Smisson Psychology Services, P.A.

Therapy, Assessment, and Consultation

1415 North Loop West, Suite 660D
Houston, TX 77008
Telephone: 832.769.5594
Fax: 832.433.7641

PATIENT INFORMATION

Date: ____________________

Patient Name: ________________________________ Preferred Name: ________________

Date of Birth: ________________________________ Current Age: _________

Contact Information: OK to leave a message?
Cell Phone: ____________________________________ Yes No
Home Phone: __________________________________ Yes No
Email Address: _________________________________ Yes No

Present Address:
____
____
____

Place of Employment: ____________________________ Occupation: ____________

Reason for Requesting Services: ____
____
____

Referred by: ____

Previous Mental Health Care: Yes ______ No ______
(If yes) Provider(s): ______________________________ Date: ________________
Address: ________________________________ Phone: _______________

Provider(s): ______________________________ Date: ________________
Address: ________________________________ Phone: _______________

Provider(s): ______________________________ Date: ________________
Address: ________________________________ Phone: _______________

Provider(s): ______________________________ Date: ________________
Address: ________________________________ Phone: _______________

Smisson Psychology Services, P.A.

Therapy, Assessment, and Consultation

1415 North Loop West, Suite 660D
Houston, TX 77008
Telephone: 832.769.5594
Fax: 832.433.7641

Important Information About Your Psychotherapy

Psychotherapy Services: Dr. Hayes will provide psychological services for individuals seeking personal growth and awareness. She reserves the right to deny services to individuals whose concerns are beyond her scope of competence, as well as to any individual that abuses or misuses services in any manner (e.g., noncompliance with treatment, frequent missed appointments, delinquent payment, etc). If Dr. Hayes is unable to offer you services for your specific needs, she will discuss other local treatment options and possible referrals with you.

The Psychotherapy Process: The therapy process is a partnership between you and your psychologist to work on areas of concern or dissatisfaction in your life, to develop growth and insight, to help you achieve your desired goals, and to improve your overall well-being. In order for therapy to be effective, it is necessary for both the psychologist and patient to take an active role in this process. Participation involves being open to the psychologist's thoughts and ideas, being honest with your psychologist, discussing concerns about the process with your psychologist, completing outside assignments (when appropriate), and providing ongoing feedback to the psychologist about the process. While therapy is often beneficial for many people, some people may not find it helpful. The therapy process can also evoke strong feelings and sometimes produce unanticipated changes in one's thoughts, feelings, and behaviors. In order for you to maximize your experience, it is helpful to discuss with your psychologist any questions or discomfort you may experience during the therapeutic process. Dr. Hayes will work to help you understand the experience and/or use different methods or techniques that may lead you towards the growth you desire.

You have the right to decide not to enter or continue therapy with your psychologist. If you feel that you are not making progress towards your goals, you may terminate the therapeutic relationship at any time. Upon your request, your psychologist will provide you with a list of referrals for other appropriate mental health professionals in the community. In an effort to help you transition, your psychologist may request one last formal session so you can provide feedback and consider your next steps. You will be responsible for any outstanding payments for services received.

Dr. Hayes will respect you as an individual and will convey this respect by maintaining appointments with you or by contacting you if a change in times is necessary. You have the right to ask any questions, at any time, about what occurs during therapy, and to receive answers that satisfy you. If you wish, she will explain her theoretical orientation or therapy style to you. You have the right to refuse the use of any therapy technique. If Dr. Hayes plans to use any unusual techniques, she will inform you and discuss the benefits and risks. You and your psychologist also will negotiate your frequency of sessions, number of sessions, and goals. You and your psychologist may re-evaluate the frequency of your sessions as situations arise and/or as you

move towards your goals. Sessions typically last from 45-50 minutes. Your psychologist will obtain your informed consent in writing (in advance) if she would like to audiotape/videotape a session. You have the right to refuse any such recording at any time. A patient recording sessions without the psychologist's consent would represent a breach of the therapeutic relationship.

Confidentiality: Dr. Hayes will maintain your confidential information ethically and legally. Your information will be released to other parties ONLY with your expressed written consent. Under most circumstances, all information about you, in written or verbal form, obtained in the counseling process (including your identity as a patient) will be kept confidential. Information will not be disclosed to any outside person(s) or agency without your written permission except in certain situations, which include, but are not limited to:

a. If you are determined to be in imminent danger of harming yourself or someone else;
b. If you disclose abuse or neglect of children, the elderly, or a disabled person(s);
c. If you disclose sexual misconduct by a mental health professional;
d. In a criminal court proceeding; or
e. Where otherwise legally required.

Please note that any information *you* share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The above is considered a summary. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with Dr. Hayes. You may also contact the American Psychological Association at www.apa.org or the Texas State Board of Examiners of Psychologists at (512) 305-7700 or http://www.tsbep.state.tx.us.

Access to Records: Upon request, you may review your therapy records. You will be asked to arrange an appointment with Dr. Hayes to review the information. You reserve the right to *request* that corrections or additions to your records be made, but changes are not guaranteed. You may be charged a full or partial session fee for administrative costs/time related to getting copies of your records. Therapy records are maintained for 7 years after your last contact with your psychologist.

Therapist Qualifications: Dr. Hayes is a licensed psychologist by the State of Texas. If you would like more information about her credentials, or if you would like to file a formal complaint against her, please contact the Texas State Board of Examiners of Psychologists at (512) 305-7700 or http://www.tsbep.state.tx.us.

Access to Services: You may reach Dr. Hayes at the designated phone number or via email to schedule an appointment. If it is not an emergency, she will attempt to follow-up with you within 24-72 hours. If you are experiencing an emergency, please call 911 or contact The Harris Center's 24-hour Crisis Line at 713-970-7000 (option 1) or the Crisis Intervention of Houston Hotline at 832-416-1177.

Counseling Appointments: Therapy is more effective when an individual attends appointments on a consistent basis. It is expected that you are on time for your appointments. Sometimes emergencies do arise. If Dr. Hayes needs to cancel or change an appointment time, she will give

you as much notice as possible. It should be noted, however, that personal and professional emergencies may arise that lead her to reschedule your appointment on short notice. **You must provide at least 24 hours notice if you need to cancel your scheduled appointment. If, for any reason, you do not give at least 24 hours notice, you will be charged the full fee for the time reserved with payment information in your file. If your appointment is rescheduled for the same week without more than 24 hours notice, you will still be charged for the reserved time.**

Therapy Fees: Therapy is a personal investment in one's own growth and overall well-being. It is expected that you will pay for the therapeutic services provided. The fee for service is $200.00 for a typical 45-50 minute session, and payment must be rendered at the end of each session. Payment can be made with cash, money order, personal check, or credit card. **Please note that a credit card number will be kept in your file and will automatically be charged after a missed session.** Your psychologist understands that therapy is a significant personal and financial commitment. If you have insurance coverage, your psychologist will be glad to provide you with a receipt or statement you can send to your insurance company that you may use for out-of-network reimbursement. However, your psychologist will not have any communication with your insurance company directly. **You are responsible for filing for any reimbursement to which you may be entitled by your insurance company.**

If Dr. Hayes's services are needed for court proceedings, the fee for testifying is $400.00 per hour with a minimum of three hours plus any travel costs (if applicable).

Email: Although email has become a major means of communication between individuals, internet communication has significant limitations. Please note the following guidelines for use of email as a form of communication with your psychologist.

- Dr. Hayes cannot provide therapy solely through email, but she may offer limited support via email. Please be aware that email communication is not a substitute for psychotherapy.
- Dr. Hayes cannot guarantee that your email will remain confidential. Although she may keep your email message private, she cannot ensure complete confidentiality from administrators of the system or computer hackers. Please do not send bank account or credit card information via email.
- Although email is typically a fast and efficient means of communication, Dr. Hayes may not have the ability to check email frequently and consistently depending on her schedule. Absence from the office, a busy schedule, unexpected illness, or difficulty accessing the Internet may mean that several days could pass before a message is received or returned. If you do not hear back after several days, please follow up via email or her designated phone line to ensure communication.

The laws and rules on confidentiality are complicated. Please bear in mind that Dr. Hayes is not able to give you legal advice. If you have special or unusual concerns and need special advice, it is strongly recommended that you speak with an attorney to legally protect and act in your best interests.

***The signature below indicates that I have read, discussed, understand, and agree to abide by the points presented above*.**

____
Signature of Patient/Legal Guardian

____ _____________________
Printed Name Date

Smisson Psychology Services, P.A.

Therapy, Assessment, and Consultation

1415 North Loop West, Suite 660D
Houston, TX 77008
Telephone: 832.769.5594
Fax: 832.433.7641

RELEASE OF INFORMATION

Dr. Cassandra Smisson Hayes (Smisson Psychology Services, P.A.) requires permission from you to discuss your treatment or evaluation with a third party. Your permission is also needed to obtain information from other sources. The following is your agreement to do so, if appropriate.

The following information is regarding: ____
Name of Patient

_______ I authorize Dr. Hayes to *release* records to individuals/entities listed below.
Initial

_______ I authorize Dr. Hayes to *obtain* records from the individuals/entities listed below.
Initial

Name	Address	Phone	Relationship

I authorize release of the following (please check all that apply):

______ Assessment reports
______ Confirmation of treatment
______ Treatment summary
______ Session attendance
______ Progress notes
______ Verbal updates

I authorize this release for the following time period: ___________ to __________.
Effective date End date

I understand this authorization can be revoked by me in writing at any time. In addition, I may also add individuals/entities as needed in writing at any time.

____
Signature of Patient/Legal Guardian

____ ____________________
Printed Name Date

Smisson Psychology Services, P.A.

Therapy, Assessment, and Consultation

1415 North Loop West, Ste. 660D
Houston, TX 77008
Telephone: 832.769.5594
Fax: 832.433.7641

CONSENT TO EMAIL PROTECTED HEALTH INFORMATION

- When we send you an email or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for many people, so in its latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.
- The information is available in a PDF (page 5634) on the U.S. Department of Health and Human Services website: http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

OPTION 1: ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted emails and do hereby give permission to Smisson Psychology Services, P.A., to send me personal health information via unencrypted email.

____
Signature Date Printed Name Email address

I also give Smisson Psychology Services, P.A., permission to send my attorney personal health information about me via unencrypted email (if applicable).

____
Signature Date Printed Name Email address

OPTION 2: DO NOT ALLOW UNENCRYPTED EMAIL

I do not wish to receive personal health information via email. ____________________________
Signature

Smisson Psychology Services, P.A.

Therapy, Assessment, and Consultation

1415 North Loop West, Suite 660D
Houston, TX 77008
Telephone: 832.769.5594
Fax: 832.433.7641

TEXAS NOTICE FORM

Acknowledgment of Notice

I acknowledge that I have read and understand the Texas Notice Form. I have asked my psychologist about any questions I may have regarding these policies.

____
Signature of Patient/Legal Guardian

____ ____________________
Printed Name Date