Today's Date		

Personal Information	Patient's Name	
	Date of Birth	
	Gender	□ Male □ Female
	Social Security Number	
	Marital Status	□ Single □ Married □ Widowed □ Divorced □ Separated

Home Address	Street	
	City	
	State	
	Zip Code	

Phone Numbers	Home Phone	
	Cell Phone	
	Work Phone	

Responsible Party	Name	
	Relationship	

Emergency Contact	Name	
	Phone Number	

Please bring your driver's license and insurance card to your first appointment.

THE CLINIC FOR ADULT ATTENTION PROBLEMS, P.A.

A. Timothy Butcher, M.Div., Ph.D.

CONSENT TO TREATMENT

Name of Patient: _____

I (for) the undersigned do hereby voluntarily consent to evaluation, recommendation and/or treatment by A. Timothy Butcher, M.Div., Ph.D. I am aware that the practice of psychology is not an exact science. As a consequence, I acknowledge that no guarantee has been made to me concerning the result of any evaluation or treatment which may be rendered. Further, I understand that evaluation and treatment will involve discussion of personal events in my own history, which at times can be discomforting and at all times very personal.

Limitations on Confidentiality:
The law protects the privacy of all communications between a patient and a mental health provider. In most situations the provider can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by law. Your signature on this Agreement provides consent for those activities as follows:

- Your doctor may occasionally find it helpful to consult other health and mental health professions about a case. During a consultation, every effort is made to avoid revealing the identity of any patient. The other professionals are also legally bound to keep information confidential. If you don't object, you will not be told about these consultations unless the provider feels that it is important for your care. However, all consultations would be noted in your Clinical Record.
- You should be aware that the doctor practices with other mental health professionals and that administrative staff is employed. In most cases, there is need share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and agreed not to release any information outside of the practice without the permission of a professional staff member.
- The office also has contracts with an electronic billing service. As required by law, a formal business associate contract is established with this business, in which it promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, you may be provided with the name of this organization and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

I understand my rights of confidentiality apply to communications with the physician or psychologist subject to the limitations described below. Specifically, I understand that the Doctor is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to the following:

- (1) If I am evaluated to be a danger to myself or others;
- (2) If I am a minor, elderly, or disabled person and the Provider believes that I am the victim of abuse or if I divulge information about such abuse;
- (3) If I divulge information which would cause the Provider to develop reasonable belief that I have abused or neglected a minor, elderly or disabled person, or a member of a protected class;
- (4) If I file suit against the Provider for malpractice;
- (5) If a court order, other legal proceedings, or statute requires disclosure;

- (6) If the patient is a minor, a parent has access to the medical record, unless limited by court order; the Provider may limit access if there is reasonable belief that the parent is either not acting in the best interest of the patient, or that such disclosure would be detrimental to the patient.
- (7) I further acknowledge that a third payer may have access to otherwise confidential information.

I agree that his authorization will remain in effect for the duration of all medical services rendered, or until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original.

Release of Information:

I further authorize and instruct **A. Timothy Butcher, M.Div., Ph.D.** to release to the person or organizations herein specified, or to any other agency concerned with the payment of my charges of further treatment, any and all psychiatric/psychological information (including copies of records) requested or required by such persons or organizations, or to release information as otherwise required by law, such release my include substance abuse information otherwise protected under 42 C.F.R.

Primary Care Physician: _____

_____

Person or agency to whom information is to be released, including third party payers.

_____ _____

Signature of Patient/Guardian Date

Assignment of Benefits:

I hereby authorize insurance payment directly to **The Clinic for Adult Attention Problems, P.A**., not to exceed the reasonable and customary charge for services provided.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Signature of Witness Date

OFFICE POLICIES

Patient Rights:

The law provides you with several new or expanded rights with regard to your Clinical Record and disclosure of protected health information. These rights include access to patient information about you, requesting that the provider amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, including our privacy policies and procedures.

_____
Patient's Initials

Treatment Philosophy:

Treatment is goal-directed and problem-focused. This means that a treatment goal or several goals are established after a thorough assessment. A treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will have an active role is setting and achieving your treatment goals. Your commitment to a treatment plan is necessary for you to experience the most successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask. Should medication be part of your treatment, your physician will provide information as to the risks, benefits and alternatives to treatment and document having done so in your medical record. By initialing below, you grant consent to the physician to prescribe such medications as deemed appropriate without necessity for completing and signing another document.

_____
Patient's Initials

Emergency Access:

A covering practitioner or your doctor is available after hours to handle emergencies. By calling the main office number at **713-523-0058** during or after hours, you will be instructed how to contact the on-call practitioner. You may be charged for telephone consultation in excess of 3 minutes, or for after hours emergency contact.

_____
Patient's Initials

Financial Terms - Insurance Coverage and Co-Payments: ▱ N/A (Self-Pay)

You are responsible for obtaining prior authorization for treatment from your insurance carrier; we will assist in that task. We will bill your insurance, however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Co-payment amounts are set by your benefit plan. These payments are due and payable at each appointment.

The practitioner is responsible for informing you of costs when you are beyond or outside your benefits. For special modalities of treatment not covered by your insurance plan, a written agreement needs to be signed between you and this office/practitioner. This agreement should outline your understanding that it is not a covered benefit,

should cover fees and the treatment plan you may expect. The fees agreed upon should never contain fees that exceed the benefit plan's fee for service discount rates.

At any time during treatment should I become ineligible for insurance coverage, I will notify the practitioner and understand I will be responsible for all of the charges.

_____
Patient's Initials

Missed Appointment Policy:

Missed appointments are not covered by your insurance and the charges associated with them are your responsibility. If you do not call to cancel an appointment at least twenty-four (24) hours in advance, you will be charged for the appointment at usual customary rates.

_____
Patient's Initials

Appeals and Grievances

Insured Patients Only:
I acknowledge my right to request reconsideration (as Appeal) in the case that outpatient care is not certified. I understand that I can request an Appeal directly through my Health Plan and that I risk nothing in exercising this right.

I also understand that I may submit a Grievance to my Practitioner at any time to register a complaint about my care, or I may send the complaint directly to my Health Plan. My practitioner has access to information and forms to facilitate this.

_____
Patient's Initials

All Patients:
I further understand that I may submit, in writing, a complaint to the Texas Licensing Board of the affected Practitioner concerning any aspect of care that is unprofessional, illegal or unethical.

_____
Patient's Initials

Acknowledgment:

I acknowledge that I have read and initialed this document and have received a copy for my own use.

_____ _____
Name of Patient Date

_____ _____
Signature Date

For Patients Using Insurance

Clinic for Adult Attention Problems (CAAP)
Official Informed Consent Form

Patient Name: Date:

Background

This document contains important information about professional services and business policies of the Clinic for Adult Attention Problems, P.A. Please read it carefully. As you read, please write down any questions you might have so that you can discuss them with the clinician working with you. When you sign this document, it will represent an agreement between you and the staff of the Clinic for Adult Attention Problems, P.A.

Purpose of the Clinic for Adult Attention Problems

The purpose of the Clinic for Adult Attention Problems, P.A., is to provide assessment and treatment services for adults experiencing problems with various forms of attentional difficulties (e.g., poor concentration, distractibility, restlessness, impulsivity) and other problems that often arise when attention difficulties are present (e.g., low self-esteem, conflicts in relationships, poor performance at work).

CAAP Procedures

Your involvement in this clinic will initially include participation in a psychological assessment that occurs in two-to-four sessions, each of which will last between one-to-four hours. During these sessions, you will 1) complete an extensive interview in which you will be asked questions about attention difficulties, depression, anxiety, and various other psychological problems that you may have experienced across childhood, adolescence, and adulthood; 2) complete questionnaires that ask you to recall behavior difficulties you may have experienced at various times in your life; 3) perform computerized tests of attention and information processing; and 4) complete a battery of tests that includes measures of intellectual, academic, and memory functioning. In addition, we will ask your permission to contact your parents (if available) so that we may ask them to complete questionnaires concerning attentional and other difficulties you may have experienced as a child and adolescent, and that may continue to hinder your functioning as an adult. Also, we will ask you to identify two more adults (e.g., spouse, significant other, friend, sibling, co-worker, employer, college professor, etc.) whom you know well and see often, and whom you feel comfortable allowing us to contact to request they complete a form about your current patterns of behavior. However, you are under no obligation to allow us to contact your parents, or anyone else, to request this information, and your participation in this clinic is in no way contingent upon your giving permission for us to contact these individuals. Nonetheless, information from parents about your formative years, and information from parents and others about your patterns of behavior as an adult, will facilitate our efforts to provide you with a comprehensive and accurate psychological assessment.

Upon completion of the psychological assessment, CAAP psychology staff will review your assessment findings and provide you with a one-hour, face-to-face interpretation, and a written summary, of your assessment results. During the one-hour working feedback session, we will 1) review the findings of your

evaluation, 2) explain the implications of your assessment results, 3) propose a treatment plan that is individually-tailored to meet your therapeutic needs, and 4) provide an opportunity for you to ask questions about the findings and the recommended treatment plan. If you were referred to CAAP by another mental health professional for consultation, we will provide your written report to him/her as soon as possible after testing, and he/she will review the findings with you. In addition, if the psychology staff determines that you likely meet diagnostic criteria for an attentional disorder (and/or another disorder for which psychiatric treatment is available), and if you are not already under the care of a prescribing physician, the psychology staff will refer you to a psychiatrist to consider whether medication treatment may be appropriate for you.

Discomforts/Risks from Participating in the CAAP Clinic

Your participation in this clinic may involve the potential risk of discomfort or embarrassment associated with answering questions about psychological problems patients sometimes experience. This discomfort may arise as you attempt to answer questions concerning whether you have ever experienced any of a wide variety of emotional, attentional, interpersonal, educational, and occupational difficulties. We will also ask if you have ever used street drugs, abused alcohol, engaged in reckless sexual behavior, or violated the law. However, your answers to our questions about these areas of your life will help us provide meaningful answers to the questions you asked us to address when you were initially referred to the Clinic for Adult Attention Problems, P.A. (e.g., Do you meet diagnostic criteria for an attentional, learning, or other psychiatric disorder?).

Freedom to Withdraw

If you experience distress as a result of receiving service through the Clinic for Adult Attention Problems, P.A., and wish to terminate participation, you may choose to discontinue at any time and an appropriate referral will be offered. You are free to withdraw from participation in this clinic at any time, without penalty. You also have the option to not answer any question(s) at any time during the assessment.

Anonymity of Subjects and Confidentiality of Results

The results of this evaluation will be kept strictly confidential. Clinicians will not release your results to anyone except in the case where you have indicated that you may hurt yourself or someone else, the records have been subpoenaed by a court of law, or you have requested in writing that we release information about you. All files will be stored in a locked room or locked filing cabinet at the clinic. If any member of the staff knows you or your family, and you feel uncomfortable with his/her participation in your assessment and/or treatment, you may request that he/she not participate in the delivery of clinic services to you. If you request that a CAAP team member not participate in your assessment and/or treatment, he/she will not discuss your information with other team members, and he/she will not review your file.

Insurance Payment Agreement

If using insurance to pay for all, or a portion of, my assessment fees, I understand that the charged rate will be $225.00 for the first session of intake, $175.00 for each subsequent session, and $150.00 per hour of psychological testing. I agree to pay any remaining portion of my deductible (if applicable) at the first session of my assessment (i.e., unless the deductible exceeds the cost of my first assessment session). Moreover, I agree to pay my co-pay prior to starting my assessment and testing sessions. In addition, I agree to pay any portion of my assessment fees that are not covered by my insurance policy. Finally, I understand that if I miss a scheduled appointment and have not given 24-hour notice of my cancellation, I will be charged for one hour of service as a non-cancellation fee, which will not be covered by my insurance. Full-length standard reports are not covered by insurance and will be charged at a rate of

$200.00 per report, while documentation of disability to substantiate a need for academic or occupational accommodations will be charged at a rate of $300.00 per report.

Participant's Permission

I have read the above description of the clinical services offered through the Clinic for Adult Attention Problems, P.A. I have had an opportunity to ask questions about these services and have them answered. I hereby acknowledge the above and give my voluntary consent for participation in this clinic. I further understand that if I participate, I may withdraw at any time without penalty. I also understand that should I have any questions regarding this service, or should I encounter any difficulties related to receiving services through the Clinic for Adult Attention Problems, P.A., I may contact any of the persons named below:

A. Timothy Butcher, M.Div., Ph.D., Director, CAAP Licensed Clinical Psychologist	713-523-0058 (Office) 832-465-3236 (Cell)
Lisette Rosiles Front Office Manager	713-523-0058 (Office)
Amy Bronstad Senior Psychometrician	713-523-0058 (Office)

_____ _____

Patient Signature Date

_____

Patient Name (Please Print)

_____ _____

Witness Signature Date

_____

Witness Name (Please Print)

For Self-Pay Patients (No Insurance)

Clinic for Adult Attention Problems (CAAP)
Official Informed Consent Form

Patient Name: Date:

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Upon completion of the psychological assessment, CAAP psychology staff will review your assessment findings and provide you with a one-hour, face-to-face interpretation, and a written summary, of your

assessment results. During the one-hour working feedback session, we will 1) review the findings of your evaluation, 2) explain the implications of your assessment results, 3) propose a treatment plan that is individually-tailored to meet your therapeutic needs, and 4) provide an opportunity for you to ask questions about the findings and the recommended treatment plan. If you were referred to CAAP by another mental health professional for consultation, we will provide your written report to him/her as soon as possible after testing, and he/she will review the findings with you. In addition, if the psychology staff determines that you likely meet diagnostic criteria for an attentional disorder (and/or another disorder for which psychiatric treatment is available), and if you are not already under the care of a prescribing physician, the psychology staff will refer you to a psychiatrist to consider whether medication treatment may be appropriate for you.

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Out-of-Pocket Payment Agreement

I understand that I will be charged $225.00 for the intake session with Dr. Butcher, an hourly rate of $175.00 for further sessions with Dr. Butcher, and an hourly rate of approximately $150 for testing. At these hourly rates, I understand that my psychological assessment will cost, and I agree to pay, approximately $1,925.00. I also agree to pay my out-of-pocket assessment fee on the day of my session. Moreover, I understand that the typical "one-hour" session with Dr. Butcher will be of 40-to-45 minutes in duration (although at times, sessions may be somewhat longer). In addition, I understand that if I miss a scheduled appointment and have not given 24-hour notice of my cancellation, I will be charged a one-hour non-cancellation fee. Full-length standard reports will be charged at a rate of $200.00 per report,

while documentation of disability to substantiate a need for academic or occupational accommodations will be charged at a rate of $300.00 per report.

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_____ _____

Patient Signature Date

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Patient Name (Please Print)

_____ _____

Witness Signature Date

_____

Witness Name (Please Print)