Doray Psychological Services
212 North McKinley Street
Little Rock, AR 72205
501.404..2077 (voice), 501..228..8189 (fax)
Intakes@DorayPS.com

Welcome to our Practice

The following pages contain important information about our services and business practices. Please make sure to read through them before signing them, as it is important for you to understand this information. For the purpose of these documents, "you" refers to the client (child), and "legally authorized representative" refers to someone who has the legal authority to make health care decisions for the child (for example, a parent or legal guardian of a child under 18, a DHS caseworker of a child under 18 in DHS custody, or a family member who has legal guardianship). No one can make such decisions for another person unless they have the legal authority to do so.

We are required legally and ethically to obtain informed consent to services by the Ethics Code of the mental health professional (American Psychological Association; American Counseling Association; etc) and the Health Insurance Portability and Accountability Act (HIPAA), a federal law that gives clients certain rights related to the use and disclosure of their health information. This packet contains the following documents, each of which the legally authorized representative (parent or guardian) must review and sign:

- A HIPAA Privacy Documentation form to document that we have provided you with the included HIPAA Notice of Privacy Practices for Protected Health Information.
- A psychotherapy service agreement, which contains general information about our business policies and practices as well as clients' rights and responsibilities. A consent form, which indicates that you agree to participate in services with us, are aware of the business practices described in these documents, and agree to adhere to our business policies.
- A history form, which asks about the reasons for seeking services and gathers general background information.

When you meet with your clinician, you will have an opportunity to discuss any questions or concerns that you have about the information in this packet.

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HIPAA Notice of Privacy Practices For Protected Health Information

This notice describes how clients' health care information may be used and disclosed and how they can obtain access to this information. Please read it carefully.

Doray Psychological Services, P.L.L.C. (DPS) is permitted by federal privacy laws to make uses and disclosures of a client's health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to the client. Such information may include documentation of the client's symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing-related documents for those services.

I. Uses and Disclosures of Protected Health Information

Protected health information (PHI) is information that can be used to identify the client (for example, name, social security number, telephone number), and relates to past, present or future health conditions, treatment, and related health care services. A client's protected health information may be used by DPS and disclosed to others in order to provide treatment to the client, obtain payment for the services provided to the client, carry out the health care operations necessary to support our practice, and fulfill any other purpose permitted or required by law.

Treatment refers to the use and disclosure of PHI to provide, coordinate, and manage a client's health care and related services. Examples of treatment include but are not limited to meeting with DPS clinicians for the purpose of evaluation, testing, and/or therapy. In order to coordinate the client's care, we may talk to other health care providers, such as the client's primary care physician or psychiatrist. If we refer the client to another health care provider, we may give the other provider information about the client so that they can be more effectively evaluated and/or treated. If we believe that the client is at risk of harming himself or herself, we may disclose information about him or her to family members, partners, friends, other health care providers, or legal authorities to the extent needed to ensure his or her safety. When the client's clinician is away from the office for an extended period of time, a colleague may cover their practice and take emergency calls. The client's clinician will provide their colleague with any information about the client that they believe will be necessary to assist during their absence.

Payment refers to the use and disclosure of the client's PHI to obtain payment for the health care services provided to him or her. Examples of payment activities include but are not limited to calling the client's health insurer to verify coverage/benefits, sending treatment plans to the health insurer in order to get pre-authorization for treatment, submitting health insurance claims to the health insurer, and collection activities. Health Care Operations refers to the use and disclosure of the client's PHI to carry out the business activities of DPS practice. Examples of health care operations include but are not limited to quality assessment and improvement activities; performance evaluation, enhancement, and/or training activities; health care fraud and abuse detection/compliance; and arranging for legal services to enforce/defend DPS legal rights.

Use applies only to activities within the DPS office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies the client.

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Disclosure applies to activities outside of the DPS office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses And Disclosures Requiring Authorization

DPS may use or disclose PHI for purposes outside of treatment, payment, or health care operations when appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when DPS is asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from the client or the client's legally authorized representative before releasing this information. We also will obtain an authorization before releasing psychotherapy notes. Psychotherapy notes are notes the clinician has made about their conversation with the client during a private, group, joint, or family counseling session, which they have kept separate from the rest of the health care record. These notes are provided a greater degree of protection than PHI. The client or client's legally authorized representative may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. They may not revoke an authorization to the extent that (1) DPS has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

DPS will also obtain an authorization from the client or client's legally authorized representative before using or disclosing:

- PHI in a way that is not described in this Notice.

III. Uses And Disclosures With Neither Consent Nor Authorization

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

- **Child Abuse**. If we have reasonable cause to suspect that a child has been subjected to child maltreatment or has died as a result of child maltreatment, or we have observed a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, we must immediately notify the child abuse hotline.
- **Adult and Domestic Abuse**. If we have reasonable cause to suspect that an endangered or impaired adult has been subject to conditions or circumstances that would reasonably result in abuse, sexual abuse, neglect or exploitation, we must immediately report this to an appropriate authority.
- **Health Oversight Activities**.. If we receive a subpoena from the Arkansas Board of Psychology, we may be required to disclose PHI to comply with that subpoena.
- **Judicial and Administrative Proceedings**. If the client is involved in a court proceeding and a request is made for information about his or her diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information without a court order or the written authorization of the client or the client's legally appointed representative. The privilege does not apply when the client is being evaluated for a third party or where the evaluation is court-ordered. The client or client's legally authorized representative will be informed in advance if this is the case.
- **Serious Threat to Health or Safety**. If the client communicates to DPS a threat of physical violence against a reasonably identifiable third person, we may disclose relevant PHI and take the reasonable steps permitted by law

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to prevent the threatened harm from occurring. If we believe that there is an imminent risk that the client will inflict serious physical harm on himself or herself, we may disclose information in order to protect him or her.

- **Worker's Compensation**. We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- When use and disclosure without the consent or authorization of the client or client's legally authorized representative is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- There may be additional disclosures of PHI that we are required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

IV. Client Rights

- The client or client's legally authorized representative has the right to request restrictions on certain uses and disclosures of protected health information about the client. We may but are not required to agree to any restrictions requested.
- The client or client's legally authorized representative has the right to receive confidential communications of PHI by alternative means and at alternative locations.
- The client or client's legally authorized representative has the right to inspect and/or obtain a copy of the client's PHI for as long as the PHI is maintained. The request must be made in writing and we will charge a fee for the costs associated with inspecting/copying the information. Under certain circumstances, we may deny the request. At the request of the client or client's legally authorized representative, we will discuss with them the details of the request and denial process.
- The client or client's legally authorized representative has the right to request an amendment of the client's PHI. The request must be made in writing and must provide a reason to support the requested amendment. We may deny the request. At the request of the client or client's legally authorized representative, we will discuss with them the details of the amendment process.
- The client or client's legally authorized representative generally has the right to receive an accounting of disclosures of the client's PHI for which neither consent nor authorization has been provided. At the request of the client or client's legally authorized representative, we will discuss with them the details of and exceptions to the accounting process. The first accounting provided within a 12 month period is free. A fee will be charged for each subsequent request within a 12-month period.
- The client or client's legally authorized representative has the right to obtain a paper copy of the notice from DPS upon request, even if they have agreed to receive the notice electronically.

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- The client or client's legally authorized representative has the right to restrict disclosures when they have paid for the client's care out of pocket. The client or client's legally authorized representative has the right to restrict certain disclosures of PHI to a health plan when they pay out-of pocket in full for our services.
- The client or client's legally authorized representative has the right to be notified if there is a breach of the client's unsecured PHI. They have a right to be notified if: (a) there is a breach (a use or disclosure of PHI in violation of the HIPAA Privacy Rule) involving the client's PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that the client's PHI has been compromised. See breach Addendum below.

V. Our Duties

- We are required by law to maintain the privacy of PHI and to provide the client or client's legally authorized representative with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify the client or client's legally authorized representative of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our privacy policies and procedures, we will provide all current clients with a written copy of the revised Notice. Former clients will be notified of revisions only upon request.

VI. Complaints

If you believe that we have violated the client's privacy rights or you disagree with a decision we have made about access to the client's PHI, please notify DPS in person, by phone at (501) 404-2077, or by mail at 212 N. McKinley St., Little Rock, AR 72205. You also may file a complaint with the Regional Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202; Telephone: (214) 767-4056 or (800) 368-1019; Fax: (214) 767-0432; TDD: (214) 767-8940.

VII. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on May 15, 2014. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. Current clients will be provided with a copy of the revised Notice. Former clients will be given a copy of the revised notice upon request.

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Breach Notification Addendum to Policies & Procedures

- When DPS becomes aware of or suspects a breach as defined below, DPS will conduct a risk assessment, The risk assessment considers the following four factors to determine whether PHI has been compromised: the nature and extent of PHI involved; to whom the PHI may have been disclosed; whether the PHI was actually acquired or viewed; and the extent to which the risk to the PHI has been mitigated. DPS will keep a written record of that risk assessment. The HITECH Act added a requirement to HIPAA that psychologists (and other covered entities) must give notice to patients and to HHS if they discover that unsecured Protected Health Information (PHI) has been breached. A breach is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule. Examples of a breach include but are not limited to stolen or improperly accessed PHI, PHI inadvertently sent to the wrong provider, and unauthorized viewing of PHI by an employee in the practice. PHI is "unsecured" if it is not encrypted to government standards.
- Unless DPS determines that there is a low probability that PHI has been compromised, DPS will give notice of the breach. If notice is required, DPS must notify any client affected by a breach without unreasonable delay and within 60 days after discovery. A breach is discovered on the first day that DPS knows (or reasonably should have known) of the breach.
- The risk assessment can be conducted by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, DPS will provide any required notice to clients and to HHS.
- After any breach, particularly one that requires notice, DPS will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

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HIPAA Privacy Documentation

Acknowledgment of Receipt of Notice of Privacy Practices

- The Notice of Privacy Practices tells me how Doray Psychological Services, P.L.L.C. will use the client's health information for the purposes of treatment, payment for treatment, and health care operations.
- The Notice of Privacy Practices also explains in more detail how Doray Psychological Services, P.L.L.C. may use and share the client's health information for other than treatment, payment, and health care operations.
- Doray Psychological Services, P.L.L.C. also will use and share the client's health information as required or permitted by law.

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with the effective date of 5/15/2014. I understand and agree to the statements above.

_____	_____
Signature of Client	**Date**
_____	
Printed Name of Client	
_____	_____
Signature of Client's Legally Authorized Representative	**Date**
_____	_____
Printed Name of Client's Legally Authorized Representative	**Relationship of Legally Authorized Representative to Client**

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Psychotherapy Service Agreement and Consent

General Information

The purpose of psychotherapy is for a person to obtain help with problems that are bothering her or him, or that are keeping them from being satisfied or successful in important areas of life such as school, work, and relationships. People enter therapy for different reasons. For example, you may be entering therapy because you want to talk with someone about your problems, or because someone in your life such as a family member, teacher, or doctor has concerns about you. Or you may be seeking therapy for your child or another person in your care because you are concerned about her or his well-being. Therapy is a process that varies depending on the personality of the participants and the problems that the client is experiencing. We view it as a partnership between client and therapist, with the support of collateral participants (family members, friends, and other concerned parties who participate in treatment in order to help the client). It involves regularly scheduled meetings between the therapist, client, and collateral participants to work toward identified goals. The therapist suggests a general plan and specific strategies for working toward those goals. Effective therapy requires active engagement, commitment, communication, and trust on the part of everyone involved. The client's active participation both inside and outside of sessions is required in order to change the thoughts, feelings, behaviors, relationships, and/or situations that are interfering with her or his functioning.

Therapy has both benefits and risks. Because it often involves discussing unpleasant aspects of life, people participating in therapy may at times experience uncomfortable levels of sadness, anxiety, guilt, frustration, anger, loneliness, or helplessness. They may recall unpleasant memories that bother them at school, at work, or at home. Personal or family secrets may need to be told or discussed. Therapy may lead a person to make changes in her or his life that are unsettling, unpopular, or difficult. It is possible that problems may initially get worse, or that therapy may not seem to work. Most of these issues are to be expected when people start to make important changes in their lives, and most will be temporary. In the long run, therapy often leads to a significant reduction in distressing feelings; higher achievement and productivity in school and at work; greater satisfaction in family and social relationships; healthier skills for coping with life stress; a clearer sense of values, purpose, and goals; and better overall functioning.

Preparation

If the client has ever had any mental health or educational evaluations, psychotherapy or counseling, medication management, or other services, please arrange to have records of those services sent to us before the initial appointment. We prefer to receive either photocopies by USPS mail or electronic copies by email, as faxed copies can often be difficult or impossible to read. If you provide us with original documents, our fee for copying or scanning records is 25 cents per page plus a $20 per hour administrative fee, with a minimum charge of one hour.

It is important that the client be in good physical health during therapy sessions. If they are physically ill especially if the illness is contagious and/or the **client has a fever**—please call us to cancel and reschedule for another day. We ask that only the client and others directly participating in therapy sessions (for example, parents, spouses) attend appointments. Children who are not the person(s) receiving or participating in therapy are not allowed to attend sessions, and we cannot provide supervision for them while their family members are in session, so we respectfully ask that you make other arrangements for their care.

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What to Expect

The first one to three sessions of therapy involve assessment and treatment planning. The therapist will gather background information about the client's history and current functioning, and will, if necessary, develop a formal diagnosis. The therapist, client, and supporting participants will develop an understanding of what is and is not going well for the client, as well as a mutually agreed-upon set of goals to work toward. They will evaluate whether they feel comfortable working with each other and whether the therapist is the best person to provide the services needed to meet the identified goals. If either the client or therapist does not feel comfortable with the other, if there are services needed that the therapist cannot provide, or if the client's needs would be better met by a professional with more specialized knowledge or skills, the therapist will recommend that the client see someone else and will provide referrals as necessary.

Therapy typically begins with a 45-or 55-minute session once per week and lasts for up to 6-12 weeks. The frequency of sessions may be gradually reduced to every other week or once per month as the client is feeling better and functioning better. Clients have the right to end therapy at any time. However, it is our hope that the ending will be mutually agreed upon and planned so that the final sessions can be used to review the progress that has been made, to discuss any future work that needs to be done, and to say goodbye.

Role of Collateral Participants

Collateral participants are not considered to be clients. The role of a collateral participant varies depending on the client's needs and preferences, and may involve attending treatment sessions (either alone or with the client) or providing information by phone, email, or other means. Clients and collateral participants in therapy often experience intense and/or distressing emotions, and may experience tension in their relationships with each other. Collateral participation in therapy may result in better understanding of the client or an improved relationship with the client, or may help in the collateral participant's own personal growth. Participation of collaterals in therapy is often important, and is sometimes necessary for success, especially in the treatment of children and adolescents. The collateral participant may not be responsible for payment for services unless he or she is financially responsible for the client (or has been ordered by Court).

The therapist's primary legal and ethical responsibilities are to the client, and this includes protection of the client's privacy. Except in cases where in the therapist's professional judgment it is necessary in order to protect the client from serious and immediate harm to self or others, the therapist will not share with collateral participants the specifics of what the client has disclosed in one-on-one sessions.

Although no charts are kept on collateral participants, information about them may be entered into the client's records. The confidentiality of information in the client's records is protected by law and by the professional's Ethics Code, and this information cannot be disclosed without the consent of the client or the client's legally authorized representative except under the circumstances noted in the HIPAA Notice of Privacy Practices and as discussed below. Collateral participants have no right to access the records without the client's consent, except in cases where the collateral is the client's legally authorized representative (for example, the parent or guardian of a child or adolescent under 18). The collateral participant is expected to maintain the confidentiality of the client.

One potential risk of therapy with a child or adolescent involves disagreement between parents and/or disagreement between parent(s) and therapist about the best interests of the child. If any such disagreements occur during the course of a child's treatment, the therapist will strive to understand everyone's perspectives and to fully explain her or his own. This

discussion may lead to a resolution of the disagreement or to an agreement to disagree, so long as this enables the child's progress in therapy. In the end, the child's parent(s) will decide whether therapy will continue. If the parent(s) decide that therapy should end, the therapist will honor that decision. However, we ask that the therapist be allowed the option of having a few closing sessions with the child to appropriately end the treatment relationship.

Confidentiality and Communication With Third Parties

We communicate with other service providers, school personnel, family members, and other interested parties when necessary or appropriate. We do this in order to obtain relevant historical and current information about the client's functioning in different contexts, to coordinate recommended interventions, and to assist in advocating for the client's needs. We do this only with the knowledge and permission of the client and/or the client's legally authorized representative, and we obtain necessary releases of information as required by law. Examples of situations in which the therapist might communicate with a third party include talking to a client's teacher or counselor to find out how things are going in school or to provide suggestions for school-based interventions, or talking to the health care provider prescribing a client's medication to give feedback about whether the medication is helpful.

There are some situations in which the therapist either cannot or may not maintain a client's confidentiality because she or he is required by law and/or by professional ethical guidelines to disclose information that was shared in confidence. Examples of such situations include the following:

- The therapist has reason to believe that the client has plans to cause serious harm or death to themselves or to someone else who can be identified, and that she or he has the intent and ability to act on that plan within the very near future. In such cases, the therapist will inform family members and other parties as needed to protect the client and others from harm.
- The client is engaged in behaviors that could cause serious harm to self or others, even if no harm is intended. In such cases, the therapist will use her or his professional judgment to decide whether anyone should be informed.
- The therapist has reason to believe that the client is being neglected or abused physically, sexually, or emotionally, or has been neglected or abused in the past. In such cases involving either a child or an impaired adult, the therapist is mandated/required by law to make a report to the Arkansas Department of Human Services (DHS) Child Abuse Hotline or Adult Abuse Hotline, depending on the client's age. If this information has already been reported, the therapist will report only new information to DHS.
- The client is involved in a court case and a request is made for information about therapy. In such cases, the therapist will not disclose information without the written consent of the client or the client's legally authorized representative unless she or he is required by the court to do so. The therapist will do everything she or he can within the law to protect the client's confidentiality, and will inform the client if she or he is required to disclose information to the court. **If the therapist is required to testify, the therapist is bound ethically not to give their opinion about either parent's custody or visitation suitability unless it is required by law.** If the court appoints a custody evaluator, attorney ad litem, or caseworker, the therapist will provide information as needed (if appropriate releases are signed or a court order is provided); however, the therapist will not make any recommendation about the final decision regarding custody and/or visitation.

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Confidentiality for Kids

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy especially is important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it often is necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom which may involve issues either inside or outside of the home and that they may not feel comfortable sharing with their parents. This particularly is true for adolescents who naturally are developing a greater sense of independence and autonomy. Consequently, it is our policy for therapists to provide parents with only general information about their child's treatment. Such information would include, for example, whether the child attends her or his sessions, what issues are being discussed, what progress has been made, and in what areas further intervention may be helpful.

As a general rule, the therapist will not share with parents the specific details of what a child has disclosed in one-on-one therapy sessions unless she or he has the child's permission to do so. It is important to note that if the child is an adolescent, these disclosures may involve sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors that her or his parent(s) would not approve of or would be upset by. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may warrant intervention. The therapist will discuss with the parent(s) their feelings and opinions regarding acceptable behavior, and will use his or her professional judgment to decide whether and how to intervene. As a general rule, if the therapist has reason to believe that a child's behavior is placing her or him in serious and immediate danger of harm to self or others, the parent(s) will be informed and a plan will be implemented to address the behavior. Examples of situations in which the therapist generally would not disclose information shared in confidence include a teenager reporting that he or she has tried alcohol at a few parties, or is having protected sex with a boyfriend or girlfriend. Examples of situations in which the therapist generally would disclose information shared in confidence include a teenager reporting that she or he has a drug or alcohol problem, is driving while under the influence of drugs or alcohol, is a passenger in a car with a driver who is under the influence of drugs or alcohol, or is having unprotected sex with people she or he does not know or in unsafe situations. If a child has questions about the types of information that would be disclosed to her or his parent(s), they may ask the therapist in the form of hypothetical situations (for example, "If someone told you that they were doing _____, would you tell their parents?").

In cases where the therapist feels that it is not necessary to disclose information to the parent(s) but feels that it is important for parent(s) to know what is going on, she or he will encourage the child to tell the parent(s) and help the child find the best way to do so. The therapist also may talk to the parent(s) about what is going on in general terms, without going into specifics, in order to help the parent(s) understand how to be supportive to the child. It should be noted that under Arkansas law, a child's parent/guardian has the right to access the child's therapy records. However, requesting your child's records may impede on the therapeutic relationship and affect your child's trust in their therapist. Please note that the client will be informed if their records have been requested by that legal guardian and/or court.

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Service Fees (as of 11/10/2018)

General financial information is shown below.
Specific information will be addressed in your Financial Obligation Review.

Fee Schedule for Psychologist:

Diagnostic assessment / Intake appointment:	$250
45-minute therapy session:	$175
60-minute therapy session:	$200
30-minute therapy session:	$110
Family therapy session (up to 60 minutes):	$200
Telephone/email contact:	Free for the first 15 minutes, then $200 per hour

Fee Schedule for Master Level Therapist:

Diagnostic assessment / Intake appointment:	$200
45-minute therapy session:	$120
60-minute therapy session:	$160
30-minute therapy session:	$85
Family therapy session (up to 60 minutes):	$160
Telephone/email contact:	Free for the first 15 minutes, then $160 per hour

Insurance and Claim Information

As a courtesy, we will file all applicable charges with the client's insurance company. Some insurance plans do not cover certain behavioral (mental) health services. For example, some plans limit the amount of time for an appointment to 45 minutes and/or do not cover family therapy services and/or psychological evaluation services. You should contact the client's insurance company to confirm coverage for specific behavioral (mental) health services. Insurance companies determine if a service is medically necessary. Doray Psychological Services will provide them with an appropriate diagnosis(es) as classified by one or more ICD-10 codes.

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Court Fees

If you currently are involved or become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all of the clinician's professional time related to the court case, and will be charged an up-front retainer fee. Charges will include the costs of preparation, telephone calls with attorneys, and transportation to court hearings/depositions, even if your therapist is subpoenaed to testify by another party. Fees may be charged for professional services not listed below that are needed and/or are requested of us. This includes requests from other parties in the case. We will discuss any such fees with you before the service is provided so that you will be aware of the costs and an updated Financial Obligation Review will be completed. Fees may be prorated if your therapist works less than a full hour.

Court Fees (as of 11/10/2018)

Fee Schedule for Psychologist:

Court-related services:	$225 per hour
Telephone/email contact:	$225 per hour
Retainer to hold ½ day of court testimony	50% of the retainer is not refundable While billed at $225 per hour, a retainer is required in the amount of $1200. This includes preparation, travel time, wait time and actual testimony
Retainer to hold 1 day of court testimony	50% of the retainer is not refundable While billed at $225 per hour, a retainer is required in the amount of $2400. This includes preparation, travel time, wait time and actual testimony

Fee Schedule for Master Level Therapist:

Court-related services:	$200 per hour
Telephone/email contact:	$200 per hour
Retainer to hold ½ day of court testimony	50% of the retainer is not refundable While billed at $200 per hour, a retainer is required in the amount of $1000. This includes preparation, travel time, wait time and actual testimony
Retainer to hold 1 day of court testimony	50% of the retainer is not refundable While billed at $200 per hour, a retainer is required in the amount of $2000. This includes preparation, travel time, wait time and actual testimony

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Billing and Payment Information

We would like to minimize any misunderstanding regarding billing and payment. Therefore, before any services can begin, you will be given a "Financial Obligation Review" which includes a schedule of estimated payment based on the coverage information that you have provided. You also will need to agree to assume financial responsibility for charges even if you are covered by insurance or another third party payer. These charges may include any co-pay/co-insurance amount and any unsatisfied deductible required by the plan. In general, any outstanding balance must be paid prior to or at the time of the next appointment. Payment for services is expected at the time services are rendered. Payments may be made with cash, check, or card at the time of the service. Accounts more than 90 days past due will be charged a finance fee of 1% per 30 days past due and may be sent to a third party for collection.

You are ultimately responsible for all charges

Late Arrivals, Cancellations, and Missed Appointments

Appointment times are reserved specifically for you and/or others participating in your evaluation or treatment. The clinician will do her or his best to start appointments on time. If you arrive late for an appointment, your clinician probably will not be able to meet for the full scheduled time, and your appointment may be canceled and rescheduled for another time at the discretion of the clinician. If you need to cancel an appointment, please do so as far in advance as possible. If your clinician can find another time during the week to meet, they will do so. If you do not keep a scheduled appointment, you will be charged for the clinician's time, and you may not be given the opportunity to reschedule it. If you miss an appointment or do not cancel it at least 24 hours in advance, a cancellation/no-show fee of up to 50% of the charges for the scheduled session will be charged, and you will be asked to pay the fee at or before your next visit. If you arrive for an appointment late enough that it must be canceled and rescheduled, you will be charged the cancellation/no-show fee.

Exceptions to these policies may be made in cases where you and the clinician both agree that you were unable to attend an appointment due to circumstances beyond your control. Examples of such cases include unforeseeable, incapacitating illness, client has a fever, or bad weather in which motorists are being asked to stay off the roads and/or schools and businesses are closing. Please note, you're financially responsible for paying cancellation/no-show fees as insurance plans do not cover these fees.

Communications With Clinicians and Staff

Because clinicians do not answer the telephone when in session with clients, you generally will not be able to reach them directly. You may leave messages with front office staff during business hours. You may leave voicemail messages at any time. When you leave a voicemail, please make sure to clearly state your name, telephone number, and a brief message indicating the purpose of your call. Clinicians and staff make every effort to return phone calls within 24 to 48 hours, with the exception of weekends and holidays. If you choose to communicate with us by text message, the privacy of your communication cannot be guaranteed. Any emails that you send to a clinician will be responded to within the same time frame as phone calls. In the event that your clinician will be unavailable for an extended period of time, you will be provided with the name of a colleague to contact, if necessary. If you are in an emergency situation, please call 911 or go to the nearest emergency room or mental health facility.

Your Copy – Do Not Return To Office

We are sensitive to our clients' privacy and confidentiality in public settings. With this in mind, if you happen to encounter a clinician or office staff member around town, he or she will not acknowledge your relationship or initiate a conversation unless you do so first. In essence, though they are pleased to chat briefly with you outside of the office, it is up to you whether to initiate conversations with them in public settings.

Use of Third Party Software, Applications, and Electronic Communication

We use a number of software, web-based, and electronic applications created and administered by third party providers. These include but are not limited to LuxSci (Lux Scientiae), Claims Processing Services, and various phone providers. Additionally, third party applications may be implemented by our practice without any additional disclosure to you at any point in the future. While these vendors were chosen based on their professionalism and reputation, we cannot guarantee their compliance with HIPAA and other regulations, with the exception of LuxSci and Claims Processing Services, with which Doray Psychological Services, PLLC has HIPAA Business Associate Agreements. By signing this agreement and receiving services from this practice, you exempt Doray Psychological Services, PLLC from liability or blame for any privacy violations that occur due to one of these vendors.

Questions and Concerns

If at any time you have questions about a clinician's qualifications or practices, please discuss your concerns with the clinician in question. Similarly, if you have any questions or concerns about the process or progress of an evaluation or therapy, please discuss them with the clinician. Any concerns about clinical issues that remain unresolved may be directed to Dawn P. Doray, Psy.D. Dr. Doray can be reached by phone at (501) 404-2077 ext 2, or by email at drdawn@dorayps.com.

If at any time you have questions or concerns about our administrative practices, policies, or processes that remain unresolved, please direct them to Eric Doray. Mr. Doray can be reached by phone at (501) 404-2077 ext 11, or by email at eric@dorayps.com.

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Consent For Psychotherapy

I have read and understand the above policies.

I understand that Doray Psychological Services, P.L.L.C. will share the client's health information according to federal and state law for the purposes of treatment, payment, and health care operations.

I authorize the insurance provider to pay Doray Psychological Services, P.L.L.C. for services rendered.

I understand that as the client or other legally authorized representative, I am responsible for all charges incurred, regardless of the client's insurance coverage.

I consent to treatment for myself or for the client for whom I am the legally authorized representative.

I understand and agree to the statements above.

_____	_____
Signature of Client	**Date**
_____	
Printed Name of Client	
_____	_____
Signature of Client's Legally Authorized Representative	**Date**
_____	_____
Printed Name of Client's Legally Authorized Representative	**Relationship of Legally Authorized Representative to Client**

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History Form

Please feel free to use additional pages to provide information where needed.

Demographic Information

Child's full legal name: _____ Preferred name: _____

Child's DOB: _____ Child's age: _____ Child's gender: ☐Male ☐Female ☐Other _____

Contact Information

Name of Parent(s)/Guardian(s): _____

Mailing address: _____

Please indicate which forms of communication are acceptable and provide the relevant contact information for you:

☎ Primary Number: _____ Do you give consent that we:
leave you a message? ☐Yes ☐No ____
text you? ☐Yes ☐No ____

☎ Secondary Number: _____ Do you give consent that we:
leave you a message? ☐Yes ☐No ____
text you? ☐Yes ☐No ____

✉ Primary Email: _____ Do you give consent that we email you at this address? ☐Yes ☐No

✉ Secondary Email: _____ Do you give consent that we email you at this address? ☐Yes ☐No

Emergency contact other than the parent(s)/guardian(s) listed above:

Name: _____ Phone: _____ Relationship to the child: _____

Referral Information

Who were you referred by? _____

What are your reasons for seeking services? Please indicate all that apply and underline most prominent concerns:

❒ **Mood problems**
(for example, sadness or tearfulness; not interested in doing things or talking to people; low self-esteem; feeling worthless; feeling hopeless; talking or thinking about death or suicide, attempting suicide; irritability, anger, resentfulness, or hostility; easily annoyed; losing temper frequently or easily; extreme or abnormal cheerfulness)

❒ **Anxiety**
(for example, excessive or unrealistic worries; feeling tense, nervous, "on edge," or panicky; easily startled; extreme or unusual fears of specific objects or situations; extremely self-conscious; clingy or afraid to be away from parents or other family members; concerns about doing things perfectly; having to do things a certain number of times or the exact same way each time)

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- ❒ **Trauma/maltreatment**
  (for example, death of a loved one; abandonment by parent/caregiver; traumatic accident or injury; exposure to violence; exposure to natural or man-made disasters; physical, sexual, verbal, or emotional abuse or neglect)
- ❒ **Family problems**
  (for example, trouble communicating; frequent arguments; emotionally distant; trouble adjusting to separation or divorce; trouble adjusting to blended family; trouble managing child's behavior; need help with parenting strategies)
- ❒ **Attention problems**
  (for example, trouble paying attention or concentrating; not listening even when spoken to directly; easily distracted; trouble organizing or finishing tasks or activities)
- ❒ **Hyperactivity**
  (for example, restless or fidgety; unable to sit still or stay seated; always moving; talking too much; engaging in non-stop activity)
- ❒ **Cognitive or learning problems**
  (for example, trouble with learning, comprehension, thinking, or memory; mental confusion; trouble with reading, writing, or math; failing in school)
- ❒ **Impulse control problems**
  (for example, not thinking before acting; doing things that are risky, reckless, or irresponsible; talking out of turn; interrupting or intruding on others; trouble waiting)
- ❒ **Behavior problems**
  (for example, breaking rules; arguing with others; annoying others on purpose; lying, cheating, or stealing; running away from home; skipping school; destructive toward property; aggressive toward people or animals; threatening or intimidating toward others)
- ❒ **Social/peer problems**
  (for example, few or no friends; not interested in having close relationships; trouble forming or maintaining close relationships; trouble getting along with others; loneliness; withdrawn, abnormally shy or excessively friendly; poor social skills; not caring about other people's feelings; bullying)
- ❒ **Odd behaviors or experiences**
  (for example, seeing things or hearing voices that aren't there; strange, illogical, or nonsensical beliefs or ideas; thoughts are disorganized or run together; making poor eye contact; showing no emotion; laughing or crying inappropriately; having unpredictable outbursts; getting very upset over small changes in routine or surroundings; making strange movements; talking in a strange way; showing interest in very few topics or things; strange interests in or preoccupation with certain subjects or objects)
- ❒ **Other problems:** _____

How long have you had these concerns? _____

Did anything in particular seem to set off these concerns/problems? ☐Yes ☐No, if yes, please explain: _____

Do these concerns seem to be ☐staying the same ☐getting worse ☐getting better?

Is anyone else encouraging, pressuring, or forcing you to seek help for the child at this time? ☐Yes ☐No

Please provide any other information about the reasons for seeking therapy at this time that you think might be helpful or important: _____

_____

_____

_____

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Mental Health History

Please list all mental health services that the child has received or is currently receiving (including psychological evaluations, educational evaluations, psychotherapy or counseling, medication management, residential treatment, and inpatient hospitalizations):

Provider/Facility	From / To	Types of Service	Reason(s) for Service

If the child has had therapy or counseling, was the therapy or counseling helpful or not helpful and explain?_____

_____

_____

_____

Child's School Information

What school is the child currently attending? _____

What grade is the child currently in? _____ (last grade completed if currently between school years)

Has the child ever repeated a grade in school? ☐Yes ☐No If yes, which grade(s)? _____

Do you have concerns about the child's academic performance or behavior in school?

☐No

☐Yes, please explain: _____

_____

Please indicate any special services the child is currently receiving or has received in the past:

- ☐ Special education/IEP services (for example, resource services, self-contained classes, inclusion services)
- ☐ Section 504 services/accommodations ☐Tutoring ☐Occupational therapy
- ☐ Speech-language therapy ☐Gifted & Talented programming ☐Testing for eligibility for special services
- ☐ Other services: _____

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Family and Social Information

☐Mother ☐Father ☐Legal Guardian	☐Mother ☐Father ☐Legal Guardian
Name: Age: If deceased, when?	Name: Age: If deceased, when?
Education: ❒ Eighth grade or less ❒ Some high school ❒ High school graduate or GED ❒ Some college or post-high school education ❒ College graduate ❒ Advanced graduate or professional degree	Education: ❒ Eighth grade or less ❒ Some high school ❒ High school graduate or GED ❒ Some college or post-high school education ❒ College graduate ❒ Advanced graduate or professional degree
Employment Status ❒ Working, full-time or part-time ❒ Unemployed, looking for work ❒ Unemployed, not looking for work ❒ Disabled ❒ Retired ❒ Other: _____ Occupation, if working:	Employment status: ❒ Working, full-time or part-time ❒ Unemployed, looking for work ❒ Unemployed, not looking for work ❒ Disabled ❒ Retired ❒ Other: _____ Occupation, if working:
Are the parents? ☐still together ☐separated or ☐divorced or, ☐never married and no longer together	
Any Stepparents? ☐Yes ☐No	Any Stepparents? ☐Yes ☐No

Has the child been adopted or raised by adults other than his or her biological parents?

☐No

☐Yes , please explain: _____

Has the child ever been in foster care?

☐No

☐Yes, please give reasons for placement: _____

Please list any siblings (full, step or half), also indicate whether they live in the same household as the child:

Name	Age	Gender	Same Household?
		☐Male ☐Female ☐Other	☐No ☐Yes
		☐Male ☐Female ☐Other	☐No ☐Yes
		☐Male ☐Female ☐Other	☐No ☐Yes

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Is the child's family unusual in any way?

☐No
☐Yes, please explain: _____

Please provide any other information about the child's family that you think might be helpful or important, including mental health or substance abuse issues in close family members: _____

_____

Does the child have any close friends other than family members? ☐No ☐Yes, If yes, how many? _____

_____

How often does the child spend time with friends outside of school in a typical month? _____

_____

Does the child have any trouble making or keeping friends? ☐Yes ☐No, If yes, please explain: _____

_____

Does the child generally have any trouble getting along with others his or her age? ☐No ☐Yes, If yes, please explain: _____

_____

Does the child participate in any organized activities (for example, sports, dance, scouting)? ☐No ☐Yes If yes, what and how often? _____

Does the child have any hobbies or interests that he or she pursues on a regular basis? ☐No ☐Yes, If yes, what and how often? _____

Does the child engage in any exercise or physical activity on a regular basis? ☐No ☐Yes, If yes, what and how often? _____

_____

Child's Medical and Developmental Information

Child's pediatrician or family doctor:

Name: _____ City, State: _____

Please list any major physical illnesses, injuries, surgeries, and developmental problems (for example, delays in speech, language, or motor skills; problems with toilet training; problems learning self-care skills) the child currently has or has had in the past: _____

_____

_____

Please indicate if the child often experiences any of the following?

☐Sleep problems
☐Problems with appetite or eating behavior
☐Trouble breathing or shortness of breath
☐Chest pain or discomfort
☐Fatigue or low energy
☐Weight problems
☐Heart racing or pounding, or irregular heartbeat
☐Stomach pain

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- ☐ Nausea, vomiting, or diarrhea
- ☐ Dizziness, lightheaded, or fainting
- ☐ Numbness or tingling of body parts
- ☐ Vision problems
- ☐ Problems with sexual functioning or behavior
- ☐ Headaches
- ☐ Trembling or shaking
- ☐ Chills, hot flushes, or sweating
- ☐ Hearing problems
- ☐ Alcohol or drug use

When was the child's most recent physical exam? _____

Were there any findings that concerned you or the child's doctor? ☐ No ☐ Yes If yes, please provide details: _____

_____

Please list any prescription or over-the-counter medication(s) the child currently taking:

Medication	Dose	Purpose

Other Information

What are the child's strengths? _____

_____

_____

_____

What are the child's weaknesses? _____

_____

_____

Please provide any other information that you think might be helpful or important: _____

_____

_____

_____

Thank you for your time and consideration in completing this form!