Client Information
for Wanda Johnson-Roberts, Ph.D.

PATIENT_____**REFERRBY**_____

MAILING ADDRESS_____**PHONE #**_____

CITY_____**ST.**_____**ZIP**_____**Date of Birth**_____

EMPLOYER_____**Phone**_____

SS#_____**MARITAL STATUS (CIRCLE ONE) MARRIED SINGLE**

SPOUSE OR GUARDIAN NAME_____

PHONE NUMBER _____**EMPLOYER** _____

CHILDREN: NAMES, AGES_____

IN CASE OF EMERGENCY CONTACT:_____**PHONE #**_____

RELATIONSHIP TO YOU_____

How may we contact you? Phone_____**May we leave a message?**__

Other phones?_____**May we leave a message? yes no**

e_mail_____ **May we e-mail you? yes no**
Please note, Email correspondence is not considered to be a confidential medium of communication

HAVE YOU PREVIOUSLY RECEIVED ANY TYPE OF MENTAL HEALTH SERVICES? (PSYCHOTHERAPY, PSYCHIATRIC SERVICES, ETC.?)

PREVIOUS THERAPIST/PRACTITIONER_____

THERAPIST'S/PSYCHIATRIST'S TELEPHONE NUMBER_____

I understand that payment is due at the time service is rendered

Signature_____ _**Date**_____

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Primary Insurance

Name of Insured_____

circle one Self Spouse Parent Other

Date of Birth_____**Insurance Co.**_____

Identification #_____**Group/Account #**_____

Insurance Co. Phone #_____**Employer**_____

Secondary Insurance_____

Assignment and Instruction for Direct Payment of Doctor
Private or Group Health Insurance

Patient:_____

Employer _____

SS# or ID #_____

I hereby instruct and direct that _____insurance company pay Wanda Johnson-Roberts, Ph.D. The payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ _____
Signature of patient or parent/guardian **Date**

_____
Witness

Wanda Johnson-Roberts, Ph.D.

1201 N. Watson Rd., Suite 144
Arlington, TX, 76006
Telephone 817-633-2092 Fax 817-633-2094
doctorwanda.org e-mail dr_wanda@sbcglobal.net

Client Information and Consent

Dr. Wanda Johnson-Roberts is a licensed professional counselor and a licensed marriage and family therapist engaged in private practice, providing mental health services directly to clients and as an independent contractor provider for various managed care entities.

Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The therapist, using her knowledge of human development and behavior will make observations about situations as well as suggestions for new ways to approach them. It will be important to you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to therapy sessions if you feel it would be helpful or if this is recommended by your therapist.

Appointments

Appointments are made by calling 871-633-2092 Monday through Friday between the hours of 9:00 a.m and 3:00 p.m. Please call to cancel or reschedule appointments at least 24 hours in advance or you will be charged for the missed appointment. Third-party payers will not usually cover or reimburse for missed appointments.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits

Therapy sessions are 45-60 minutes in length. Psychological testing may take longer.

Relationships

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Goals, Purposes and Techniques of Therapy

There may be alternative ways to effectively treat the problem you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting the goals of your therapy. As therapy progresses these may change. The initial goals, purposes and techniques of therapy agreed upon by you and the therapist will be decided in the first or second session.

Cancellations

Cancellations must be received at least 24 hours before your scheduled appointment, other-wise you will be charged the customary fee for the missed appointment. You are responsible for calling to cancel or reschedule your appointment.

Payment for Services

The charge for your initial session is $150.00 and $125.00 for any subsequent session. Dr. Johnson-Roberts does not normally accept assignment of insurance benefits but may be do so in connection with certain managed care contracts. We look to you for full payment of your account and you will be responsible for payment of all charges. Different co-payments are required by various group-coverage plans. Your co-payment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the co-pay may be different for the first visit than for subsequent visits. You are responsible for and are expected to pay your co-pay portion of the undersigned therapist's charges for services at the time the services are provided. It is recommended that you determine your co-payment before your first visit by calling your benefits office or insurance company.

Although it is the goal of the therapist to protect confidentiality of all records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or the therapist's testimony are requested by you, or are required by law, you will be responsible for and expected to pay the costs involved in producing the record and the therapist's normal hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time, or prior to the time these services are rendered by the therapist. The therapist may require a deposit for anticipated court appearance and preparation.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse, abuse of the elderly or disabled, abuse of patients in mental health facilities, sexual exploitation: AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases; suits in which the mental health of a party is an issue; situations where the therapist has a duty to disclose or where in the therapist's judgment, it is necessary to warn, notify, or disclose: fee disputes between the therapist and the client; a negligence suite brought by the client against the therapist or filing of a complaint with a licensing board or other state or federal regulatory authority. FOR FURTHER INFORMATION, REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THE CLIENT INFORMATION AND CONSENT DOCUMENT. If you have any questions regarding confidentiality you should bring them to the attention of your therapist when you and the therapist discuss this matter further. By signing this information with all persons mandated by law with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, you are also releasing and holding harmless the therapist from any departure from you right of confidentiality that may result.

Risks of Therapy

Therapy is the greek word for change. You may learn things about yourself that you don't like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the

quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce options.

After Hours Emergencies

A mental health professional or your therapist is on call when your therapist's office is closed and can be reached for emergencies on a 24 hour, seven days per week basis, by calling the office number. If the office is closed, you will be directed to leave your number in the emergency selection and your therapist will call you back. Emergencies are urgent issues requiring immediate action.

Therapist's Incapacity or Death

I acknowledge that, in the event that the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. That therapist is bound by the same confidentiality requirements as my therapist. By signing this information and consent form, I give my consent to allow another Licensed Mental Health Professional selected by the therapist to take possession of my file and records and provide with copies upon request, or to deliver them to the therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am in danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in a position to prevent harm to myself or another person. In addition to medical and law enforcement personnel, and the following persons:

Name_____Telephone Number_____

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization shall expire upon the termination of my therapy with the therapist. I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the therapist has not taken action in reliance

on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the therapist that I have received and reviewed. I have been advised by the therapist of the potential of the re-disclosure of my protected health information by the authorized recipients and that it will no longer be protected by the Federal Privacy Rule.
I further acknowledge that the treatment provided to me by Dr. Roberts was conditional on my providing this authorization.

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When the client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult) or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third party payers are given information that they request regarding services to clients.
Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____Date_____

_____
Client signature (Client's Parent/Guardian if under age 18)