business location will be reported to law enforcement.
8. Involuntary Clients: Information regarding clients who are being treated involuntarily pursuant to law, will be shared with other treatment providers legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
9. Family Members: Except for certain minors, incompetent clients or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if you object, PHI will not be disclosed.
10. Emergencies: In life threatening emergencies, I will disclose information necessary to avoid serious harm or death. **11. Client Authorization to Release of Information:** I may not use or disclose PHI in any other way without a signed Authorization or Consent to Release Information. When you sign a consent to release information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent I have already taken action in reliance thereon.
D. Your Rights as a Client:
1. Access to Protected Health Information (PHI): You have the right to inspect and obtain a copy of the PHI information that I have regarding you and the record. There are some limitations to this right, which will be explained to you at the time of your request, if such a limitation applies. To make such a request, please talk to me. Jason S Berman, PhD, PLLC; Licensed Psychologist; 12830 Hillcrest, Suite d-111; Dallas, Texas 75230 www.TalkItOutDallas.com
2. Amendment of Your Record: You have the right to request that I amend your PHI. I am not required to amend the record if it is determined that the record is accurate and complete or when there are other exceptions, which will be provided to you at the time of your request, along with an appeal process. **3. Accounting of Disclosures:** You have the right to receive an accounting of certain disclosures that I have made regarding your protected health information. That accounting does not include disclosures that were made for the purpose of treatment, payment, or healthcare operations. There are other exceptions that will be provided to you, should you request an accounting.
4. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of PHI from me by alternative means or locations. For example, if you do not want bills sent to your home, you may request a different address. There are limits to such requests that will be provided to you. **5. Copy of the Notice:** You have the right to obtain another copy of this Notice upon request. **E. Additional Information: 1. Privacy Laws:** I am required by State and Federal Law to maintain the privacy of PHI. In addition, I am required by law to provide clients with notice of its legal duties and privacy practices with respect to PHI. That is the purpose of this notice.
2. Terms of Notice and Changes to the Notice: I am required to abide by the terms of this Notice and any amended notice that may follow. I reserve the right to change the terms of this notice and to make new Notice provisions for all PHI that it maintains. **3. Additional Information:** If you desire additional information about your privacy rights, please contact me.

I have read, understood and received a copy of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and as the written explanation of the privacy polices of Dr. Jason Berman's practice in clinical psychology

________________________________ ____________________

Signature. &. Printed name Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION	
Patient's Name:	Date of Birth:

This form when completed and signed by you, authorizes Jason S Berman, PhD, PLLC to release protected information from your clinical record to the person you designate.
I ______________________________ authorize Jason S Berman, PhD, PLLC to correspond and release/obtain relevant information to/from:

(Name of health care provider, insurance company, agency, etc.)

(Address)

(Phone & Fax)

For the purpose(s) of: ____

In authorizing the release of confidential information, I hereby waive all restrictions and privileges imposed by law and release Jason S Berman, PhD, PLLC and its staff from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation or communication.
I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected. I understand that this authorization may be revoked at any time, except to the extent that Jason S Berman, PhD, PLLC has already taken action in release on it. My revocation must be in writing in a letter to Jason S Berman, PhD, PLLC at the address listed on this authorization form. I certify that I have read and received a copy of this authorization upon request. This authorization supersedes any and all previous authorizations.

_________________________________ __________________
Patient's signature/Authorized Individual Date