Penny Frohlich, Ph.D.
Clinical Psychologist

# Intake Form

Today's Date: _____

Full Name: _____ Date of Birth: _____ Age: _____

Address: _____ Zip: _____

Phone/email (H) _____ (Cell) _____

(W) _____ (email) _____

Please check your preferred contact number(s): Home_____ Work_____ Cell_____

May I leave a message at this number? Yes_____ No_____

Education (Last grade completed) _____ Degree Earned: _____

Occupation: _____

Marital Status: _____ Years of Marriage (most recent):____ Spouse's name:_____

Children's names & ages: _____

_____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Psychiatrists: _____ Phone: _____

Referred by: _____

**Insurance Information** (Please complete the following if you intend to file for insurance):

1. Social Security of Client: _____-____-_____
2. Insured's Full Name (if same as client, skip to item # 4): _____

   Insured's Date of Birth: _____ Patient Relationship to Policy holder: _____

   Social Security of Insured: _____-____-_____
3. Insured's Address: _____
4. Insured's employer: _____

   Employer's address:_____
5. Insured's Insurance Plan Name: _____

   Group #. _____ Member ID#: _____

   Insurance Claim Address: _____

   _____

   Phone #:_____ Ext. _____
6. I authorize the release of medical or any other information to process insurance claims regarding service provided by Penny Frohlich, Ph.D.

   Signature: _____

**Health History**

1. Briefly describe your reasons for seeking treatment: _____

_____

_____

_____

2. When did the problem begin and what motivated you to seek treatment now? _____

_____

_____

3. What have you done thus far to improve or alleviate the problem?_____

_____

4. List all past or present mental health treatment:

| Dates | Type of treatment | Therapists Name | Where |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

5. List all current medications:_____

_____

6. List all past psychiatric medications you have taken: _____

_____

7. List any non-prescription drugs (e.g., alcohol, marijuana, cocaine) you currently or periodically use:

_____

_____

8. Please place an "X" for any of the following that have ever applied to you:

| Medical | Psychological | |
|---|---|---|
| ___ Liver disease | ___ Juvenile delinquency | ___ Family problems |
| ___ Kidney disease | ___ School phobia | ___ Work problems |
| ___ Thyroid disease | ___ ADHD/hyperactivity | ___ Legal problems |
| ___ Heart trouble | ___ Running away | ___ Binge/compulsive eating |
| ___ Lung problems (e.g., asthma) | ___ Truancy | ___ Anorexia |
| ___ Diabetes | ___ Physical abuse | ___ Incest |
| ___ Cancer | ___ Sexual abuse | ___ Rape |
| ___ Epilepsy | ___ Bed wetting | ___ Sexual problems |
| ___ Pancreatitis | ___ Childhood fears | ___ Sexual identity problems |
| ___ Head injury | ___ Learning disorders | ___ Other _____ |
| ___ Veneral disease | ___ Behavior problems | ___ Other _____ |
| ___ AIDS or HIV+ | ___ Teenage pregnancy | ___ Other _____ |

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# Letter of Agreement

Psychological consultation is a joint venture in which you are an equal participant. The more you are willing to be active in understanding and developing plans to change, the more you will benefit from therapy.

These papers explain how we will work together and what you can expect from our alliance. As part of this agreement I will ask you to list your goals and sign the agreement to indicate your commitment towards achieving those goals.

The course of consultation often has highs and lows, so please be prepared for both easy and hard times. It is important that you commit to attend regularly since the difficult times (when you might be most tempted to miss a session) are often when the most progress is made. Unless we previously agree that infrequent sessions are best for your situation, erratic attendance will make it far more difficult to benefit from therapy.

I do not accept clients, whom, in my professional opinion, will not benefit from treatment with me. I will, therefore, enter our relationship with optimism and eagerness to work with you.

In choosing to participate in therapy, you will be making a commitment of time, money and energy. Since it is important that you are comfortable and optimistic with your therapist, our work together needs to be as direct and honest as possible. My style is very collaborative and I depend on your feedback. If at any time you feel uncomfortable with our work together, or have other concerns about it, please talk to me. It is important that I know if you are unhappy or dissatisfied with any part of our relationship, and I will always do what I can to remedy it.

You have a right to ask me about other treatments for your problems and their potential risks and benefits. If these are treatments I do not provide, but from which you could benefit nonetheless, it is my job to assist with finding those treatments. If at any time you desire a second opinion, I will be happy to help you in getting one.

The first 1 to 2 sessions are essentially an initial evaluation and goal-setting period. Furthermore, it is also an opportunity for both of us to determine if I am the best person to provide the services you need. These initial sessions, as well as all subsequent individual psychotherapy sessions, are typically 50 minutes in length (the remainder of the hour will be used for writing notes and reviewing).

The most important factors influencing the length of therapy are your goals for therapy and the complexity of the difficulties you are facing. Therapy can be brief (10 or fewer sessions) or longer depending on the nature of these factors. Typically after the initial evaluation, I can give you my professional opinion regarding approximately how much time should be needed.

Termination is a very important part of our work. Ideally, we are in mutual agreement about when to end consultation. After a decision to end consultation is made, we generally will meet for at least one last session to review our work together and to say goodbye. This last meeting is often a critical part of treatment.

Before we begin our work together, I recommend that you see your family physician and that you have a clear understanding of any medical conditions that might affect your psychological situation. For people with depression, anxiety disorders, substance use problems, sexual dysfunction, or chronic illness and fatigue, this step is invaluable because medical conditions can play a large role in these problems and thus affect the way in which we will work together. It is often helpful for me to communicate briefly with your physician to ensure that we are working together in your best interest; however, I will not do so without your written consent.

I am often not immediately available by phone, though I have voice mail and make every effort to return call within 24 hours except on weekends and holidays. In emergencies, if you cannot reach me, and cannot wait for a return call, alternative resources include the 24-hour hotline at Austin State Hospital (472-4357/472-HELP), St. David's Pavilion Psychiatric Hospital (867-5800), or Seton Shoal Creek Psychiatric Hospital (452-0361).

I am a sole practitioner; any group arrangements are made for the purposes of office sharing only.

## Confidentiality of Records

My professional and personal ethics require me to keep everything you discuss in therapy in the strictest confidence. While you are free to discuss your therapy with anyone whom you wish, I do not discuss such matters without your consent. Confidentiality of the information you provide during our work together is of the utmost importance and will be strictly guarded. Thus, information you share with me will not be discussed with anyone without obtaining your written consent.

There are certain situations written into the laws, however, that deny me complete control over confidentiality of communication. For example, I am legally required to report any situation of suspected child or elder abuse of which I become aware, unless I know that it has already been reported to the authorities. I may also be obliged to warn a potential victim if I come to believe that a client may be intending to do them harm. If a client is actively suicidal, I am required to make efforts to assure their safety.

There are also rare cases where a therapist's records are subpoenaed, and the therapist is forced to yield them to the court. Since I do not support any violation of your privacy, I will do everything I can to resist such a situation. However, I must obey the law. If such a situation were to occur, I would attempt to discuss with you beforehand any information I might be compelled to release.

Under some circumstances, I may consult with other colleagues about my clients, and some aspects of your case might be shared. However, I will do this in a manner that would not identify you. My colleagues, like myself, are ethically required to maintain your confidentiality.

I am giving you this information so I can be certain you are aware of it, and so that we can discuss it further if it is of concern. I will always inform my clients if such an obligation arises with regard to their records.

If you ask me to release information to someone else, I will ask you to sign a Release of Information form. This allows me to legally and ethically communicate information.

I have read the above information about confidentiality, and I understand and agree to it.

_____ _____

Signature Date

## Fees, Billing, and Insurance

1. Office charges for initial evaluation are $210, and for individual, couples, and sex therapy are based on a rate of $175 per 50-minute session (the remainder of the hour will be used for writing notes and reviewing).

2. All fees are payable at the time of the appointment, unless specific alternate arrangements are made. If you need to be billed, terms for payment should be made in advance.

3. Since scheduling an appointment insures that a space in my schedule will be reserved for you, the standard fee will be charged for missed appointments unless they are cancelled within 24 hours or more in advance (this advance notice will allow me to try to fill that time slot).

4. Delinquent accounts may be subject to action by a collection agency, although every effort will be made to avoid this. If efforts to arrange payment are unsuccessful and the bill is sent for collection, the balance due will be increased by the total of all collection agency fees.

**Insurance**: If you would like, I am happy to help with the process of billing your insurance company to determine what they are willing to pay. However, because my primary relationship is with you**,** and not with your insurance provider, you are responsible for paying for any services provided that are not reimbursed by your insurance provider. Alternatively, if you wish to keep your information absolutely private (no diagnosis, no clinical information to insurance companies) you have the right to pay for my services yourself.

I have read this information and I understand it.

_____ _____

Signature Date

I am a sole practitioner; any group arrangements are made for the purposes of office sharing only.

**Goal Sheet**

**Goals:**

We have read this agreement and understand its terms. We have listed the goals of our relationship above and will continue to work together until our goals are reached or until we decide together to discontinue.

I understand the information presented, have had an opportunity to discuss it with Dr. Frohlich, and give my informed consent to these arrangements.

_____ _____

Signature Date

I appreciate the opportunity to work with you and will do my best to help you accomplish your goals. If you are happy with my services as we proceed, I would be pleased to have you refer other people who might also benefit from consultation with me.

Treatment plan:

Modality:

Frequency:

Penny Frohlich, Ph.D.
Clinical Psychologist

**Penelope Frohlich, Ph.D., 2499 S. Capital of Texas Hwy, A-105, Austin TX 78746 Tel. 512.626.2637**

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (PHI), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician, psychologist, or psychiatrist.
    - *Payment* is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operations of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abuse, I must by law make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse**: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Abuse by a Therapist**: If you tell me of any sexual involvement with a mental health professional, I will report this to the appropriate State Examining Board.
- **Health Oversight**: If a complaint is filed against me with the appropriate State Board overseeing me – the Texas State Board of Examiners of Psychologists – they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety**: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation**: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and My Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send information to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you in details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a paper Copy* – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you a revised copy at your next visit or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, talk to me about these concerns.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

Vi. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice at your next visit or by mail.