Marian R. Zimmerman, Ph.D.
Clinical Health Psychology
www.mzpsychology.com

3550 Parkwood Blvd., 306
Frisco, TX 75034

(214)618-1451 Phone
(214)618-2102 Fax

New Patient Information

Patient Name: _____ Age: _____ Date of Birth: _____
Address: _____
Street Address City State Zip Code
Phone Numbers May we leave a message? (circle one)
Home : _____ yes no Work : _____ yes no
Cell : _____ yes no Other: _____ yes no

Please list your primary concerns at this time: _____
_____
_____
_____
_____

Emergency Contact: _____ Relationship _____
Address: _____
Street Address City State Zip Code
Phone: _____ Alternate Phone: _____

Who referred you to this office? _____

Personal Information
Gender _____ Race _____
Marital Status _____ Number of Children _____
Years of Education and Highest Degree Obtained _____
Occupation: _____
Employer: _____

Household Members:
Name Age Relationship to Patient
_____
_____
_____
_____
_____

Medical History
Name and address of your primary physician:
Physician's name: _____
Address: _____

Please list any major illnesses and/or operations you have had (please include dates): _____
_____
_____

Please list your current medications. Include dosage, frequency, and purpose of medications. _____

_____

_____

_____

Have you ever been given a specific psychiatric diagnosis by a doctor or mental health professional?

☐ Yes ☐ No

If yes, please list: _____

Have you ever received psychiatric care, psychotherapy, or other mental health services?

☐ Yes ☐ No

If yes, when and where: _____

_____

Have you ever been hospitalized for a psychiatric condition?

☐ Yes ☐ No

If yes, dates and hospital: _____

_____

Have any members of your family been diagnosed with a psychiatric condition or substance abuse problem?

☐ Yes ☐ No

If yes, please specify which family members and their diagnoses: _____

_____

Do you use tobacco products?

☐ Yes ☐ No ☐ Used in the past but have now quit. Date of last use _____

Type and amount typically used: _____

Do you drink alcohol?

☐ Yes ☐ No ☐ Used in the past but have now quit. Date of last use _____

Type and amount typically used: _____

Do you use other drugs or substances?

☐ Yes ☐ No ☐ Used in the past but have now quit. Date of last use _____

Type and amount typically used: _____

Have you ever taken medications prescribed by a physician more frequently or in greater quantities than recommended by the doctor?

☐ Yes ☐ No

Other relevant information _____

_____

_____

_____

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Psychological Services Agreement

Welcome! Please read the following information regarding the services and policies pertaining to this office. You are encouraged to bring any questions to your next meeting and to request clarification as needed at any time.

SERVICES
Individual psychological services are provided to adult patients through this office. A psychological evaluation may be conducted that could include a clinical interview and psychological testing to assess thoughts, feelings, behaviors, symptoms, personality traits, and other psychological factors. Cognitive Behavioral Therapy is the primary method of treatment which is used to assist patients examine and modify their thinking and behavior in order to feel differently and achieve their goals. Treatment involves setting clear goals and the completing tasks outside of the sessions to facilitate and expedite change. You will work with Dr. Zimmerman to clearly define these goals, which will then be used to design an individualized Plan of Care that will serve as a roadmap for the course of your therapy.

POTENTIAL RISKS AND BENEFITS
Like any healthcare service, no guarantee can be made about the outcome of psychological therapy. Evaluation and treatment may bring to light uncomfortable or undesired feelings and it can seem like you feel worse before you feel better. This is a normal part of the process and you are encouraged to discuss this in your sessions. Of course, there are also many potential benefits including reduced distress, new skills or techniques, decreased stress and worry, improved quality of life, and better relationships.

APPOINTMENTS
Sessions are generally between 45-60 minutes long, typically every week, but may occur more or less frequently depending on your individual needs. Appointments are reserved for you each time you visit. This time is kept for you will not be filled by another patient. Once a session is scheduled, you will be expected to keep your appointment unless you provide 24 hours advance notice of cancellation. **Appointments not canceled 24 hours prior to the scheduled session will be charged $75.00 to the individual.** (Insurance will not pay for missed sessions). If a patient misses two consecutive scheduled sessions, the patient will be considered to have given notice of termination of therapy.

TELEPHONE ACCESSIBILITY & EMERGENCIES
Due to my work schedule I may not be immediately available by telephone and will generally not answer the phone when I am with a patient. My phone is answered by an office staff member during regular business hours and by a voicemail system evenings, weekends, and holidays. The staff can schedule appointments and relay messages to me. I will return your call at the first opportunity. In case of an emergency, you may contact the Suicide and Crisis Center of North Texas Hotline at 214-828-1000 or go to your nearest emergency room.

OTHER FORMS OF COMMUNICATION
I generally do not communicate with patients via **email or text.** These forms of communication are less secure and your privacy cannot be guaranteed. I am not responsible for any information lost in transit or viewed by a third party. Emergencies, therapeutic issues, sensitive personal information, and scheduling should all be communicated to me or the office staff over the telephone or in person.

CONFIDENTIALITY
The confidentiality of our communications is generally protected by law. In order for me to provide information to a third party at your request, your written permission is required. You will be asked complete a Release of Information form for each person or entity I share information with.

Legal exceptions to the confidentiality of your information are as follows:

- Active or suspected abuse (physical, emotional, or sexual) or neglect of a child, an elder, or a dependent adult must be reported to the appropriate protective services.
- If the patient shows serious intent to harm themselves, I must take action to maintain their safety. This may include hospitalization or law enforcement intervention.
- If a patient threatens serious bodily harm to another person, I may be required to take protective actions such as notifying the potential victim, contacting law enforcement, or hospitalization.
- Sexual abuse of a patient by a mental health professional must be reported.
- Court ordered testimony or release of records.

Occasionally, I may find it beneficial to consult with other professionals about a case. Consultations do not include the identifying information about the patient and the consultant is also legally bound to keep information confidential. Unless you object, I will not tell you about these consultations

unless it is helpful in our work together. The administrative staff are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice.

PROFESSIONAL RECORDS

The laws and standards of my profession require that we keep Protected Health Information about you in your clinical record. The clinical record includes information about your reasons for seeking therapy, a description of the ways in which the problem impacts on your life, the diagnosis, the goals that we set for treatment, progress towards those goals, medical and social history, treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone. Except in unusual circumstances that involve danger to yourself and/or others or when there is a need to protect the integrity of a test we administered, you may examine and/or receive a copy of your clinical record, upon written request. You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers, I recommend you either review them in my presence so that we can discuss the contents or have them forwarded directly to another mental health professional. In most circumstances, I charge a copying fee of $0.50 per page.

In addition, I may also keep a set of psychotherapy notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of psychotherapy notes vary from client to client, they can include contents of our conversations, my analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your clinical record. These psychotherapy notes are kept separate from your clinical record. You may examine and/or receive a copy of your psychotherapy notes unless we determine that release would be harmful to your physical, mental or emotional health. If you become involved in litigation, be advised that these psychotherapy notes may be subject to release to other parties pursuant to a valid subpoena or court order.

PATIENT RIGHTS

You have the right to:

- Ask questions about the process and course of therapy.
- Voice your concerns or complaints to me about our work together or contact the Texas State Board of Examiners of Psychologists about unethical treatment by a psychologist.
- Decide not to receive treatment from me. I can provide you with referrals to other professionals.
- End therapy at any time. I do request that you inform me of this decision, and if possible allow time to wrap-up and provide some closure.
- Expect that I will maintain appropriate professional and ethical boundaries. This includes not acknowledging you in public or entering into any other type of relationship with you (personal, financial, professional, etc.) in order to maintain the privacy and integrity of our work together. If for some reason such a situation cannot be avoided, we will discuss this together.

I have read and understand this Agreement, and my questions have been answered. I agree to the terms of this Agreement, as indicated by my signature below. I also acknowledge that I have received the Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.

_____ _____

Patient/Legal Representative Date

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Financial Policy

I am committed to providing you with the best care possible. This goal is best achieved if everyone is aware of my policies. Your clear understanding of my financial policy is important to our professional relationship. Everyone is treated equally and fairly.

PROFESSIONAL FEES AND PAYMENTS

My standard fee for psychological services is $150.00 per 45-60 minute session and $150.00 per hour of psychological testing (including test administration, scoring, interpretation, and report writing) This fee includes consultations with other professionals, if needed, to coordinate your care (i.e. psychiatrist, physician, previous therapist). **Payment for services is due at each session.** "Payment" includes deductibles, co-insurance, and co-pays for participating insurance companies. Cash and credit cards are accepted.

If I am a network provider with your insurance company, I will submit a claim to your insurance company for payment. Any services not paid by your insurance carrier for whatever reason within 90 days will become your responsibility. Although I verify your insurance benefits, insurance plans vary considerably and I cannot predict or guarantee what part of my services will or will not be covered. It is your responsibility to know your insurance benefits. It is your responsibility to inform my office of either new insurance or any change in your current policy. If the new insurance information is not provided and verified 24 hours prior to your appointment, you will be responsible for the charges for that date of service and any subsequent appointments.

If I am not a network provider with your insurance company, I will provide you with a receipt for services, which you may submit to your insurance company to request reimbursement.

All personal balances over 120 days will be sent to a collection agency. In such situations, only the minimum amount of information needed to collect payment will be provided. By signing this agreement, you authorize me to employ the services of an outside collection agency or attorney to seek payment of all unpaid fees.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to Marian R. Zimmerman, Ph.D. I understand that I am financially responsible for non-covered services. I also authorize Marian R. Zimmerman, Ph.D. to release information required in the processing of insurance claims. I have read and fully understand the financial policy set forth by this office. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to me.

_____ _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

I, _____, hereby authorize Marian R. Zimmerman, Ph.D., P.A. to release and receive my psychological, personal, and medical information to/from the following individuals:

_____
Name

_____
Address

_____
Phone Number

I understand that disclosure of this information to the above individual will be made in order to assist my treatment. I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

_____ _____
Client Signature/Legal Representative Date

_____
Witness

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Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT 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 your health record 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 healthcare. Examples of payment are when I disclose your PHI to your health insurer 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 of 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 above and beyond the general consent that permits only specific disclosures. 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 medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of 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 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 such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to 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 such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the 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, and I will not release information, without written authorization from you or your personal or legally appointed representative, or 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. Patient's Rights and Psychologist's Duties

Patient's 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 your bills to another address.)
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) 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 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 neither provided 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.

Psychologist's 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.
- If I revise my policies and procedures, I will notify you in person or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please contact my office.

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

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 1, 2013.

I reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in person or by mail.