Donna C. Abbott, Ph.D.

305 Miron Dr.
Southlake,Texas 76092
972-869-2954

Welcome!

Thank you for making your first appointment and I look forward to working with you. Please be aware that I am in sole private practice and am an independent practitioner, and am not professionally associated with anyone else in this suite of offices. I would ask that you read and sign this paperwork.

1. Therapy sessions are 45 to 60 minutes in length.

2. The fee for the initial evaluation and assessment session is $**180.00**. Fees for subsequent sessions of 45 minutes are $**160.00**, and sessions 50 – 60 minutes are $**160.00**. If you have coverage and I am on your plan, then you are responsible for any deductibles or co-pays. **Please be aware that you are responsible for fees incurred regardless of insurance coverage. I have no role in deciding what your insurance covers. This is an agreement between your employer and your insurance company.**

3. As a member of several psychological associations, strict standards of practice are followed. Everything said in session is privileged information and strictly confidential and will not be disclosed to anyone without your written permission except in circumstances required by or allowed by law. These limits are discussed fully in the Notice of Privacy Practices (HIPAA) paperwork which is in a separate packet.

4. Your session time is reserved for you. If you are unable to be here for your appointment, please give 24 hours' notice. Clients are responsible for fees incurred for missed appointments. Your insurance company will not pay for missed appointments. The fee for a missed appointment is $50.00.

5. While it is convenient at times to email or send a text, please be advised that while I will do my best to keep correspondence confidential, this may not always be possible. Texts or emails will be responded to during business hours. Encrypted emails may be sent via the therapy appointment website which is therapyappointment.com. You will need to sign in with a login and password.

6. **DO NOT SEND EMERGENCY INFORMATION VIA TEXT OR EMAIL**. If you have a life-threatening emergency please call 911 or go to the nearest emergency room and then call me at 214-728-6498.

7. In the event of my death or inability to practice, your file will be kept by Dr. Jack Verdi, 972-869-2965.

By signing, I acknowledge I have read the above information.

Signed:_____ Date:_____

I acknowledge I have read the Notice of Privacy Practices (HIPAA) attached to these forms.

Signed: _____Date:_____

INDIVIDUAL CLIENT QUESTIONNAIRE

Your cooperation in completing this questionnaire will be helpful in planning services for you.

Full Name: _____ Today's Date:_____

Address: _____

_____

Telephone Numbers:_____/_____/_____

Home Cell Work

Email address: _____

Emergency Contact: _____Phone:_____

Relationship to you: _____

Date of Birth: _____Age: _____ Marital Status: _____

Social Security Number: _____

Occupation: _____ Employer: _____

Education: _____

Briefly describe your reason for seeking help_____

_____

Who referred you to my office? _____

List any major health problems _____

Date of last medical exam: _____ Name of your doctor_____

List any allergies: _____

List current medications_____

CHECKLIST OF CONCERNS

Please mark all of the items below that apply, and feel free to add any others at the bottom of this list. You may add a note or details in the space next to the checked concerns:

___Abuse – physical, sexual, emotional – either current or as a child

___Aggression, violence

___Alcohol use

___Anger, irritability

___Anxiety, nervousness

___Career concerns, goals, choices

___Depression, sad mood, crying

___Divorce/separation

___Drug use – prescription, over-the-counter, or street drugs

___Eating problems – overeating, under-eating

___Emptiness

___Fatigue, tiredness, low energy

___Fears, phobias

___Financial problems

___Gambling

___Grieving, deaths, losses

___Guilt

___Headaches, or other aches or pains

___Health concerns

___Impulsiveness, loss of control, outbursts

___Irresponsibility

___Judgment problems

___Lack of interest or enjoyment in formerly enjoyable activities

___Legal matters

___Loneliness

___Marital issues

___Mood swings

___More energy than usual

___Obsessive thoughts (thoughts that keep repeating, or dwelling on problems)

___Do you feel like you have to do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, repeating, collecting, or arranging things

___In the past month have you been bothered by recurrent thoughts, or impulses that were unwanted, distasteful, or distressing

___Panic or anxiety attacks

___Parenting issues

___Self-esteem

___Sexual issues – conflicts, desire differences

___Sleep problems – too much, too little, cannot get to sleep

___Stress

___Suicidal thoughts or attempts

INSURANCE INFORMATION

Health Insurance Company:_____

Insured's Name and Birth Date:_____

Insured's Employer_____

ID Number _____

Group Number _____

Authorization Number:_____

ASSIGNMENT AND RELEASE OF INFORMATION: I hereby authorize my insurance benefits be paid directly to Donna C. Abbott, Ph.D. **I realize I am financially responsible for non-covered services**. I also authorize Dr. Abbott to release all information, within the rules of the Notice of Privacy Practices (HIPAA) required by my insurance company to obtain authorization, communicate regarding my treatment and to process my claim. This may include a diagnosis and sometimes the completion of paperwork regarding your mental health status, any medications you may be taking, and dates of our meetings.

SIGNATURE:

_____ Date:_____

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operation purposes with your consent. To help clarify these terms here are some definitions:

* "PHI" refers to information in your health record that could identify you.
* "Treatment" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I (with your consent) consult with another health care provider, such as your family physician or another psychologist.
*"Payment" is when I obtain reimbursement for your health care or to determine eligibility or coverage.
*"Use" applies only to activities with my office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
*"Disclosure" applies to activities outside my office such as releasing, transferring, or providing access to information about you to others.

II. Uses and Disclosures requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time provided each revocation is in writing. You may not revoke an authorization to the extent that I (1) have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

* Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report within 48 hours to the Texas Department of Protective and Regulatory Services, or to any local or state law enforcement agency.

* Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
* Health Oversight: If a complaint is filed against me with the State Board of Examiners of Psychologists they have the authority to subpoena confidential mental health information from me relevant to that complaint.
* Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment, such information is privileged under state law, and I will not release information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

*Serious Threat to Harm or Safety: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical and/or law enforcement personnel.

* Worker's Compensation: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV: Patient's Rights and Psychologist's Duties

Patient Rights:

* Right to Request Restrictions: You have the right to request restrictions to certain uses and disclosures of PHI about you. However, I am not required to agree to a restriction you request. * Right to Receive Confidential Communication by Alternative Means at Alternative Locations: For example, you may not want a family member to know that you are seeing me.
* Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny access to PHI under certain circumstances, but in some cases you may have this decision reviewed.
* Right to Amend: You have the right to amend your PHI for as long as the PHI is maintained in the record. I may deny your request.
* Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of the above).
* Right to restrict certain disclosures of PHI to a health plan if you pay out-of-pocket in full for services.
* Right to be notified if there is a breach of your unsecured PHI.

Psychologist's Duties:

* I am required by law to maintain the privacy of PHI and to provide you with a copy of these rules. * I reserve the right to change my privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect.

IV: Complaints:

If you are concerned that I have violated your privacy rights, or disagree with a decision I made about access to your records, you may contact the Texas State of Examiners and Psychologists at (800-821-3205).

Please keep this copy for your records.