

## CONSENT TO OUTPATIENT THERAPY (ADULT)

This document contains important information about my professional services and policies. Please read it carefully and write down any questions you might have so that we can discuss them when we meet. When you sign this document, it will represent an agreement between us.

### PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, as well as the particular problems you bring forward. There are many different methods I may use to deal with the issues that you hope to address. Psychotherapy is not like a visit to your medical doctor. Instead, it requires a very active effort on your part. In order for therapy to be most successful, you will have to work on things that we discuss both during our sessions together and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have benefits for people who go through it. Therapy often contributes to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience in therapy or of what you may gain from it.

Our first few sessions will involve an evaluation of your needs. By the end of this evaluation, I will be able to offer you some initial impressions of what our work together will include, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

I normally conduct an **initial evaluation** that will last from 2 to 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is initiated, I will usually schedule one 45 to 50-minute session at a frequency that we agree upon.

### INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, *you (not your insurance company) are responsible for full payment of my fees*. It is very important that you find out exactly what mental health services your insurance policy covers. If you do not have insurance, or I am not an in network provider, you will be expected to pay the full fee at the time services are delivered.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

**Jay Ruebel, Psy.D., PA**  
**www.kellerpsych.com**

**CONTACTING ME**

I meet with clients throughout the day so I rarely answer the phone. I prefer to communicate via email and this is often the fastest means of getting in touch. If you **DO NOT** want to be contacted via email, please let me know. I can also be reached through voicemail and I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room.

**PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests (photocopying records, chart review).

**CONFIDENTIALITY**

Dr. Ruebel will not release information about you to another party unless:

- 1) You authorize him to do so in writing (you may revoke this at any time afterward).
- 2) He has reason to believe that you pose an imminent risk to your safety or the safety of an identifiable person(s).
- 3) You disclose that a child under the age of 18, an elderly person, or a disabled person is or has been physically or sexually abused by you or someone you know.
- 4) He is required by a court of law to disclose information (for example, if you use your mental health treatment as a defense in legal proceedings).

By signing below, I attest that I have read the terms of this consent form and have been given an opportunity to ask questions.

\_\_\_\_\_  
Signature of client or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client

**Acknowledgement of receipt of Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information**

Your signature below acknowledges your receipt of the *Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information* (referred to as the "Notice") for the office of Jay Ruebel, Psy.D., PA.

\_\_\_\_\_  
*Signature of patient or legal guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed name of patient*

I hereby permit Dr. Jay Ruebel to release and furnish all medical and financial data related to my care that may be necessary for the collection of data for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO and PPO managed care organizations contracting with any of the above entities to perform such functions.

\_\_\_\_\_  
*Signature of patient or legal guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed name of patient*

*You have the right to request that Dr. Jay Ruebel restrict uses and disclosures of your health information; however, Dr. Ruebel is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that Dr. Ruebel has previously taken action in reliance to this consent. Your treatment is conditional in your signing this agreement.*

**INSURED/RESPONSIBLE PARTY INFORMATION**

*Please complete this section regardless of insurance coverage.*

Insurance Company name or Mental Health Network: \_\_\_\_\_

Phone number from insurance card: \_\_\_\_\_  
*(Please make sure to write down the number for mental health/substance abuse services)*

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Cardholder's Name: \_\_\_\_\_

Primary Cardholder's SS#: \_\_\_\_\_

Primary Cardholder's date of birth: \_\_\_\_\_

I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Authorization number (if you have one): \_\_\_\_\_

**\*\*Please bring your insurance card and driver's license to the first appointment so copies can be made\*\***

**AUTHORIZATION AND RELEASE**

1. I authorize use of information on this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to Jay Ruebel, Psy.D., 1858 East Keller Parkway, Suite D, Keller, Texas 76248
5. I hereby permit a copy of this to be used in place of an original.
6. It is my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by my insurance the day and time that services are provided.

Signature of client or Policyholder: \_\_\_\_\_

Date: \_\_\_\_\_

**PAYMENT POLICY**

Fee Schedule

Initial Consultation / Intake (60 minutes)	\$160.00
Therapy session (45-50 minutes)	\$140.00
Psychological Testing (includes test administration, scoring and interpreting tests, as well as report writing time)	\$150/hour
Interpretative session (review test results)	\$140.00/hour
Review of clinical records / Consultation	\$140/hour
School observation (includes travel time to and from)	\$150/hour
Court preparation (includes travel time to and from)	\$150.00/hour

1. **Full payment for each session is required at the time the service is rendered.** Payment may be made by cash, check, or debit/credit card. A co-payment of insurance will be accepted after insurance coverage is verified.
2. Filing of insurance is a courtesy provided by this office. If you prefer to file your own claim, a duplicate receipt will be provided.
3. There will be a **\$30.00 fee** for any **NSF check returned**.
4. Prior to psychological testing reports being released, full or partial payment of outstanding balance is required.
5. Any account that becomes delinquent may be subject to additional service charges and turned over to an outside agency.

**I have read, understand, and agree to abide by the above stated fee policy.**

Signature of patient or policyholder: \_\_\_\_\_

Printed name of patient or policyholder: \_\_\_\_\_

Date: \_\_\_\_\_

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**SCHEDULING POLICY**

I use an online scheduling program called **Schedulicity.com** that allows clients to view my schedule online and make appointments. This service will also send email reminders one day prior to your appointment.

**Schedulicity.com** is FREE to use and only requires that you create a profile with your email address and a password.

If you need to CANCEL or CHANGE existing appointments, you can use **Schedulicity.com** to view your existing appointments and make changes. If you make any changes, I will be notified via email and you DO NOT need to notify me.

If you do not have access to the internet or do not wish to use **Schedulicity.com**, please let me know and I will make appointments for you in the system.

**CANCELLATION POLICY**

The time you have reserved for a session is one for which you are financially accountable. As a courtesy, **Schedulicity.com** will provide email reminders of sessions one day prior to each session. If you do not wish to use email, please let me know and I will arrange to notify you by phone. If you should need to cancel or reschedule your appointment, please do so at least **24 in advance** of your appointment time. You can always use **Schedulicity.com** to view upcoming appointments as well as cancel or change your appointments.

If you fail to cancel an appointment and do not attend at the scheduled time, you will be financially responsible for **the full negotiated fee** for that session.

You will not be charged for missing a session due to emergencies or other events outside of your control.

Signature of client or policyholder: \_\_\_\_\_

Printed name of client or policyholder: \_\_\_\_\_

Date: \_\_\_\_\_

## Personal Information

Today's date: \_\_\_\_\_

Client's full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Sex: M / F

Employer: \_\_\_\_\_ Job title: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Is it okay to leave messages for you at: Home Y / N Cell Y / N Email Y / N

Family Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Please indicate the **PRIMARY** problem that has led you to seek help today.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Sad or depressed mood      | <input type="checkbox"/> Problems with friends | <input type="checkbox"/> Physical health problems |
| <input type="checkbox"/> Anxiety, worries, or fears | <input type="checkbox"/> Work problems         | <input type="checkbox"/> Family problems          |
| <input type="checkbox"/> Substance use              | <input type="checkbox"/> Other problems: _____ |   |

How long have you had the problems for which you are seeking treatment?

- Less than 1 month     1-3 months     4-6 months     7-12 months     One or more years

Why have you decided to seek treatment/evaluation at this time?

What have you done to this point to address these problems?

What type of assistant do you hope to receive from this evaluation?

### Your family

Married? Y / N How long: \_\_\_\_\_ Spouse name: \_\_\_\_\_ Age: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ Employer: \_\_\_\_\_

Quality of relationship with you: \_\_\_\_\_

**Children:** Name \_\_\_\_\_ Age: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ School: \_\_\_\_\_

Quality of relationship with you: \_\_\_\_\_

Name \_\_\_\_\_ Age: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ School: \_\_\_\_\_

Quality of relationship with you: \_\_\_\_\_

Name \_\_\_\_\_ Age: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ School: \_\_\_\_\_

Quality of relationship with you: \_\_\_\_\_

Name \_\_\_\_\_ Age: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ School: \_\_\_\_\_

Quality of relationship with you: \_\_\_\_\_

**Mother:** Name \_\_\_\_\_ Living?: \_\_\_\_\_ Age: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ Employer: \_\_\_\_\_

Quality of relationship with you: \_\_\_\_\_

**Father:** Name \_\_\_\_\_ Living?: \_\_\_\_\_ Age: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ Employer: \_\_\_\_\_

Quality of relationship with you: \_\_\_\_\_

**Sister(s):** Name(s) \_\_\_\_\_ Living?: \_\_\_\_\_ Age: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ Employer: \_\_\_\_\_

Quality of relationship with you: \_\_\_\_\_

**Brother(s):** Name(s) \_\_\_\_\_ Living?: \_\_\_\_\_ Age: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_ Employer: \_\_\_\_\_

Quality of relationship with you: \_\_\_\_\_

Significant family mental health problems? \_\_\_\_\_

### Your health

Who is your physician? \_\_\_\_\_ Last visit: \_\_\_\_\_

Current medications (include dosage): \_\_\_\_\_

Medications prescribed in past 3 years: \_\_\_\_\_

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List, beginning at birth, all diseases, illnesses, accidents and injuries, hospitalizations, seizures/convulsions, and other medical conditions that you have had: \_\_\_\_\_

Any other concerns related to your health? \_\_\_\_\_

What types of physical activity do you do? \_\_\_\_\_

How much caffeine do you consume daily (cola, coffee, tea)? \_\_\_\_\_

Any dietary restrictions? \_\_\_\_\_

Average hours of sleep: weekday: \_\_\_\_\_ weekend: \_\_\_\_\_

Problems sleeping? \_\_\_\_\_

Appetite problems? \_\_\_\_\_

What would you say are some of your STRENGTHS, both psychologically and socially?

Have you ever been evaluated for psychological, behavioral, or learning problems? **YES / NO**

Do you recall who evaluated you, what type of evaluation it was, when it occurred, and what you were told? \_\_\_\_\_

Have you ever received psychiatric or psychological treatment? **YES / NO**

What type of treatment did you receive and how long did it last?

Who provided this treatment? \_\_\_\_\_

Have you ever received any medication for your behavioral or emotional problems? **YES / NO**

What type of medication, what dose, for how long?

**Your education history**

Ever held back/repeated a grade? \_\_\_\_\_ If yes, what grade(s) and why? \_\_\_\_\_

Typically what grades did you make? \_\_\_\_\_

Were there dramatic changes in your grades? Please explain \_\_\_\_\_

What did teachers and school personnel say about you? \_\_\_\_\_

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Were you suspended or expelled from school? Explain. \_\_\_\_\_

\_\_\_\_\_

How often do you use:

Quantity used:

Alcohol: \_\_\_\_\_ / \_\_\_\_\_

Tobacco: \_\_\_\_\_ / \_\_\_\_\_

Marijuana: \_\_\_\_\_ / \_\_\_\_\_

Other drugs: \_\_\_\_\_ / \_\_\_\_\_

Do you feel guilty about your current or past use of substances?	YES	NO
Have you ever tried to cut down on your use?	YES	NO
Have friends or family members ever expressed concern?	YES	NO
Has your use ever interfered with your work or family roles?	YES	NO
Have you ever received inpatient/outpatient substance-abuse treatment?	YES	NO

When: \_\_\_\_\_ Where: \_\_\_\_\_

Have you ever participated in a 12-step program? YES NO

Which program(s) and when? \_\_\_\_\_

\_\_\_\_\_

Problems at work?: \_\_\_\_\_

\_\_\_\_\_

Other important information \_\_\_\_\_

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