

Lisa Fitzgibbons, Ph.D.
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(479) 271-8778

Dear Client:

Thank you for the opportunity to work with you and/or your child. 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)
- Custodial documentation (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 <i>not</i> contact you or leave messages.	

Client History (if the client is <18 years of age)

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

If you need any more space for any of the following 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 Hyperactivity
 Attention problems Learning/School Motivation Developmental
 Autism Challenging behaviors (please specify): _____

Other mental health and/or behavioral concerns (specify): _____

Family History**Parents**

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? ___ Yes ___ No

Client's Mother

Name: _____ Age: _____ Occupation: _____

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ___ Yes ___ No

___ Natural parent ___ Step-parent ___ Adoptive parent ___ Foster home

___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___ Yes ___ No If Yes, please explain: _____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name: _____ Age: _____ Occupation: _____

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? Yes No

Natural parent Step-parent Adoptive parent Foster home

Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father?

Yes No If Yes, please explain: _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client			
				home	away		
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____ home	_____ away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____ home	_____ away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____ home	_____ away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____ home	_____ away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
Others living in the household			Relationship (e.g., cousin, foster child)				
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____		<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____		<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____		<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____		<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good

Comments: _____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Deafness | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Perceptual motor disorder |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cleft lips | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Multiple sclerosis | _____ |

Comments re: Family Health: _____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? Yes No

If Yes, describe: _____

Was the pregnancy with child planned? Yes No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number of total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? Yes No If Yes, what amount: _____

Did the mother use drugs of alcohol? Yes No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)
 Yes No

If Yes, describe: _____

Length of labor: _____ Induced: Yes No Caesarean? Yes No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

Describe any complications for the mother or the baby after the birth: _____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

Breastfed Milk allergies Vomiting Diarrhea
 Bottle fed Rashes Colic Constipation
 Not cuddly Cried often Rarely cried Overactive
 Resisted solid food Trouble sleeping Irritable when awakened Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

The child's development was: slow average fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

Education

Current school: _____ School phone number: _____
 Type of school: Public Private Home schooled Other (specify): _____
 Grade: _____ Teacher: _____ School Counselor: _____
 In special education? Yes No If Yes, describe: _____
 In gifted program? Yes No If Yes, describe: _____
 Has child ever been held back in school? Yes No If Yes, describe: _____
 Which subjects does the child enjoy in school? _____
 Which subjects does the child dislike in school? _____
 What grades does the child usually receive in school? _____
 Have there been any recent changes in the child's grades? Yes No
 If Yes, describe: _____
 Has the child ever undergone psychological testing? Yes No
 If Yes, describe: _____
 Check the descriptions which specifically relate to your child.

Feelings about School Work:

Anxious Passive Enthusiastic Fearful
 Eager No expression Bored Rebellious
 Other (describe): _____

Approach to School Work:

Organized Industrious Responsible Interested
 Self-directed No initiative Refuses Does only what is expected
 Sloppy Disorganized Cooperative Doesn't complete assignments
 Other (describe): _____

Performance in School (Parent's Opinion):

Satisfactory Underachiever Overachiever
 Other (describe): _____

Child's Peer Relationships:

Spontaneous Follower Leader Difficulty making friends
 Makes friends easily Long-time friends Shares easily
 Other (describe): _____

Who handles responsibility for your child in the following areas?

School: Mother Father Shared Other (specify): _____
 Health: Mother Father Shared Other (specify): _____
 Problem behavior: Mother Father Shared Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? Poor Average Good Excellent
 Current employer: _____ Position: _____ Hours per week: _____
 How have the child's grades in school been affected since working? Lower Same Higher
 How many previous jobs or placements has the child had? _____
 Usual length of employment: _____ Usual reason for leaving: _____

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, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hives | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Influenza | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congenital problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Severe colds |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Severe head injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Wearing glasses |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other skin rashes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Paralysis | _____ |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Pleurisy | _____ |

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: _____			

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes _ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Gambling | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Generous | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Attachment to dolls | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Avoids adults | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Shares |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Irritable | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Lazy | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Listens to reason | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Loner | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Suicidal threats |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Messy | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Moody | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Obedient | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Often sick | <input type="checkbox"/> Tics or twitching |
| <input type="checkbox"/> Drugs dependence | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Over active | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Overweight | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Psychiatric problems | _____ |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Quarrels | _____ |

Please describe any of the above (or other) concerns: _____

How are problem behaviors generally handled? _____

What are the family's favorite activities? _____

What does the child/adolescent do with unstructured time? _____

Has the child/adolescent experienced death? (friends, family pets, other) ___ Yes ___ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

___ Yes ___ No If Yes, describe: _____

Are you (on behalf of your child) or your child involved in any legal proceedings? (custody, probation, etc.)

Any additional information that you believe would assist me in understanding your child/adolescent?

Any additional information that would assist me in understanding current concerns or problems?

What are your goals for the current consultation, evaluation, or therapy request? _____

What family involvement would you like to see? _____

Do you believe the child is suicidal at this time? ___ Yes ___ No

If Yes, explain: _____

For Psychologist's Use

Psychologist's comments: _____

Psychologist's signature: _____ Date: ___/___/___

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 or a Floortime approach for addressing challenging behaviors.

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 child's needs as determined during the diagnostic interview
3. **Scoring, interpretation, and report writing** by the psychologist
4. **Parent conference** to provide interpretation about testing results, diagnostic impressions, and treatment recommendations, about 2 to 4 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 or who have worked with your child. This could include pediatricians, mental health therapists or counselors, teachers, speech and language therapists, occupational therapists, or other individuals. If this is needed, you will need to sign additional written consent(s). Also, depending on your child's situation, I may request to do a school observation. This helps me get a better idea of how your child is functioning in an educational setting.

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 Parent Conference. The results of the evaluation may not answer all questions about you or your child's situation. Therefore, other referrals may also be made to other service providers.

Consultation Services

Individuals and their families 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
- Evaluation of progress towards meeting developmental milestones
- Additional education and training on topics related to child development and mental health
- Recommendations for how to address challenging behaviors in the classroom, socially, or at home

Parents, health care professionals, and educators often have questions about a child's development and behavior and a consultation can help address these questions. When I conduct a consultation, I typically start the process with a 60 minute diagnostic interview. The diagnostic interview is conducted with the parent(s) 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 or your child's 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 and/or your child will be treated with great care. Legal and ethical considerations prevent my office from divulging information about you and/or your child, 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, your child, 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.

