Lisa Fitzgibbons, Ph.D.
3214 NW Avignon Way, Suite 2
P.O. Box 2449
Bentonville, AR 72712
(479) 271-8778

Dear Client:

Thank you for the opportunity to work with you. I look forward to providing top-quality psychological services. Enclosed in this packet is important information about the services I offer and forms for you to complete in preparation for your initial appointment.

You will need to complete all of the enclosed paperwork and gather other records before your first appointment. It helps if you can return the materials before your appointment in order to provide me time to review the information and create your chart. To assist you in preparing for the first appointment, a checklist of the materials needed is listed below:

Forms included in this packet:
__ Contact Information Form
__ History Form (child/adolescent version and adult version attached; please complete the appropriate form)
__ Informed Consent Information Packet
__ Notice of Privacy Practices
__ Consent Documentation

Other materials needed that are not included in this packet:

__ Insurance card (if you would like assistance filing a claim with your insurance company)
__ Government ID for patient (acceptable identification includes: Driver's license, state-issued ID card, social security card, passport, etc.) – **Please note: This request for patient identification is required by HIPAA**
__ Copies of previous evaluations (if applicable)

I may also request additional records and materials in order to provide quality services. Please call me if you have any questions or concerns. I want to make this a helpful experience for you. I truly appreciate the chance you have given me to be of professional service to you, and look forward to a successful relationship with you. If you are satisfied with my services as we proceed, I (like any professional) would appreciate your referring other people to me who might also be able to make use of my services.

Sincerely,

Lisa Fitzgibbons, Ph.D.
Licensed Psychologist
AR#: 07-19P
OK#: 894
TX#: 32121

Contact Information Form

Date______________ Client's Social Security #___________________________________ Chart #________________

Client's First Name_______________________________________ Last Name_______________________ MI_______

Address____ City______________________ State________Zip___________

Telephone (Home)______________________________________ (Work)____________________________________

Birthdate_____/_____/______ Age_______ Gender __F __M Race____________________________________

Name of Parent/Guardian____Phone___________________

Address____ City___________________ State_______ Zip_________

Person Responsible for Payment_______________________________________ Soc. Sec. #_____________________

Signature of Person Responsible for Payment **X**__________________________________ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) ________________________________ Relationship_____________ Phone_____________Work_________

Address____ City___________________ State________ Zip_________

Physician____ Phone_________________________

Address____ City___________________ State_______ Zip_________

Psychiatrist____ Phone___________________

Address____ City___________________ State_______ Zip_________

Current Medications____

Allergies____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place____ Phone__________________________Hrs____

Spouse: Place____ Phone__________________________Hrs____

Referral Source

How did you hear of my office (or from whom)?____

Address____City________________ State________ Zip__________

Phone____ Relationship to referral source__________________

Contact information	
Telephone	
Email (password protected)	
Mail	
Please indicate if there is a method you prefer that Dr. Fitzgibbons *not* contact you or leave messages.	

Client History Form – Adult Version

Client's name:_________________________________Date: ___________________
Gender: __ F ___ M Date of birth: _________ Age: ________
Form completed by (if someone other than client): ______________________________

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

__ Anger management ___ Anxiety __ Coping _ Depression
__ Eating disorder ___ Fear/phobias __ Mental confusion __ Sexual concerns
__ Sleeping problems ___ Addictive behaviors __ Alcohol/drugs __ Psychosis
__ Relationship problems
__ Other mental health concerns (specify): __________________________________

Family Information

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother	______________________	_______	___	___	___	___
Father	______________________	_______	___	___	___	___
Spouse	______________________	_______	___	___	___	___
Children	______________________	_______	___	___	___	___
	______________________	_______	___	___	___	___
	______________________	_______	___	___	___	___

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
___________	______________________	_______	___	___	___	___
___________	______________________	_______	___	___	___	___
___________	______________________	_______	___	___	___	___
___________	______________________	_______	___	___	___	___

Marital Status (more than one answer may apply)

__ Single ___ Divorce in process ___ Unmarried, living together
Length of time: _______ Length of time: ________
__ Legally married ___ Separated ___ Divorced
Length of time: ________ Length of time: _______ Length of time: ________
__ Widowed ___ Annulment
Length of time: ________ Length of time: _______ Total number of marriages: ________

Assessment of current relationship (if applicable):
_____ Good _____ Fair _____ Poor

Parental Information

__ Parents legally married ___ Mother remarried Number of times: ______
__ Parents have ever been separated ___ Father remarried Number of times: ______
__ Parents divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): ____

Development

Are there special, unusual, or traumatic circumstances that affected your development?
___ Yes ___No
If Yes, please describe: ____
Has there been history of child abuse? ____ Yes ____ No
If Yes, which type(s)? ___ Sexual ___ Physical ____Verbal
If Yes, the abuse was as a: ___ Victim ____ Perpetrator
Other childhood issues: ___ Neglect ____ Inadequate nutrition
Other (please specify): ____
Comments re: childhood development: ____________________________________

Social Relationships

Check how you generally get along with other people: (check all that apply)
__ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often ___ Follower
___ Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn ___ Submissive
___ Other (specify): ____
Sexual orientation: ___________ Comments: ______________________________
Sexual dysfunctions? ____ Yes ____ No
If Yes, describe: ____
Any current or history of being as sexual perpetrator? ___ Yes ____No
If Yes, describe: ____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? ______________________
Are you experiencing any problems due to cultural or ethnic issues? ___ Yes ___ No
If Yes, describe: ____
Other cultural/ethnic information: ____

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ____ Moderate ____ Much
Are you affiliated with a spiritual or religious group? _Yes ____ No
If Yes, describe: ____
Were you raised within a spiritual or religious group? ___ Yes ___ No
If Yes, describe: ____
Would you like your spiritual/religious beliefs incorporated into the counseling?
____ Yes ____ No
If Yes, describe: ____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? __ Yes ___ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: __

Are you presently on probation or parole? ___ Yes ____ No

If Yes, please describe: ____________________

Past History

Traffic violations: ___ Yes __ No DWI, DUI, etc.: ___ Yes __ No

Criminal involvement: __ Yes __ No

Civil involvement: ___ Yes __ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: ____________________

Currently enrolled in school? ___ Yes ____ No

__ High school grad/GED

__ Vocational: Number of years: _____ Graduated: ___ Yes ____ No

Major:____________________

__ College: Number of years: _____ Graduated: ___ Yes ____ No

Major: ____________________

__ Graduate: Number of years: ____ Graduated: ___ Yes _____ No

Major: ____________________

Other training: ____________________

Special circumstances (e.g., learning disabilities, gifted): ____________________

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ___ FT __ PT __ Temp __ Laid-off __ Disabled ___ Retired

___ Social Security ________ Student

___ Other (describe): ____________________

Military

Military experience? _____ Yes ____________________ No Combat experience? __ Yes ______ No

Where: ____________________

Branch: ______________________________ Discharge date: ______________________
Date drafted: __________________________ Type of discharge: ____________________
Date enlisted: _________________________ Rank at discharge: ____________________

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
____________	__________	__________
____________	__________	__________
____________	__________	__________
____________	__________	__________

Medical/Physical Health

___ AIDS
___ Alcoholism
___ Abdominal pain
__ Abortion
___ Allergies
__ Anemia
___ Appendicitis
__ Arthritis
___ Asthma
___ Bronchitis
___ Bed wetting
___ Cancer
___ Chest pain
___ Chronic pain
___ Colds/Coughs
___ Constipation
___ Chicken Pox
___ Dental problems
___ Diabetes
___ Diarrhea
___ Dizziness
___ Drug abuse
___ Epilepsy
___ Ear infections
___ Eating problems
___ Fainting
___ Fatigue
___ Frequent urination
___ Headaches
___ Hearing problems
___ Hepatitis
___ High blood pressure
___ Kidney problems
___ Measles
___ Mononucleosis
___ Mumps
___ Menstrual pain
___ Miscarriages
___ Neurological disorders
___ Nausea
___ Nose bleeds
___ Pneumonia
___ Rheumatic Fever
___ STD's
___ Sleeping disorders
___ Sore throat
___ Scarlet Fever
___ Sinusitis
___ Smallpox
___ Stroke
___ Sexual problems
___ Tonsillitis
___ Tuberculosis
___ Toothache
___ Thyroid problems
___ Vision problems
___ Vomiting
___ Whooping cough
___ Other (describe): _____
____

List any current health concerns: ____
List any recent health or physical changes: ____
____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	___________________	___ No __ Low __ Med __ High
Lunch	____ / week	___________________	___ No __ Low __ Med __ High
Dinner	____ / week	___________________	___ No __ Low __ Med __ High
Snacks	____ / week	___________________	___ No __ Low __ Med __ High

Comments: ____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ___ Yes ____________ No

If Yes, describe: ____

____

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

____

Family history of medical problems: ____

____

Please check if there have been any recent changes in the following:

__ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level

__ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: __________________________

____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								

Caffeine ___________ _______ _____ _____ ___ ___ ___ __
Nicotine ___________ _______ _____ _____ ___ ___ ___ __
Over the counter ___________ _______ _____ _____ ___ ___ ___ __
Prescription drugs___________ _______ _____ _____ ___ ___ ___ __
Other drugs ___________ _______ _____ _____ ___ ___ ___ __

____

Substance of preference
1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

Substance Abuse Questions

Describe when and where you typically use substances: _________________________

____

Describe any changes in your use patterns: __________________________________

____

Describe how your use has affected your family or friends (include their perceptions of your use): ____

____

Reason(s) for use:
__ Addicted ___ Build confidence ___ Escape ___ Self-medication
__ Socialization ___ Taste ___ Other (specify): _______________

How do you believe your substance use affects your life? ________________________
Who or what has helped you in stopping or limiting your use? ___________________
Does/Has someone in your family present/past have/had a problem with drugs or alcohol?
__ Yes __ No If Yes, describe: _______________________________________
Have you had withdrawal symptoms when trying to stop using drugs or alcohol? __ Yes __ No
If Yes, describe: ____
Have you had adverse reactions or overdose to drugs or alcohol? (describe):_______

____

Have drugs or alcohol created a problem for your job? ___ Yes _____ No
If Yes, describe: ____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_______	___________	__________________________
Suicidal thoughts/attempts	___	___	_______	___________	__________________________
Drug/alcohol treatment	___	___	_______	___________	__________________________
Hospitalizations	___	___	_______	___________	__________________________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_______	___________	__________________________

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

__ Aggression	___ Elevated mood	___ Phobias/fears
__ Alcohol dependence	___ Fatigue	___ Recurring thoughts
__ Anger	___ Gambling	___ Sexual addiction
__ Antisocial behavior	___ Hallucinations	___ Sexual difficulties
__ Anxiety	___ Heart palpitations	___ Sick often
__ Avoiding people	___ High blood pressure	___ Sleeping problems
__ Chest pain	___ Hopelessness	___ Speech problems
__ Cyber addiction	___ Impulsivity	___ Suicidal thoughts
__ Depression	___ Irritability	___ Thoughts disorganized
__ Disorientation	___ Judgment errors	___ Trembling
__ Distractibility	___ Loneliness	___ Withdrawing
__ Dizziness	___ Memory impairment	___ Worrying
__ Drug dependence	___ Mood shifts	___ Other (specify): _____
__ Eating disorder	___ Panic attacks	______________________

Briefly discuss how the above symptoms impair your ability to function effectively: _________________

____

____

____

____

____

____

____

____

____

Any additional information that would assist me in understanding your concerns or problems:

____

____

____

____

____

____

____

____

What are your goals for therapy? ____

____

____

____

____

____

____

____

Do you feel suicidal at this time? _____ Yes ___________ No

If Yes, explain: ____

____

For Psychologist's Use

Psychologist's signature: ______________________________Date: ______________

Notes: ____

____

Informed Consent Information
Policies & Procedures for Psychological Services

This Informed Consent form is designed to explain the policies and procedures for psychological services at my office. The document delineates what my responsibilities are to you and what your responsibilities are to me as we work together. Please thoroughly review this entire document as it contains information that is very important for you to know.

Psychological Services Offered

I offer three primary types of psychological services: therapy, evaluations, and consultations. I will describe each of these services separately.

Therapy Services

If you are seeking therapy services, the first appointment will consist of a diagnostic interview. During this appointment, we will discuss what you are seeking help for and I will gather background information. We will also review the informed consent materials and discuss the therapy process. I will also describe the treatment strategies that I think will be most beneficial for addressing your concerns. For instance, I may suggest cognitive-behavioral interventions for addressing symptoms of anxiety.

I think of my approach to helping people with their problems as an educational and collaborative one. I want my clients to be able to use the tools they gain from therapy without me. I view therapy as a partnership between us. You define the problem areas to be worked on; I use some special knowledge to help you make the changes you want to make. Psychotherapy is not like visiting a medical doctor. It requires your very active involvement.

I expect us to plan our work together. In our treatment plan we will list the areas to work on, our goals, the methods we will use, the time and money commitments we will make, and some other things. I expect us to agree on a plan that we will both work hard to follow. From time to time, we will look together at our progress and goals. If we think we need to, we can change our treatment plan, its goals, and its methods.

Evaluation Services

The evaluation process takes place in four primary stages:

1. **Diagnostic Interview** to obtain a history, review concerns, discuss the reason for the evaluation, determine what testing needs to be done, and review informed consent and evaluation procedures
2. **Testing** may take place in one 3-hour or 4-hour session, a series of 1-hour or 2-hour appointments, or other arrangement based on your needs as determined during the diagnostic interview
3. **Scoring, interpretation, and report writing** by the psychologist
4. **Conference** to provide interpretation about testing results, diagnostic impressions, and treatment recommendations, about 2 to 3 weeks after completion of the testing process

In addition to the stages of the evaluation described above, other services are sometimes needed. It is often helpful for me to speak with other professionals who are working with you. This could include physicians, mental health therapists or counselors, teachers, or other individuals. If this is needed, you will need to sign additional written consent(s).

A comprehensive written report will be generated and copies will be provided to you as part of the evaluation costs. Typically, the written report is provided to you at the time of the feedback conference. The results of the evaluation may not answer all questions about you. Therefore, other referrals may also be made to other service providers.

Consultation Services

Individuals request consultation services for a variety of reasons including:

- Evaluation of the success for implemented interventions
- Identification of behaviors that may benefit from intervention(s)
- Determination of factors which contribute to challenging behaviors

When I conduct a consultation, I typically start the process with a 60 minute diagnostic interview. The diagnostic interview is conducted to obtain a history, to review the informed consent documents, and to review the consultation procedures. At this meeting, I may ask for releases of information to obtain copies of records or consent to contact other individuals who may have information relevant to the consultation. If you have previous testing results, educational materials, or other records it is often useful to bring these items to the diagnostic interview. During this meeting, we will also review the procedures to be used for completing the consultation and the amount of time I expect will be required to address your questions.

Benefits and Risks

Associated with Therapy

As with any treatment, there are some risks as well as benefits with therapy. You should think about both the benefits and risks when making any treatment decisions. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. Clients may recall unpleasant memories. These feelings or memories may bother a client at work or in school. In addition, some people in your community may mistakenly view anyone in therapy as weak, or perhaps as seriously disturbed or even dangerous. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital relationship and sometimes may even lead to a divorce. Sometimes, too, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work out well for you.

While you consider these risks, you should know also that the benefits of therapy have been shown by scientists in hundreds of well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or the problems are solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions-as persons, in their close relationships, in their work or schooling, and the ability to enjoy their lives.

I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress.

Associated with Evaluations and Consultations

I want you to be aware of both the benefits and the risks associated with an evaluation or consultation. The benefits of evaluation or consultation include diagnostic clarification, appropriate treatment recommendations to handle challenges and maximize strengths, having a written report that can be used to facilitate services at school or in the community, and insight into the nature of your strengths and weaknesses, among others.

Despite the benefits of evaluation, there may also be some risks involved. The person being evaluated may experience discomfort (including frustration, anxiety, embarrassment, etc.). Though rare, it is possible that the evaluation will not answer all of your questions, and further evaluation by another professional may be needed. While my testing and treatment recommendations are based on best practices, you or others may not agree with my professional judgment. No one is required to follow my recommendations, including you, as my reports do not carry the force of law.

My Background

I graduated with my doctoral degree in clinical psychology from the University of Tulsa (an APA-accredited program) in 1999. Since then I have worked as a practicing psychologist, statistician, teacher, and researcher in psychiatric hospitals, a prison, community agencies, schools, hospitals, and clinics. I am trained and experienced in conducting psychological evaluations and doing therapy with children, adolescents, and adults. I have these qualifications:

- I completed an APA-approved internship at Napa State Hospital.
- I am licensed as a psychologist in Arkansas, Oklahoma, and Texas.
- I am a member of the APA.

Confidentiality

As part of the psychologist-client agreement, all of the information gathered about you will be treated with great care. Legal and ethical considerations prevent my office from divulging information about you, including information about whether you are a patient in my office, without your express written consent.

However, you should know before we begin our professional relationship that there are certain legal and ethical limits to confidentiality. In some circumstances, I am required to break confidentiality in order to protect you or others, as follows:

*If a patient threatens grave bodily harm or death to another person, I may be required to inform appropriate legal authorities and the intended victim.

*If a patient expresses a serious intent to grievously harm himself/herself, I may be required to notify family members and/or persons authorized to respond to such emergencies, in order to protect the patient from harm.

*If I have good reason to suspect that a child is the victim of physical or sexual abuse, or a victim of neglect, I am required to report the abuse or neglect to the appropriate authority.
*If a patient is being evaluated in response to court order, the results of the evaluation will be revealed to the court.
*If a court of law issues a court order signed by a judge, I am required to provide information (though I will restrict the information to that which is specifically requested in the court order).
*If your insurance company (or other third-party payer) requests information including diagnosis, reports, recommendations, and/or chart notes, this information must be provided.
*If you fail to meet the financial obligations outlined in this form, I reserve the right to pursue collections or small claims court.
*Please note that noncustodial parents can access a child's records, unless the parent's rights have been terminated. As a result, it is important for me to have a good understanding of the custody arrangements and parental rights at the start of services and if the circumstances change during the course of services.

Please be assured that I take your confidentiality very seriously, and I will make every effort to safeguard it. In any of the above situations, when I must break confidentiality, I will discuss this with you ahead of time, unless there is a good reason not to do so. Additionally, I would only reveal the specific information required in the situation.

Financial Policy and Obligations

I understand that obtaining psychological services can be a substantial financial commitment on your part. As such, I believe it is extremely important for you to know exactly what your financial obligations are. You are responsible for ensuring that all of the associated fees are paid on your account. Since you are responsible, this means that even if another person/entity, such as another parent or your insurance company, is expected to cover the charges and does not, you will be held financially responsible. If for any reason, your account is delinquent, I have the right to pursue collections action, either through a collections agency or in small-claims court. A monthly late-fee of $25.00 will be applied to balances that remain unpaid for 30-days (unless prior payment plan arrangements have been made).

In the event that a check is returned to because of insufficient funds, I will notify you that an alternative means of payment is required plus a $25.00 returned check fee. I reserve the right to refuse to accept personal checks from persons who have previously written checks which were returned.

If you have insurance, I am happy to collect that information from you. As a courtesy, I will call your insurance company to verify your benefits; however, it is only an estimate. *You are strongly encouraged to confirm your benefits with your insurance carrier.* If you change insurance companies for any reason during the course of treatment, it is your responsibility to notify me prior to your next scheduled appointment so that insurance coverage can be verified.

If your health insurance will pay part of my fee, I will help you with your insurance claim forms if you would like or I will file the claims for you. I am considered an in-network provider with several insurance companies. If your insurance carrier indicates that pre-authorization is required for testing, I will complete the necessary paperwork after the Diagnostic Interview. I will keep track of the authorization process for you, but it is in your interest for you to keep track as well since you are responsible for all of the charges associated with testing.

The fee for the Diagnostic Interview is $210 (this fee is due at the first appointment). The fee for therapy is $130 per hour. The charge for evaluation and consultation services varies, although I will try to provide an estimate of the time for the process. In addition to the face-to-face testing done with the patient, I also charge for scoring the tests, contacting other professionals when needed, reviewing records, writing the report, and conducting the feedback session. However, in order to make the total charges for the evaluation more reasonable, I charge for only a portion of the time involved in scoring, report writing, and record review. The hourly fee for these services is $155.00. I ask that clients pay half of the fee for evaluation services at the time of the first testing appointment and the remaining balance at the feedback session. An evaluation may take 4-9 hours depending on the amount of testing required.

Please note that if I am asked to testify in court, for a deposition, or consult as part of court proceedings, I charge $250 per hour with a four hour minimum. The initial $1000 deposit for my time and expertise is required at least 36 hours before the scheduled deposition or court appearance. Also, I charge $200 an hour for my preparation time on all court-related matters.

I accept Mastercard, Visa, checks, and cash. Also, payment plans are available, although I expect that payment plans be agreed upon before the start of treatment.

Appointments and Scheduling

I consider each scheduled appointment to be very important, and I ask you to do the same. Out of courtesy to me and to other clients who are also waiting for an appointment, please call as soon as you determine that you will be unable to keep your scheduled appointment, so that the time can be offered to another client. If I must postpone an appointment, I will make every effort to reschedule you as quickly as possible. If you fail to show for an appointment, you will be asked to prepay for your next appointment.

Requests for Forms, Letters and Reports

A comprehensive written report is included in the charges for the evaluation. There is also no charge for completion of forms needed to secure pre-authorization for testing from your insurance company. However, the following charges will apply for other forms or letters that are needed, including but not limited to, letters to insurance companies for justification of diagnosis, evaluation, or treatment, letters or forms needed for schools or state agencies regarding diagnosis, treatment, or information for IEP planning, letters to attorneys, etc. The charge for completion of brief forms and letters is $25.00. Each additional form requested at the same time will be charged at $10.00 each. Charges for lengthy or more detailed letters will be at the hourly rate $155/hour based upon the time involved in preparation. Payment for all forms must be made before the forms will be completed or the letter written. Please be aware there may be some forms issued to you that I am not capable of completing. Also, be aware that in most cases, I will not be able to complete forms on the same day as they are received and, in some instances, there may be a 10-day turn-around period for completion of forms or letters. However, I will make every effort to be as prompt as possible in addressing your request.

If You Need to Contact Me

I cannot promise that I will be available at all times. You can leave a message on my voice mail or with my assistant and I will return your call as soon as I can. Please note that if you have an issue that requires more than a few minutes of time, then I may recommend that we schedule an appointment so we can more thoroughly address your concern.

If you have an emergency or crisis and cannot reach me immediately by telephone, then you or your family members should call 911 or go to the nearest hospital emergency room.

Regarding email: Clients may email me at DrFitz@Fitzpsych.com; however, I ask that therapeutic issues and concerns be addressed in person.

Statement of Principles and Complaint Procedures

It is my intention to fully abide by all the rules of the American Psychological Association (APA) and by those of my state licenses (Arkansas, Oklahoma, and Texas).

Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me at once. Our work together will be slower and harder if your concerns with me are not worked out. I will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I, or any other therapist, has treated you unfairly or has broken a professional rule, please tell me. You can also contact the state psychological association and speak to the chairperson of the ethics committee. He or she can help clarify your concerns or tell you how to file a complaint. You may also contact the Arkansas Psychology Board (501-682-6167) or the Oklahoma State Board of Examiners of Psychologists (405-524-9094). These are the organizations that license those of us in the independent practice of psychology.

In my practice, I do not discriminate against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, as well as being required by federal, state, and local laws and regulations. I will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

Privacy Policies

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

My Legal Duties

State and Federal laws require that I keep your medical records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and my duties. I am required to abide these policies until replaced or revised. I have the right to revise my privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or therapy session are covered by the law as private information. I respect the privacy of the information you provide us and I abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with my office for diagnosis, treatment planning, treatment, and continuity of care. I may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with my office such as billing, quality enhancement, training, and audits.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of my office not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to report this information to legal authorities and may need to seek hospitalization for the client. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, I may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

For Operations

I may use and give information about you to make sure that the services and benefits you get are correct and of high quality. I may share your health information with business partners who perform work for my office and I require that my business partners use the same level of privacy and security as I do when handling your health information.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts or I may

elect to pursue small claims court. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the office or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the office or by outside sources specializing in (and held accountable for) such procedures.

In the event in which my office must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify me in writing where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say the name of my office or the nature of the call, but rather my first name only. If this information is not provided to me (below), I will adhere to the following procedure when making phone calls: First I will ask to speak to the client (or guardian) without identifying my full name. If the person answering the phone asks for more identifying information I will say that it is a personal call. I will not identify my office (to protect confidentiality). If I reach an answering machine or voice mail I will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $.15 per page, plus postage.

You have the right to cancel a release of information by providing me with written notice. If you desire to have your information sent to a location different than the address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if I do not agree with these restrictions, I am not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to me in writing.

You have the right to disagree with the medical records in my files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

You will be given a written copy of this notice.

Complaints

If you have any complaints or questions regarding these procedures, please contact Dr. Fitzgibbons. I will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services, the Arkansas Psychology Board, and/or Oklahoma State Board of Examiners of Psychologists. If you file a complaint I will not retaliate in any way.

Lisa Fitzgibbons, Ph.D., PLLC
Informed Consent Agreement – Version 1/2012

I, the client (or his or her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed the informed consent materials (Version 1/1/2012); it does not indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with you, the psychologists, before I start (or the client starts) psychological services. I also understand that any of the points mentioned above can be discussed and may be open to change. I have read or have had read to me, the issues and points included in the informed consent packet. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this document.

Your signature below indicates that you have had sufficient opportunity to read and understand the informed consent materials, and that you have asked me to clarify anything that you did not understand. Your signature also signifies that that you are giving Dr. Lisa Fitzgibbons, Licensed Psychologist, consent to engage in the evaluation and treatment of you.

____

Signature of client/Parent/Guardian Date

____

Printed Name

Signed by: __client __guardian __personal representative

I, Dr. Lisa Fitzgibbons, have met with this client (and/or his or her or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this brochure. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent.

____

Signature of Lisa Fitzgibbons, Ph.D. Date
Licensed Psychologist

Acknowledgement for Receipt of Privacy Practices – Version 1/2012

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications. My signature indicates I have received a copy of the office's privacy practices.

Client's name (please print): ____

Signature: ___________________________________ Date: _____/_____/_____

Signed by: __client __guardian __personal representative

Consent to Submit Private Health Information for Insurance Claims

I authorize Lisa Fitzgibbons, Ph.D. to release any protected health information (PHI) necessary to process insurance claims. I also authorize my insurance carrier to make payments to Dr. Fitzgibbons.

____________________________________ ______________________

Signature of Insured/Representative Date

Coordination of Care

___ (Initials) I would like for Dr. Fitzgibbons to coordinate my care with my primary care physician. If so, a separate authorization outlining information to be released will be obtained.

___ (Initials) I do not want Dr. Fitzgibbons to communicate information about services provided with my primary care physician.

Please note: Clients may change their mind about whether and what type of information can be shared with other treatment providers at anytime (unless the information has already been released).