Margaret M. Tripp, Ph.D.

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Consent for Evaluation/Treatment

Patient's Name: _____ Date of Birth: _____-_____-_____

I_____, hereby give full consent to receive services of Margaret M. Tripp, Ph.D. I understand my first session with Dr. Tripp is an initial consultation for evaluation of my mental health. It may take more than one session to complete the evaluation. I understand formal treatment is not initiated until Dr. Tripp and I agree to do so. I authorize Dr. Tripp to carry out the psychological evaluations and treatment that are advisable during the course of my psychotherapy. I understand that while the evaluation and treatment are designed to be beneficial, they may at times be difficult and uncomfortable. There is an expectation that I will benefit from treatment, but there is no guarantee.

CONFIDENTIALITY

I understand that any information I provide to Margaret M. Tripp, Ph.D. is confidential and generally will not be released to others without my written consent. However, I understand that professional ethical obligations, state and/or federal law might require Margaret M. Tripp, Ph.D. to disclose confidential information without my consent in the following circumstances:

1. In the event that the therapy session reveals any information concerning the abuse of a child, elder or disabled person, Margaret M. Tripp, Ph.D. is mandated by law to make a report to the proper authorities. By signing this document, I acknowledge my awareness of this fact.
2. If the course of therapy reveals any intent I may have to harm either myself or others, I acknowledge Margaret M. Tripp, Ph.D.'s legal and moral duty to prevent me from bringing this harm about. If I reveal an intent to harm myself, Margaret M. Tripp, Ph.D. has my irrevocable permission to prevent me from accomplishing that intent. I specifically give my permission, also irrevocable, for Margaret M. Tripp, Ph.D. to warn police or law enforcement authorities about parties she feels may be harmed.
3. If I plan to request Margaret M. Tripp, Ph.D. provide detailed session receipts to file for reimbursement with a managed care or insurance company, I am aware information about my health status and treatment will be disclosed. As a billing submission requirement of the managed care or insurance company, I understand Margaret M. Tripp, Ph.D. will be required to provide a mental health diagnosis for me, and in some circumstances may be required to provide the company with detailed treatment needs or a complete copy of the treatment records generated in therapy. Once these records are in the possession of the managed care or insurance company, Margaret M. Tripp, Ph.D. cannot guarantee their continued confidentiality.
4. Additionally, if a lawsuit is filed by me against Margaret M. Tripp, Ph.D. for breach of duty; or if a court order, legal proceeding, statute, or regulation requires disclosure of records, I understand legal obligations may require the release of my therapy records.
5.

TREATMENT RECORDS

It is stated law that psychologists maintain a record of the treatment given to me. This record will contain the information that will allow Margaret M. Tripp, Ph.D. to chart the course of therapy. This record is used for only that purpose and it is Dr. Tripp's intent that the file remains private.

1. I understand I may get a copy of the file by providing her with a signed release of information request. Margaret M. Tripp, Ph.D. may provide me with a synopsis of the course of treatment and outcome in lieu of the actual record.
2. I agree I will pay in advance for copying cost of the actual record or time required for the preparation of the treatment summary. This includes providing copies or reports to any court or legal representative.
3. If the therapy sessions contain more than one patient, only the identified patient may obtain the complete treatment file.
4. In the event that Margaret M. Tripp, Ph.D. becomes incapacitated or dies, it will become necessary for another provider to take possession of each patient's files and records. By signing this form, I give

consent to allow another licensed mental health professional, selected by Dr. Tripp, to take possession of my records and provide me with copies upon request, or to deliver them to a therapist of my choice.

COMMUNICATION POLICY

Continuous effort is made to provide secure communication between patient and staff by phone, email, and fax. These forms of communication are subject to use and monitoring by only trained office staff, however, cannot be guaranteed secure. Although software and security measures have been put in place to secure and monitor office communication, please be reminded that any information relayed across phone, email, or fax has the potential to be viewed by an outside party in transit or delivery.

Dr. Tripp and her staff do not use messaging on social networking sites to communicate with patients. Further, it is office policy to *not* accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, etc.). Communication or connections on social media could compromise patient confidentiality and blur the boundaries of the therapeutic relationship.

In accepting services from Dr. Tripp and authorizing communication with her office, patient agrees to knowledge of limitations/restrictions of online communication and agrees to hold harmless Margaret M. Tripp, Ph.D. and staff for information loss due to technical failure or cyber occurrence.

PAYMENT POLICY

Payment is due at the time of service. Payment schedule will be made known to me before my initial session. My consent to treatment includes an electronic payment permission, authorizing Dr. Tripp and her staff to deduct service fees from my designated account. It is my responsibility to file and collect my own insurance claims and Dr. Tripp cannot guarantee coverage of my services by my insurance company.

Payment after the day the service was rendered will include a late payment charge. I understand if I do not uphold my responsibility to pay for services, this may result in the termination of treatment with Dr. Tripp and referral for appropriate treatment services elsewhere.

MISSED SESSION POLICY

If I need to cancel a session with Margaret M. Tripp, Ph.D., I agree to provide at least 24 hours notice.

1. 24 business hours notice of cancellation is required, and 48 business hours is preferred. I understand that my appointment is reserved for me only. Dr. Tripp does not double book patients and therefore, if I fail to show up and/or provide appropriate notice of cancellation, she is unable to fill my appointment time with someone who can use that time instead.
2. Cancellation with less than 24 business hours notice or no communication of change will result in a $75 fee. Multiple 'no notice' cancellations or 'no show' for scheduled appointments will result in a charge of the full session fee. I understand and agree that the credit card on file with the office will be charged the cancellation fee whether I choose to return for follow up services.

TERMINATION OF TREATMENT

I understand the length of time required for therapy will be determined by my personal situation. I understand Margaret M. Tripp, Ph.D. will do her best to fulfill my therapeutic needs and to provide me with her best professional care. For my part, I agree to participate in the process as needed to the best of my ability. It is intended that when my needs are met, to the extent that they can be, we will terminate our relationship. There is no guarantee of a cure. I understand I may terminate treatment at any time.

My signature on this consent form verifies that I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that my questions were answered to my satisfaction by Margaret M. Tripp, Ph.D., and that I voluntarily give my consent for treatment. I understand that I have the right to withdraw my consent for treatment at any time.

_____	_____	_____
Patient's Signature	**Printed Name of Patient**	**Date**

Contact Information

PATIENT FULL NAME: _____

AGE: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

PRIMARY ADDRESS: _____

City _____ Zip _____

ALTERNATE ADDRESS: _____ (school, alternate parent, spouse, etc.)

City _____ Zip _____

PHONE — Can I leave a message on this line?

Home Phone: _____ Yes No

Work Phone: _____ Yes No

Cell Phone: _____ Yes No

Dr. Tripp provides the option of communicating or sending appointment reminders by email. Please be aware that email is not a 100% secure form of communication and thus privacy cannot be guaranteed. Email will not be used for treatment or intervention. By listing email addresses below, you are acknowledging your understanding of these statements.

EMAIL ADDRESS: _____

Signature for permission to communicate through email: _____

Reason for Re-Seeking Psychotherapy

What are you hoping to target with this current course of therapy?_____

_____

_____

_____

Primary Physician's Name: _____ Phone: _____

Psychiatrist's Name:_____ Phone: _____
(if applicable)

Changes to health status or medications since last therapy?_____

_____

_____

_____

Margaret M. Tripp, Ph.D., P.C.
Clinical Psychologist

CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

In my Notice of Privacy Practices, I provide you with information about how I can use or disclose your personal and health information. As described in my Notice of Privacy Practices, I request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review my Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: (1) Acknowledge that a copy of the Notice of Privacy Practices has been made available to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in reliance upon this Consent.

I am required by law to notify you if there is a breach of your PHI/ePHI which would allow your clinical or financial information to be identified or compromised.

_____
Patient's Name (Printed)

_____ _____
Signature of Patient, Parent, or Legal Representative Date