Gina Furr, PhD
Licensed Psychologist

Therapy Information and Office Policy Statement

Welcome!
Congratulations on your choice to find out more about therapy. This statement provides information about treatment, confidentiality, and office policies. When signed by you and by me, it also constitutes an informed consent document and treatment agreement.

Aims & Goals
An overarching goal of therapy is aiding you in identifying and coping with difficulties. In general, we will work to meet this overarching goal through:

- Increasing awareness of self and others
- Identifying personal goals
- Identifying and practicing use of effective tools to make progress towards goals
- Promoting holistic wellness

Responsibilities in Therapy/Collaborative Approach
As a psychologist, I bring certain expertise to our collaboration, including knowledge about psychology, development and healing, as well as tools and techniques for facilitating change. However, going to therapy is not like a visit to a medical doctor. You are the expert on You. You bring (and/or we work together to find/establish) self-knowledge, the ability to learn from your life experiences, and a vision of what you want your life to be. Thus you are expected to play an active and collaborative role in your treatment, including working with me to outline treatment goals, strategies, and progress. This is crucial to establishing a treatment that will be most effective in moving you towards your goals. If you have concerns or reservations about my treatment recommendations, I strongly encourage you to express them so that we can resolve any possible differences or misunderstandings. I reserve the right to terminate treatment if you do not appear to be invested in therapy (e.g., frequent cancelling/no-showing, not following through with agreed-upon tasks, disengagement during sessions). What happens outside of the therapy office is often vital in making progress towards goals. I encourage you to keep working towards goals whether or not you're in the office and we'll talk about different strategies to try as part of therapy.

I will discuss my impressions of your situation with you at the beginning of your treatment. Together, we will decide if I am a good fit for your needs and how often we should meet. If I do not believe that I can be helpful to you, or if during our work I am not effective in helping you reach your therapeutic goals, I will discuss this with you and offer my assistance in linking you with another professional. If you commit violence to, verbally or physically threaten or harass me, the office, or my family, I reserve the right to terminate your treatment unilaterally and immediately. Failure or refusal to pay for services after a reasonable time is another condition for termination of services. Please contact me to make arrangements any time your financial situation changes.

Appointments, Cancellations, Missed Appointments, and Late Arrivals
Sessions are generally 45-50 minutes. The frequency of appointments will be discussed and depend on a variety of factors (e.g. clinical indication, your schedule, financial considerations).

I am dedicated in assisting you meet your therapy goals. Consistent attendance is important and associated with better treatment outcomes. However, if you are unable to keep your appointment, *please cancel 24-hours prior to your appointment time* and I will be happy to reschedule your visit.

Giving less than 24 hours notice when you're unable to make an appointment will result in a fee of $75. Your insurance does not cover charges for late cancellations or no-shows. I understand that unavoidable situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. Thus, I allow the late cancel/no-show fee to be waived once.

Three (3) late cancellations or no-shows constitutes grounds for termination of services, though you and I would have a discussion about that prior to any termination of services.

If you arrive to session late, please be aware that we will still end your session at the originally specified time. I must to do this respect the needs and time of my other clients.

Inclement Weather Policy
If the LPS School System closes due to snow or other inclement weather, my office may or may not be open. If your appointment falls on a "snow day," I will contact you the morning of your appointment to confirm your appointment.

Contacting the Therapist
I may not always be immediately available by phone. I generally do not accept phone calls during client sessions, after business hours, or on weekends. You may leave a message on my mobile phone via voicemail or text anytime. You may also choose to e-mail me regarding scheduling or cancelling. I will make every effort to return your contact the same day it is received or on the next business day, with the exception of holidays.

Crisis contact. Keep in mind that my number is not an emergency contact number. Generally speaking, a crisis situation involves imminent danger to yourself (i.e., seriously contemplating suicide, hearing/seeing things that others do not) or to someone else (i.e., seriously contemplating hurting someone else). If you are experiencing a crisis, you may call me at any time on my mobile phone. If I do not initially answer, please leave a voicemail clearly indicating the nature of your situation. I will make every effort to get back to you. If you need to talk to someone right away, call 911 or go to your nearest emergency room. ***E-mail and/or text messaging are NOT acceptable means of alerting me about a crisis situation.***

Coverage. When I am on vacation or if I were to become seriously ill, other practitioners in my practice may temporarily assist me in providing crisis coverage to clients.

Electronic contact. I prefer to use e-mail contact for scheduling and I prefer using e-mail only to arrange or modify appointments. ***Please do not email me content related to your therapy session.*** Electronic forms of communication are not confidential. If you choose to use email, text message or other unsecured means of communication to contact me, information you share may be viewed by others. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Social Media Policy
I do not accept friend or contact requests from current or former clients on any social networking site (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.

Confidentiality

Issues discussed in therapy are personal and are generally legally protected as both confidential and privileged. However, there are limits to the privilege of confidentiality. These limits include: 1) suspected abuse or neglect of a child, elderly person, or disabled person, 2) if I believe you are in danger of harming yourself or another person, or if you are unable to care for yourself, 3) if you report that you intend to physically injure someone, the law requires me to inform that person as well as the legal authorities, 4) if I am ordered by a court to release information as part of a legal involvement in company litigation, etc., 5) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6) in natural disasters whereby protected materials may become exposed, or 7) when otherwise required by law. You will be asked to authorize a Release of Information to allow for communication between myself and other health care providers and/or family members as needed.

Minors

If you are under nineteen years of age, please be aware that the law may provide your parents the right to examine your therapy records. It is my policy to notify your parents if I believe you are at a high risk to seriously harm yourself or someone else. However, I will *always* talk with you in advance of talking to your parents or anyone else about what we discuss in therapy. You and I can work together to decide what needs to be shared with parents and how the sharing will happen.

Fees, Payment, and Insurance

My typical fee for the initial intake visit is $275. Each 45 to 50-minute session thereafter is $175. Fees for assessment will vary. Fees are subject to revision but we will discuss any fee changes in advance. Co-payment (or full cost of session, if not using insurance) is due at the time of the session unless other arrangements were made prior with me. It is your responsibility to familiarize yourself with your insurance benefits. I will file your insurance claim, though you are responsible for deductibles, co-insurance, and co-payments. You are responsible for the cost of the first session even if you decide not to pursue further treatment with me. If charges for services, including fees for late cancellation or no shows, remain unpaid after 90 days, myself or my biller will contact you to attempt to negotiate a payment plan or timeline for payment. If a negotiation cannot be reached, collections agencies may be utilized.

Complaints

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about me, your treatment, or any office policy please inform me immediately and discuss the situation. If you do not feel the complaint is then addressed and resolved adequately, you may also inform your insurance carrier and file a complaint if you so choose.

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Consent for Treatment

By signing below, I, ___________________, am stating that I have read and understood this 3-page policy statement, including information about contacting the therapist and the social media policy, and that I have had my questions answered satisfactorily. I am also agreeing that:

1. I understand that I may use Dr. Gina's mobile phone number for crisis situations. I further understand that this is not an emergency number and she may not be able to get back to me right away.
2. If I have an emergency I am to call 911 or go to the emergency room.

Dr. Gina has explained potential risks and benefits of the services being given. Alternative treatment options have been discussed and will continue to be discussed throughout the treatment process.

I accept, understand, and agree to abide by the contents and terms of this agreement. I also agree that should I obtain a different address, phone, or e-mail address, this consent would remain effective for use in contacting me. I consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Client Name (print please) ____

Client Signature ____ Date: ________________

Therapist/Witness ____

What Brings You Here

What is the main problem that brought you here?

What prompted you to make this appointment today? Why now?

What are the goals or changes you are hoping to achieve in therapy?

1.

2.

3.

What are your strengths?

1.

2.

3.

Additional comments: ____

____

Signature of person completing this page: ____

Print name: _______________________________________ Date: ____________________

Gina Furr, PhD
Licensed Psychologist

Client Information

Today's date_____________

Name____ Date of Birth___________ Age______

Gender___________________________ Sexuality____

Current Country Citizenship____

Ethnic/ Racial Identity or Heritage____

Language Preference for Therapy____

Religious/Spiritual Identity or Affiliation____

Relationship Status:
[ ] in a relationship(s) [ ] single [ ] engaged [ ] married [ ] partnered [ ] separated [ ] divorced
[ ] remarried [ ] widow(er)

Employment (check all that apply)
[ ] employed and satisfied [ ] employed and dissatisfied [ ] unemployed, looking for work
[ ] unemployed, not looking for work [ ] conflicts at work [ ] unstable work history [ ] disabled

Financial Situation (check all that apply)
[ ] no current financial problems [ ] large indebtedness [ ] eligible for state/federal aid
[ ] difficulty making ends meet [ ] relationship conflicts over finances

Community Activities – please list groups/organizations that you participate in
____

Educational History:
Highest degree completed: [ ] grade school [ ] high school [ ] college [ ] graduate/professional school
Are you currently a student? [ ] no [ ] yes

Past/Present School information:

Name of School/s:____

Major/s:__________________________ ____________________ GPA/s:_________

Legal History:
Have you ever been convicted of a felony? [ ] no [ ] yes What/when?_____________________________
Are you currently involved in any court proceedings? [ ] no [ ] yes
If yes, please explain:____

Military Service:
Have you been/are you now in the military? [ ] no [ ] yes, Dates:________________________________
If yes, were you in combat? [ ] no [ ] yes When/where?____

Psychological History

In the last 3 weeks, have you had suicidal thoughts (i.e. thoughts of killing yourself or ending your life)?
[ ] no [ ] yes
Have you seriously considered attempting suicide in the past? [ ] no [ ] yes
Have you ever attempted to commit suicide? [ ] no [ ] yes

Have you been in therapy before? [ ] no [ ] yes When/How Long _______________________________
Who with/Name of Therapist:_______________________ Issued addressed:___________________________

Have you ever been hospitalized for a psychiatric reason? [ ] no [ ] yes: when and for what reason?

Please list any previous mental health diagnoses and/or psychiatric medication:

Are you currently experiencing any of the following:

[ ] Sleep disruption
[ ] Appetite disruption
[ ] Sadness
[ ] Not caring about things you used to
[ ] Mood swings
[ ] Concentration/focus problems
[ ] Nightmares or flashbacks
[ ] Restlessness
[ ] Panic attacks
[ ] Anxiety
[ ] Feeling nervous or "on edge"
[ ] Racing thoughts
[ ] Repetitive thoughts
[ ] Physical pain
[ ] Binge/purge behaviors
[ ] Anger
[ ] Irritability
[ ] Self-destructive behavior
[ ] Relationship problems
[ ] Sexual problems
[ ] Recent loss/grief
[ ] Wondering "who am I?"
[ ] Divorce/separation
[ ] Academic problems/failure
[ ] Hearing or seeing things that others don't see/hear
[ ] Desire to hurt someone
[ ] Fear that people will harm me
[ ] Impulsivity/recklessness
[ ] Use of recreational drugs
[ ] Concerns about weight/body/food

Have you had any experiences that you consider to have been traumatic? YES NO If yes, briefly describe:

Please check if you have experienced any of the following:
[ ] emotional abuse
[ ] physical abuse
[ ] sexual abuse
[ ] discrimination
[ ] teen pregnancy
[ ] bullying
[ ] relationship violence
[ ] multiple family moves
[ ] homelessness
[ ] crime victim
[ ] loss of a child (e.g. miscarriage, abortion, adoption)
[ ] parent/guardian substance abuse
[ ] parent/guardian serious illness

Physical History

Have you had/current have any of the following:

[ ] asthma
[ ] diabetes
[ ] ulcers
[ ] blood pressure problems
[ ] heart condition
[ ] high cholesterol
[ ] stomach/bowel problems
[ ] thyroid problems
[ ] cancer
[ ] visual impairment
[ ] hearing impairment
[ ] physical disability
[ ] seizures
[ ] migraines/headaches
[ ] head injury (see below)
[ ] chronic pain
[ ] arthritis
[ ] fibromyalgia
[ ] obesity
[ ] miscarriage/stillbirth
[ ] menstrual problems
[ ] fertility problems
[ ] difficult pregnancies
[ ] abortion
[ ] STD (sexually transmitted disease)
[ ] allergies (specify) _________
____

Please list/describe any current physical health concerns or chronic conditions:

Please list any significant accidents, surgeries, illnesses or hospitalizations:

Have you ever had a head injury? If so, please describe and give date of injury:

Medication, supplements, or herbs:

Medication/supplement name	**Dosage**	**Prescribed by** (if applicable)	**Purpose**

Are your medications currently effective? ____

Are you experiencing any side effects? ____

Do you regularly use alcohol? [ ] no [ ] yes, How often do you have *4 or more drinks* in a 24-hour period?
[ ] never [ ] rarely [ ] monthly [ ] weekly [ ] several times per week
Do you consider your alcohol use a problem? [ ] no [ ] yes
Do others consider your alcohol use a problem? [ ] no [ ] yes

How many caffeinated beverages do you drink per day? ________What kind? _________________________

Family History

[ ] parents married/partnered & living together
[ ] parents never married/partnered
[ ] parents temporarily separated
[ ] parents divorced or permanently separated
[ ] mother remarried, number of times:______
[ ] father remarried, number of times:_______
[ ] parent(s) deceased:____________________
[ ] adopted

Siblings & Ages:

Spouse/partner(s) & Age:

Children & Ages:

Has anyone in your family experienced any of the following:

	Who		Who
Attention/hyperactivity problems (ADD, ADHD)		Schizophrenia	
Anxiety		Anger Management problems	
Depression		Alcohol abuse	
Bipolar disorder(manic depression)		Drug abuse	
Eating Disorder		Sexual abuse	
Obsessive-Compulsive Disorder (OCD)		Suicide attempt	

Other Information

How do you usually cope with stress?

What do you see as your strengths?

If there is any additional information you would like to provide, please note it here:

Contact and Insurance Information

Client Information:

Full name: ____ Age: _____ Date of Birth: ____________

Home Address:

____
(street) (city) (state) (zip)

SSN:________________________

Phone #:_____________________________ Voicemail okay? YES NO Text messaging okay? YES NO
Alternate Phone #:____________________ Voicemail okay? YES NO Text messaging okay? YES NO

E-mail address: ____________________________________ Emails okay? YES NO

Referral Information:

Referred by: ____ Ph.# _____________________________
Reason for Referral: (Note any legal involvement & specifics of any doctor's orders)

____

Send Bill To:

Name: ___________________________________ Relationship to Client: ________________________

Address:

____
(street) (city) (state) (zip)

Home Ph.#: ________________________________ Work Ph.#: _________________________________

Employer:____
(name) (address) (city) (state) (zip)

Insurance/Medicare/Medicaid Information:

Primary: _______________________________ Policy Holder's Name: ___________________________

Address:

____
(street) (city) (state) (zip)

ID/Policy Numbers: _________________________________ Group #: ______________________________

Date of Birth of Insured: ______________ Client Relationship to Policy Holder: ____________________

Secondary: ________________________________ Policy Holder's Name: __________________________

Address:
____
(street) (city) (state) (zip)

ID/Policy Numbers: _________________________________ Group #: _____________________________

Date of Birth of Insured: ______________ Client Relationship to Policy Holder: _____________________

Emergency Notification:

Notify in Case of Emergency: _______________________________________

Primary Ph.#: ____________________________ Alternate Ph.#: ______________________________
Address:
____
(street) (city) (state) (zip)

Relationship to Client:____

Consent and Payment Authorization

- ☐ I will check into or am already aware of the specific mental health benefits associated with my health insurance/Medicare plan.
- ☐ I hereby authorize the release of any medical information necessary to process Insurance and/or Medicare claims.
- ☐ I understand that my insurer will pay a contracted fee and that I will be responsible for co-payment or non-allowable charges. This does not apply to Medicare clients.
- ☐ I accept full responsibility for payment of services rendered.
- ☐ I understand that if I do not pay my bill, collections agencies may be utilized.
- ☐ Fees for other services will be discussed with my therapist. All fees charged are subject to revision.
- ☐ I authorize Dr. Gina or Dr. Gina's billing agency to contact me regarding financial information.

I accept, understand, and agree to abide by the contents and terms of this financial agreement.

Client or POA/Guardian Signature _____________________________________

Date: _____________________

Acknowledgement of Review of Notice of Privacy Practices, Patient Rights and Responsibilities, Member Rights and Responsibilities, and Advance Directives

Client's Name: ____________________________________ Client's DOB: ______________________

Notice of Privacy Practices: I have been given the opportunity to review Peace Practice's Notice of Privacy Practices for Protected Health Information. I understand that Peace Practice has the right to change the Notice of Privacy Practices at any time, and that I may obtain a current copy from my psychologist.

Patient Rights and Responsibilities: I have been given the opportunity to review Peace Practice's Client Rights and Responsibilities. I understand that the Peace Practice has the right to change the Client Rights and Responsibilities at any time and that I may obtain a current copy from my psychologist.

Member Rights and Responsibilities: I have been given the opportunity to review the Member Rights and Responsibilities and I understand that I may obtain a current copy from my psychologist.

Advanced Directives/Power of Attorney for Health Care: I have been given the opportunity to review the Advance Directives/Power of Attorney forms and I understand that I may obtain a current copy and further information about this from my psychologist. I certify that I have read the foregoing and as the client, client's guardian, power of attorney, parent or duly authorized by or on behalf of the client to execute the above and accept its terms.

Client/Guardian Signature: ____ Date: _____________

Printed Name: ____

*HIPAA Privacy Practices, Peace Practice's Client Rights and Responsibilities, Member Rights and Responsibilities and Advanced Directives/Power of Attorney for Health Care are available by request to review. Please let me know at your first appointment if you would like to review these documents. Thank you.