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

Psychological Services

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

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

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Meetings

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide whether I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.

Professional Fees

My hourly fee is $115. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by the other party. Because of the difficulty of legal involvement, I charge $300 per hour for preparation and attendance at any legal proceeding.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action in necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Contacting Me

I am often not immediately available by telephone. While I am usually in my office between 9 a.m. and 5 p.m. M-F, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail or the front desk. I will make every effort to return your call on the same day that you make it, with the exception of weekends or holidays. If you are difficult to reach,

please inform me of times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the clinician on call. If it is an emergency dial 9-1-1. If I will be unavailable for an extended time, I will provide you the name of a colleague to contact, if necessary.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have about what I am prepared to discuss.

Confidentiality

In general, the law protects the privacy of all communications between a client and a therapist, and I can release information about our work to others only with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include contacting the police or seeking hospitalization for the client. If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

As you know, I share an office suite with other mental health professionals. I want you to know that I am completely independent in providing you with clinical services, and I alone am fully responsible for those services. No member of the group can have access to your records maintained by me without your specific, written permission.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature: _____

Name (printed): _____

Date: _____

CLIENT CONSENT TO PSYCHOTHERAPY

I have read this statement, considered it carefully, asked questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to the release of that information and other information necessary to complete the billing process. I agree to pay the fee of $115 per session. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to undertake therapy with David Stroud, LPC. I know I can end therapy at any time and that I can refuse any requests or suggestions made by the therapist. I am over the age of eighteen.

Signed: _____ Date:_____

Print Name: _____

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____ - _____ - _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read my Notice of Privacy Practices before you decide whether to sign this Consent. The Notice provides a description of my treatment, payment activities, and healthcare operations, of the uses and disclosures I may make of your protected health information, and of other important matters about your protected health information. A copy of my Notice accompanies this Consent. I encourage you to read it carefully and completely before signing this Consent.

I reserve the right to change my privacy practices as described in our Notice of Privacy Practices. If I change my privacy practices, I will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that I maintain. You may obtain a copy of my Notice of Privacy Practices, including any revisions of my Notice, at any time by contacting:

Contact Person: David Stroud, LPC
Telephone: 972-674-9511
E-mail: david.t.stroud@gmail.com
Address: 3028 Communications Pkwy, Suite 300, Plano, TX 75093

Right to Revoke: You will have the right to revoke this Consent at any time by giving me written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action I took in reliance on this Consent before I received your revocation, and that I may decline to treat you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN Consent to Use and Disclose Health Information.

CLIENT INFORMATION

PATIENT NAME : _____
(LAST NAME) (FIRST NAME) (MI)

SSN: _____ - _____ - _____

DATE OF BIRTH : _____ / _____ / _____

SEX : _____

ADDRESS : _____

APT # : _____

CITY : _____

STATE : _____

ZIP CODE : _____

HOME PHONE : (____) _____

WORK PHONE : (____) _____

CELL PHONE : (____) _____

EMAIL : _____

WOULD YOU LIKE TO RECEIVE EMAIL STATEMENTS ? YES NO

INSURANCE INFORMATION (please provide CARD for copying)

INSURANCE COMPANY : _____

INSURANCE COMPANY ADDRESS :_____

INS. ID # : _____

POLICY GROUP # : _____

PLAN NAME : _____ INSURANCE CO. TEL. # : _____

INSUREDS NAME : _____

PATIENT RELATIONSHIP TO INSURED : _____

EMERGENCY CONTACT INFORMATION

CONTACT NAME :_____

CELL PHONE : (____) _____

HOME PHONE : (____) _____

AUTOMATIC BILLING AUTHORIZATION FORM
(Not Required)

I authorize you to charge my bill from David Stroud, PLLC, directly to my credit card(s) listed below. These charges include, but are not limited to:

x Sessions – individual or group
x Phone Sessions
x Court Appearances and associated fees
x Late cancellations or missed appointments
x Supplements

This authorization is valid until I provide you with WRITTEN cancellation.

Client Name: _____ (Please PRINT)

I do NOT accept American Express at this time.

Name on credit card – exactly as printed
Billing Address for credit card (Street, Apt #)
City, State Zip:
Credit card #
Expiry Date :
Signature :
Today's Date :

REFERRAL SOURCE :

CLIENT NAME:

PHONE NO :

ADDRESS:

Effective treatment begins after an accurate diagnosis has been made. This form is crucially important in making the correct assessment. Please answer the following questions as completely as possible. Feel free to write on the back or add additional pages as necessary.

CC: What is your chief concern at this time? : _____

_____

_____

What stressful events have recently occurred? : _____

_____

_____

HPI: Please describe in detail the symptoms you have experienced :_____

_____

When would you estimate that these symptoms began: _____

_____

What has been the course of your symptoms? (i.e. getting better, worse or staying the same and give the time frame) : _____

_____

Have you experienced similar symptoms before? (Please describe and give the time frame) : _____

_____

What have you tried that has made the symptoms better : _____

_____

What have you tried that has made the symptoms worse? : _____

_____

Please circle your answer and describe any Yes answers to the questions below.

Consistently down or depressed mood most of the day, nearly every day?	Yes	No
Diminished level of interest or pleasure in most or all activities?	Yes	No
Change in appetite?	Yes	No
Change in weight ?	Yes	No
Change in sleep pattern?	Yes	No
Feeling agitated of slowed down?	Yes	No
Fatigue or loss of energy?	Yes	No
Feelings of worthlessness or excessive guilt?	Yes	No
Difficulty thinking or concentrating?	Yes	No
Change in sex drive?	Yes	No
Irritability, rage or violent behavior?	Yes	No
Attacks of hyperventilation, palpitations or intense fear?	Yes	No
Change in drinking / drug use pattern?	Yes	No
Thoughts of death or suicide (or any attempts)?	Yes	No
Do you have access to any firearm (handgun, rifle, shotgun, etc.)?	Yes	No

PMH: Psychiatric

Any prior psychiatric evaluation? Please name the treating psychiatrist, dates of treatment, diagnosis, treatment response : _____

_____

Any prior psychiatric hospitalization? Give name of hospital, psychiatrist, dates, treatment and response : _____

_____

Have you ever been in therapy? Give name of therapist, dates and describe the issues that were addressed : _____

_____

Please list all the psychiatric medication (for depression, anxiety, insomnia, etc.) you have ever taken. Please describe any benefits or side effects that you experienced : _____

_____

Have you ever planned or made a suicide attempt? Please describe in detail : _____

_____

Any phobias or unusual fears?_____
_____

Ever experience auditory or visual hallucinations? _____
_____

Ever experience a "natural high" in absence of substance abuse (with increased energy, mood, talkativeness, decreased need for sleep, etc.)? : _____

For Women Only: Ever notice any change in mood or behavior after giving, birth or premenstrual ? Please give details : _____

PMH: CD
It is important to give honest estimates of your intake of the following:

Nicotine: _____

Packs per day: _____

Years of smoking: _____

Caffeine: Daily intake of coffee, tea, cola drinks or caffeine pills: _____
Alcohol:

Highest intake in 24 hour day: _____

Current weekly number of drinks: _____

Past:_____

Ever miss work or school due to being hung over, ever have any blackouts, accidents, legal (DWI, PI), health, marital or other problems? Please circle and describe : _____
_____

Other: Marijuana, cocaine, amphetamines, LSD, heroin (or other IV drugs), mushrooms, ecstasy, inhalants, prescription narcotics or other substances. Please circle and describe : _
_____

PMH: ED
Height: _____ Weight: _____ Highest Weight: _____Lowest Weight: _____
Any history of food binging?
Any use of laxatives, diuretics, diet pills, purging or food restriction for weight control? Please circle and describe : _____

OCD: Ever experience persistent obsessive thoughts or images of contamination, aggressive, sexual or religious fantasy or pathological doubt? : _____

Ever experience persistent compulsive behaviors, cleaning / washing, checking, counting, tapping, touching, repeating or arranging / ordering?: _____

OSA: Have you ever been informed that you snore loudly or that you stop breathing while sleeping, or wake up gasping for breath?: _____

PMH: Medical / Surgical

Personal physician(s), list name(s) and phone number(s): _____

_____

Date of most recent exam / lab work : _____

Any other health care provider you see (chiropractor, physical therapist, etc.) : _____

_____

Give details of any major medical problems you have (i.e. heart disease, high blood pressure, diabetes, thyroid disease, etc.) : _____

_____

Any prior surgeries (give date, type and any complications)? : _____

_____

Any prior hospitalizations (give date, reason, type of treatment)? : _____

_____

Any prior injuries, falls or accidents (especially any that resulted in a loss of consciousness of 5 minutes or longer)? : _____

Have you ever had a seizure or seizure disorder? : _____

Have you ever had a MRI or CAT Scan of the head? Give date and findings. : _____

_____

List all medications you currently or have recently taken (include over-the-counter coeds).
Give details:

Medication Name	**Dosage**	**Duration of usage**

List any allergic reactions you have had to any medications, foods or other substances :

_____

_____

FH:

Research has shown that heredity is important in many psychiatric disorders. Please take the time to think of your various blood related kin. Indicate any who have had similar symptoms as yourself. Also, note if any had problems (even if no treatment was received) with the following: - anxiety, depression, manic depression, post partum depression, changes in behavior or mood, eating disorders, phobias, suicidal behavior, drug or alcohol dependency, schizophrenia or Alzheimer's disease. Please note any other psychiatric or known medical problems.

RELATIVE **PROBLEM**

_____

_____

_____

_____

_____

Describe your current relationship with your family : _____

_____

_____

Marriage (s) or other long-term relationships. Give duration and describe relationship:_____

_____

Describe your children (list according to name and age) : _____

_____

Level of education : _____

Occupation : _____

Length of employment: _____

Describe work situation : _____

Current / past legal problems?: _____

Religious affiliation : _____

Military service : _____

Special interests or hobbies : _____

Number of hours spent exercising per week: _____

Type of exercise (i.e. running, walking, aerobics, weight lifting): _____