Herndon Psychotherapy and Evaluation, PLLC
Patient Information Form
(PLEASE PRINT LEGIBLY)

Patient Information Today's Date: _____

Last Name:_____First:_____Middle:_____

Birth Date:_____Social Security #:_____ Gender: ❒ M ❒ F
Marital Status: ❒ Child ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated
❒ Domestic Partner ❒ Other
Employment Status: Employed_____ Full Time Student_____ Part Time Student_____ Other_____

Telephone - Please circle the number you would like to be primary:

(Home)_____(Cell)_____(Work) _____

Mailing Address: Street: _____

City:_____ State:_____ Zip Code: _____

E-mail Address:_____❒ Decline to give
**I prefer to receive statements by: ❒ Paper Mail ❒ Email ❒ Both
Emergency Contact:_____Phone:_____❒ Decline to give

Responsible Party (if not 18):_____Phone: _____

Address of Responsible Party:_____ ❒Same as above

City:_____ State:_____ Zip Code: _____

Name of Referral: _____
Type of Referral:
❒ Healthcare Professional ❒ Family/Friend ❒ Flyer ❒ Book ❒ Internet Search ❒ Insurance
❒ Workshop ❒ Walk in ❒ Hospital ❒ Other_____

Primary Care Physician (PCP)
PCP Name:_____❒ Decline to give
PCP Address: _____
PCP Phone Number:_____PCP Fax Number: _____
❒ **I permit Herndon Psychotherapy and Evaluation, PLLC to exchange (provide and receive) information with my PCP listed above.**

INSURANCE INFORMATION

Primary Insurance

Does the back of your card indicate a phone number to call for Mental Health (MHSA)? ❒ Yes ❒ No

Insurance Company:_____ Copay Amount: _____

Claims Address: _____

City:_____ State:_____ Zip Code: _____

Insurance Phone #:_____ Group #:_____ ID #: _____

Subscriber Name:_____ Social Security #: _____

Relation to Patient:_____ Date of Birth:_____ Gender: ❒ M ❒ F

Address (if different from patient): _____

Effective Date:_____ Subscriber Employed by: _____

Additional Insurance

Does the back of your card indicate a phone number to call for Mental Health (MHSA)? ❒ Yes ❒ No

Insurance Company:_____ Copay Amount: _____

Claims Address: _____

City:_____ State:_____ Zip Code: _____

Insurance Phone #:_____ Group #:_____ ID #: _____

Subscriber Name:_____ Social Security #: _____

Relation to Patient:_____ Date of Birth:_____ Gender: ❒ M ❒ F

Address (if different from patient): _____

Effective Date:_____ Subscriber Employed by: _____

Credit Card Information/Primary Card

Name on Card:_____ Exp Date:

Card Number #:_____ CVR Code:

Billing Address: _____

City:_____ State:_____ Zip Code: _____

Credit Card Information/Secondary Card

Name on Card:_____ Exp Date:

Card Number #:_____ CVR Code:

Billing Address: _____

City:_____ State:_____ Zip Code: _____

My signature below authorizes payment from these credit cards for services received from HoPE, PLLC.

Authorization and EAP Information

Does your insurance require a referral or pre-authorization PRIOR to your first visit? ❒ Yes ❒ No

EAP Company:_____ Employer:_____ Authorization #:_____

Number of Sessions Authorized:_____ Dates Authorized:_____

Claims Address: _____

Medicare Information

If insured with Medicare, how do you qualify? ❒ Retirement ❒ Long-term Disability ❒ ESRD

Do you currently have a spouse that is employed? ❒ Yes ❒ No

If you marked yes above, are there more than 20 employees at their place of work? ❒ Yes ❒ No

Signature of Responsible Party:_____ Date:_____

Print Name of Patient: _____

HERNDON PSYCHOTHERAPY AND EVALUATION, PLLC (HoPE)

PROFESSIONAL SERVICE AGREEMENT

Policies, Procedures, and Informed Consent

Acknowledgement

I understand that my clinician, Natalie Cox Herndon, PhD, is an independent professional who operates a practice, Herndon Psychotherapy and Evaluation, PLLC, and hires outside companies and staff to provide HIPPA compliant billing, scheduling, collections, electronic medical record keeping, and other office related services.

Fee for Service

The current fee for a 45-50 minute session is $175.00 for intake appointments, and $150.00 for each additional appointment, unless different arrangements have been made and mutually agreed upon in a separate written agreement. If the duration of our work extends over years, this fee may change. All payments are due in full at the time of service, with checks or cash payments made prior to each session. Credit card payment is acceptable as well, with charges incurring once per week. The credit cards you provide on this form will be charged weekly for your outstanding balance, or for your copay amount if you have provided insurance information.

Insurance Benefits

Please fill out all information for insurance. If HoPE cannot receive payment due to insufficient insurance information, the patient will be responsible for the amount in full. Remember it is the patient's responsibility to verify their insurance benefits before the appointment. If insurance claims have been submitted and rejected, then your card on file will be charged the cash rate for the sessions which have been denied.

Other Services

Your insurance reimburses for your therapeutic treatment only (i.e., it does not cover time spent preparing documents, drafting letters, consulting with other professionals, etc.) As a result, services provided outside of regularly scheduled visits may be charged in addition to the service rates above. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than an hour.

Financial Agreement

In consideration of the mental healthcare services rendered to me, any member of my family, or any other person at my request, I agree to pay for all services rendered at the rates listed above. I understand that there will be an additional $30.00 service charge on all returned checks. I grant permission to your office to contact me at my home, place of business, via my cell phone, or to leave messages on the voicemail associated with the phone numbers I have provided. By listing my email on the Patient Information Form, I understand that I may receive email correspondence regarding my statement.

Finance Charges

In the event that my account is not paid as agreed or is delinquent, I agree to pay a collection fee of 35% of my unpaid balance in addition to my balance. In the event that it is necessary to commence legal action to collect this bill, I agree to pay reasonable attorney's fees and court costs and to submit to the jurisdiction of HoPE If any portion of this bill or the provider's services is disputed, I agree to submit myself to mediation or arbitration and in so doing will pay the associated costs.

Cancellation Policy

Over the course of our ongoing work, the days and times that we have established for your appointments each week are your set times, that I safeguard and reserve specifically for you and this important work. Likewise, all that I have is my time, and the limited number of hours each week that I make available to conduct therapy. In order to maintain your reserved appointments, you will be responsible for paying for your times, present or not. However, I do understand and support the need for vacations, important trips, or pressing matters that may take you away. Therefore, I will honor four weeks out of the year for pre-arranged absences. Pre-arranged cancelation of appointments requires a minimum of 72 hours notice (a full three days). You may request make-up sessions to reschedule pre-arranged absences, or last-minute illnesses, accidents and emergencies, based upon my availability. I will do everything I can to help us find time for these make-up sessions. I would much rather try to find an alternative date, or do a telephone consult with you, than to miss our sessions altogether and break the continuity of our ongoing work. If alternate times cannot be found, please be aware that insurance companies do not reimburse for missed appointments and you will be charged the full rate of our agreed fee for therapy.

Please initial here after reading and understanding the cancellation policy _____ .

Authorizations and Release of Information
I authorize the professional staff at HoPE to exchange information relevant to my care (written and/or verbal) with my Primary Care Physician, whom I may list on the Patient Information Form. I understand that if I fail to list my Primary Care Physician's information on the Patient Information form, continuity of care may not be complete. I authorize the release of any medical, psychiatric, and/or substance abuse information necessary to process fees for service claims to my insurer. I authorize payment of insurance benefits to HoPE or any facility authorized by HoPE. By signing this form, I am requesting that HoPE open an account in my name.

Consent for Treatment
I voluntarily consent to mental health treatment, therapy, evaluation, or consultation with practitioners operating under Herndon Psychotherapy and Evaluation, PLLC. I understand that, while most people benefit by participating in mental health services, there is no guarantee that my family members or I will be helped and in some cases symptoms may worsen. In signing for services for a minor, I certify that I am the legal guardian and I have the legal right to approve of the evaluation, treatment, and release of information. As the legal guardian, I understand that I (or another guardian) must be present for services to be rendered with an underage child.

Privacy Practices & Consumer Rights
I acknowledge that I have been provided access to a copy of HoPE Privacy Practices and Consumer Rights Policy & Procedures upon request, and on her website www.hopecanhelp.net. I acknowledge that I have been offered information regarding privacy rights and HIPPA guidelines. I understand that it is my responsibility to read this document and to ask about anything that is unclear

Confidentiality
In general, the privacy of all communications between a patient and a psychologist/therapist is protected by law, and I can only release information about our work to others 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/she determines that the issues demand it.

Duty to Warn and Protect
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 patient's treatment. If I believe that a patient is threatening serious bodily harm to themselves, to another person, or is having active psychotic symptoms which impair their ability to make decisions for their own benefit and well-being, I will take protective actions. These actions may include notifying the potential victim, notifying family members or others who can help provide protection, contacting the police, or seeking hospitalization for the patient.

Prenatal Exposure to Controlled Substances
Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Communicable Disease
If I have reason to believe that you are suspected of having or are suffering from a disease that is communicable, I am required by law to report this to the local health department.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

Abuse of Children and Vulnerable Adults
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, I am required by law to report this information to the appropriate social service and/or legal authorities with or without the client's knowledge or consent.

Professional Consultation
I may occasionally find it helpful to consult other professionals about a case. During a professional consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. The

other professionals are also legally bound to keep the information confidential. I will note all consultations in your clinical record (which is called "Protected Health Information (PHI)".

Protected Health Information

If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a government agency is requesting the information for health oversight activities, I am required to provide it forthem. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself. If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the appropriate parties, the patient's employer, the workers' compensation insurance carrier or the Labor Commission.

Communication

If you are in an emergency or crisis situation, please either call 911, call the UNI crisis line at (801)583-2500, or visit your local emergency room. I am often not immediately available after hours, but if you need to reach me you may call (801)657-3330 and leave a confidential voicemail message or email me at natalieherndon@hopecanhelp.net. I will make every effort to return your call or email on the same day you make it, with the exception of weekends and holidays. If I am unavailable for an extended time, I will leave the name and phone number of a colleague who is providing coverage on my voice mail message. If you email me content related to your therapy sessions, email is not completely secure or confidential. Any emails I receive from you and any responses that I send to you become part of your legal record.

Social Media

The following information documents my policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

I do not accept friend or contact requests from current or former clients on any social networking sites (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

It is not a regular part of my practice to search for clients on Google, Yahoo, or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

You may find my psychology practice on sites such as Psychology Today or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologist/therapists to solicit testimonials: "Psychologists [and therapists] do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence."

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend

networks for your own privacy and protection. If you use location-based services on your mobile phone or device, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive location based service application enabled on your phone or mobile device.

Program Rules

I understand that I am not permitted to bring weapons of any kind onto HoPE property at any time. I understand that I am not permitted to bring any animals onto HoPE property, with the exception of a service animal. I understand that clients at HoPE are expected to maintain respectful and lawful conduct while on the premises and while communicating with HoPE providers and staff either on the premises or over the phone. I understand that I may be asked to temporarily or permanently leave treatment if they do not maintain respectful and lawful conduct during treatment or while communicating with HoPE providers and staff. This will be at the discretion of providers and administrative staff.

Forensic Consultations

If my provider is asked to testify about me or my case then I am ultimately responsible for the financial bill for time, including preparation time and travel, spent by my provider, whether or not my provider is called to testify, and is due in advance. My fee is $175.00/hour, with a minimum 4 hours (half day) plus 3 hours preparation time. If I will likely be away for a full day, then payment for 8 hours plus 3 hours preparation time will be due in advance. Travel will be charged at .60/mile. Payment for time in testimony needs to be paid up front by check, and will be held aside until the service is provided. Scheduled court or deposition appearances that are cancelled less than 3 business days in advance are not refundable. Deposition payment should be made when the notice to appear is delivered. My provider determines his or her own fee schedule for these services. It is important in retaining my confidentiality that I not have my provider subpoenaed to the extent that I am able.

Treatment and Services

I understand that HOPE offers a variety of outpatient mental health treatment options, including but not limited to psychotherapy and psychological testing. I understand that a treatment plan including services recommended for me by my provider may include a variety of different treatment options; I understand that if HOPE does not offer mental health treatment options that I desire or that my provider recommends for me, a referral to an outside facility can be obtained upon request at the discretion of my provider.

I understand that I can expect the following from my treatment at HOPE: outpatient mental health treatment; confidentiality and secure records keeping; professionalism and competency from providers and office staff; scheduling support; referrals to outside sources if necessary and in keeping with my treatment plan. I understand that my information is confidential and may be withheld from third parties requesting my information if deemed necessary by my provider or administrative staff at HOPE. I understand that HOPE does not provide inpatient mental health services.

I understand that, because therapy and psychiatry services are typically ongoing, HOPE does not implement a formal discharge plan as part of the treatment process. I understand that treatment may end voluntarily at any time; I also understand that treatment may end involuntarily at the sole discretion of my provider(s).

Maximum Sanctions and Consequences

Your HOPE provider(s) and/or administrative staff reserve the right to refuse treatment and services to any person who does not comply with HOPE program rules. Consequences for non-compliance with program rules may include dismissal from treatment and/or HOPE property.

I, by virtue of my signature below, I have read and understand the information in this document. I agree to abide by its terms during our professional relationship. I am aware of the risks and responsibilities noted above, and agree to the inherent conditions implied or stated. If desired, a copy of this document will be provided to you for your records.

Signature of Patient or Responsible Party:_____ **Date:** _____

Please Print Name of Patient:_____

Signature of Therapist:_____ **Date:** _____

Printed Name of Therapist:_____

Medical History Form

Directions: Please answer the following questions to the best of your knowledge. Complete both the front and back of this form.

Patient Information			
Last Name	**First Name**	**MI**	**Birthdate**

Children: ☐ Yes ☐ No How many?	Number of persons living in your home?

Primary Therapist (s) or Physician(s)		
Name:	**Name:**	**Name:**
Address:	**Address:**	**Address:**
Phone:	**Phone:**	**Phone:**

Are you allergic to any medications? ☐ Yes ☐ No If yes, what medication (s)? _____
Are you allergic to any substances or foods? ☐ Yes ☐ No If yes, what substance (s)? _____

Family History

Please ▤ if your family has a history of:

☐ Diabetes ☐ Mental Illness ☐ Epilepsy/Seizure ☐ Cancer ☐ Alzheimer's ☐ History Unknown

Any other neuropsychological or psychiatric conditions? _____

If you answered "Yes" to any of the above, please explain: _____

Are you currently being treated for any medical conditions? ☐ Yes ☐ No If yes, please list: _____

Medications

(List more on separate page if necessary)

Current Medication	For what condition?	Dosage	Frequency	Date Started	Comments/Problems/Concerns

Past Medications/For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc.)

Other

☐ Yes ☐ No	Do you smoke? If yes, how many cigarettes per day?
☐ Yes ☐ No	Do you use alcohol? If yes, how often, how much?
☐ Yes ☐ No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)

REVIEW OF SYMPTOMS Please check if you currently have or have ever had the following:

Check	Symptom	Explain
	Prolonged Mood Changes	
	Changes in Sleep	
	Changes in Appetite	
	Problems Concentrating	
	Death Wishes/Suicidal Ideations	
	Hopelessness/Helplessness	
	Lack of Enjoyment	
	Unworthiness	
	Sluggishness	
	Excessive Guilty Feelings	
	Anxiety	
	Irritability	
	Racing Thoughts	
	Hallucinations	
	Bizarre Ideations	
	Paranoia	
	Phobias(specify)	
	Eating Disorders	
	Repetitive Thoughts/Behaviors	
	Bodily Complaints	
	Changes of Libido (sex drive)	
	Sexual Problems	
Other Conditions/problems not listed:		

No Harm Agreement

I make a commitment to living. I will not harm myself or anyone else in any way. I will not attempt suicide, or any other self-injury. If I begin to have thoughts of harming myself:

1) I will try to identify specifically what is upsetting me.

2) I will review alternatives to self-harm, such as thinking about my friends, family, or the future.

3) I will do at least one of the following things for 30 minutes to try to make myself feel better:

_____

_____

_____

4) I will seek out a responsible, caring and supportive person if thoughts of self-harm continue.

5) If I do not feel I can control my behavior, I will contact 911 or the or the nearest emergency room

Important, supportive people in my life I can contact:

Name Relationship Phone #

_____

_____

_____

_____

_____

_____

I certify that I have answered these questions to the best of my knowledge.

Patient (Guardian) Signature:_____ Date: _____

Therapist Signature:_____ Date: _____