David M. Wilson, Ph.D.

8140 N. MoPac Expy,
Bldg 3, Ste 225
Austin, TX 78759

www.DrDMWilson.com

(M) 512.574.0922
(O) 512.346.2332
(F) 512.346.2284

Client Information

/ /

Last Name First Name Middle Initial D.O.B. SS#

Street Address Ste#/Apt # City State Zip

We may leave a message at:

Home Phone: (_____)_____ ☐

Work Phone: (_____)_____ ☐

Mobile Phone: (_____)_____ ☐

Mobile phones are not a secure form of communication and confidentiality cannot be guaranteed.

Email Address: _____

Email is not a secure form of communication and confidentiality cannot be guaranteed. Please know that emails may not be returned promptly.

Can we contact you at your email address? ☐ Yes ☐ No

Please list an address we can mail correspondence to if different from above:

_____

Street City State Zip

Referred by: ☐ Dr:_____ ☐ Friend:_____ ☐ Other:_____

May we thank your referral source? ☐ Yes ☐ No

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CONSENT TO TREATMENT

If you have any questions about these policies please discuss them with me prior to signing. Your signature on page 4 will indicate that you understand and accept this information.

Services: I provide psychotherapy for children, adults, and couples. I also provide psychological assessment for the purpose of diagnosis and therapeutic intervention. Treatment will be provided to meet the goals that we agree upon together.

Fees:

Individual Therapy: The basic fee for a 50-minute session is $160 and an 80-minute session is $240.

Couples Therapy: The basic fee for an 80-minute session is $240.

Assessments: The fee for psychological assessment is based on the type of assessment, the length of the assessment, and the specific measures used; it is calculated individually. An estimate of the charges will be provided prior to the beginning of the assessment.

Telephone consultations: Phone calls beyond 15 minutes will be rounded to the nearest 15-minute increment and charged at the rate the caller would be charged for an office visit.

Court charges: Should Dr. Wilson be subpoenaed for any reason regarding your treatment, you will be responsible for the following fees: $250/hr document preparation in office, and $400/hr deposition and/or court appearance or meetings with third parties such as attorneys. There will be a minimum billing of 4 hours/day for scheduled court appearances regardless of whether or not they are rescheduled by parties other than Dr. Wilson.

Payment for service: Unless other arrangements have been made, you will be expected to pay for services at the time they are provided. Payments may be made by cash, check or credit card. A receipt will be available for you. If you pay by check and the check is returned for insufficient funds, any bank fees incurred as a result will be your responsibility.

Cancellations: A minimum of **24 hours notice** is required for rescheduling or canceling any appointment. The full fee will be charged for any missed sessions without such notification.

Emergencies: In the event of an emergency, and I am unable to be reached, please make use of the emergency services listed below or call 911.

24-Hour Crisis Hotline	472-4357
Brackenridge Hospital	476-6461
St. David's Pavilion Psychiatric Hospital	867-5800
Shoal Creek Psychiatric Hospital	452-0361

(Optional) In case of an emergency or if Dr. Wilson does not reach me through the contact information I provided, I give him permission to contact the following person(s):

Name: _____ Phone or Email:_____

Name: _____ Phone or Email:_____

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Unpaid Accounts: If you experience problems meeting your payment obligations, please contact me so that we may set up a reasonable payment plan. Overdue accounts (i.e., those which remain unpaid for 90-days or those for which an agreed-upon payment plan is not followed) may be turned over to a collection agency as a final resort for non-payment.

Confidentiality: Confidentiality is very important to me. As much as I am able, I will not disclose information to any person who you have not given me explicit permission to talk to. This includes giving information to the parents or spouses of individuals who are age 18 or older, even when the spouse or parent is paying for the services. In all aspects of my practice, communication between my clients and myself (and/or those whom my clients have authorized me to contact) are protected by confidentiality regulations as stipulated by federal and state laws and by professional standards and ethics.

In certain situations, I am not legally able to maintain confidentiality.

In the state of Texas there are situations in which your confidentiality will be limited or revoked. These situations include:

1. Disclosure that another mental health provider and/or clergy person has been sexually inappropriate with a client/patient. I am not permitted to disclose the identity of the client if he/she does not wish to be identified.
2. Disclosure of ongoing abuse of an elderly person, child, or disabled person.

In addition, while Texas laws do not presently mandate disclosure of the following situations, I may opt to breach confidentiality to the appropriate parties in the following situations:

1. Eminent threat to kill or seriously harm self.
2. Eminent threat to kill or seriously harm other.

Additionally, the following situations may result in the breaching of confidentiality:

1. In some circumstances, my records may be subject to a subpoena issued by court. In particular, confidentiality may be waived with regard to any suit affecting the parent-child relationship.
2. If I am contacted by an insurance company or auditor, I may be required to release client information as dictated by law. The law also permits me to release information to a collection agency in order to collect on an overdue account.
3. In certain legal situations, your psychological records can be subpoenaed and I cannot guarantee your confidentiality under those circumstances.

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INFORMED CONSENT/PAYMENT AGREEMENT

I, _____, consent to psychological treatment with David M. Wilson, Ph.D.
I have read the document titled "Consent to Treatment," and I understand the policies listed in that document.
I hereby grant my permission for any counseling, testing, or diagnostic evaluation that may be agreed upon by me and the therapist. I understand that therapy is a joint effort between the therapist and the client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances. I agree that

I will be responsible for the payment of all professional fees.

I understand the office policies regarding late cancellations or missed sessions as outlined in the consent to treatment forms I have signed and understand I may be responsible for the full fee if that occurs.

_____ _____
Client/Guardian Signature Date

_____ _____
Client/Guardian Signature Date

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Persons Assuming Financial Responsibility

If self, check here: ☐
If other:

Name: _____ Relationship: _____

DOB: _____ Phone: _____

Email: _____

Current Address:

_____
Street

_____
City State Zip

I understand that Dr. Wilson may need to contact this person to acquire payment for services. I give Dr. Wilson permission to contact this person by phone or mail for the purposes of securing payment.

_____
Client Signature Date

Fee Adjustments Due to Hardship

Any changes that have been made to the basic fee for a 50 or 80-minute session as listed on the two-page handout "Consent to Treatment" are listed here.

Individual therapy: _____ Couples therapy: _____ Group therapy:_____

I agree to the above altered fee. I recognize that this fee has been adjusted due to my current financial situation and may be renegotiated should my financial situation change. Hardship fees will be re-assessed every 3 months or sooner if circumstances change.

_____Client Signature Date

Cancellation Policy

Appointments must be cancelled more than 24 hours before the scheduled appointment time. By signing below I agree that if I cancel within 24 hours or do not show up for a scheduled appointment, Dr. Wilson have my permission to charge my credit card.

_____ _____ _____ _____
Credit Card Number Exp. Date CVV Billing Zip Code

_____ _____
Client Signature Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*) for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

"PHI" refers to information in any health care records I maintain regarding you that could identify you.

"Treatment, Payment and Health Care Operations"

Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

Payment is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to any third party pay or to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"Use" applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside my practice such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission permitting specific disclosures above and beyond those permitted by the general consent. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your individual record. Under Federal law, these notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (regarding PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the

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authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of this belief within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or any local or state law enforcement agency.

Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report this belief to the Department of Protective and Regulatory Services.

Health Oversight: If a complaint is filed against me with the Texas State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law. I will not release such information unless I have either written authorization from you or your personal or legally appointed representative or else a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**

Serious Threat to Health or Safety: If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

Worker's Compensation: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Your Rights and My Duties

Your Rights:

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send any mail to you at another address that you provide me.)

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Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both inspect and obtain a copy) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI or to psychotherapy notes under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI for which you have provided neither consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy. You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties:

* I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

* I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes; however, I am required to abide by the terms currently in effect.

* In the event that you are likely to be individually affected by a change in my policies and procedures, I will inform you of this fact and, upon your request, will provide you with a copy of the new policies and procedures via the United States Postal Service. Also upon your request, I will provide you with a copy of the new policies and procedures either through the Postal Service, via electronic mail, or in person regardless of whether you are likely to be affected by the changes in them or not.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at the address provided on my letterhead.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

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VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice goes into effect July 2009.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will publish the revised terms on my web site. In the event that you are likely to be individually affected by a material change in my terms, I will provide you with a copy of the new terms via the United States Postal Service. Also upon your request, I will provide you with a copy of the new terms either through the Postal Service, via electronic mail, or in person regardless of whether you are likely to be affected by the changes in them or not. It is your responsibility to provide a specific address and/or method of contact by which I can honor your request to send information.

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, my practice has developed a **NOTICE OF PRIVACY PRACTICES** which I am making available to you in compliance with the law. I am also giving you a document describing the nature of my services and other information I hope you find helpful.

I may revise these documents at any time without notice. A revised **NOTICE OF PRIVACY PRACTICES** may be obtained by submitting a written request to the address listed below. Additionally, a current **NOTICE OF PRIVACY PRACTICES** will be displayed in my office.

Please sign below to acknowledge that you have received a copy of the **NOTICE OF PRIVACY PRACTICES** and patient information documents.

I also ask you to give me consent to use and disclose Protected Health Information (PHI) about you to carry out treatment and receipt of payment. A description of these uses and disclosures is contained in the **NOTICE OF PRIVACY PRACTICES**. If an individual refuses to give this written consent, I reserve the right to refuse to accept that individual as a patient.

I acknowledge that I have received a copy of **NOTICE OF PRIVACY PRACTICES** and client information from Dr. Wilson.

I also give Dr. Wilson consent to use and disclose Protected Health Information (PHI) about me to carry out treatment and receipt of payment.

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient/Guardian Signature Date

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POST-DOCTORAL RESIDENCY CONSENT

I, _____, consent to psychological treatment with David M. Wilson, Ph.D., who is under the supervision of Janice Morris, Ph.D., ABPP.

Post-doctoral residents have completed a Ph.D. in Psychology and have also completed a year of internship from an accredited facility before coming to work for Dr. Morris. Their residency in Dr. Morris's practice is the last step to their training and full licensure as psychologists in Texas. As a part of this process they must work under the license and supervision of a fully licensed psychologist for one year. Any care rendered by a post-doctoral resident will be discussed with Dr. Morris in regular consultation meetings.

I understand that while Dr. Wilson will be rendering my care, ultimately Dr. Morris is responsible for my care and treatment. If I have any questions, problems or concerns about my care, I understand that I can contact Dr. Morris at 512-346-2332 to discuss them with me. I also understand that I can meet with Dr. Morris to answer questions about my care at any time by calling her for an appointment.

I agree to the treatment under the above terms.

_____

Patient Signature Date

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Social Media Policy

This document outlines my office policies related to use of social media. As new technology develops and the Internet changes, there may be times when I need to update this policy.

Friending

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Linkedln, etc.), as these sites can compromise boundaries, confidentiality, and our respective privacy.

Email, Phone, and Texting

If you need to contact me between sessions, the best way to do so is by phone at (512)574-0922 or (512)346-2332. Direct email at David@DrDMWilson.com is second best for quick, administrative issues such as changing appointment times. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Please do not use social networking sites such as Twitter, Facebook, or Linkedin to contact me. These sites are not secure and I may not read these messages in a timely fashion.

Business Review Sites

You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence."

You have a right to express yourself on any site you wish. Due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. I encourage you to bring your feelings and reactions to our work directly into the therapy process.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Texas State Board of Examiners of Psychology at W\VW.tsbep.state.tx.us/.

Location-Based Services

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible

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that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, please bring them to my attention so that we can discuss them.

I have read and understand Dr. Wilson's social media policy.

_____ _____

Patient Signature Date