Firefox no longer supports filling of PDF forms. Please use the button in the upper right to open it in Adobe Reader and you will be able to fill it in on the screen, print and bring to your first appointment.

Marie W. Wood, Ph.D., Clinical Psychologist

215 N. East Ave., #203 · Fayetteville, Arkansas 72701 · (479) 521-9696

The following questions may be completed online or printed and filled in by hand.

If you complete online, you may use TAB to get from one field to the next or use your mouse.

At the end of the forms, you will have the ability to print and bring to your first session.

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Client Information

Name_____ Date of Birth_____

Address:_____ City: _____ State:___ Zip Code:_____

Home Phone:_____ Work Phone:_____

Cell Phone: _____ Social Security Number:_____

Marital Status: S ☐ M ☐ W ☐ Div ☐ Sep ☐ Sex: Female ☐ Male ☐

Email address:_____

Employer:_____Occupation:_____

Employer's Address:_____City:_____State/Zip_____

Emergency Contact:_____

Spouse's Name:_____ Social Security No.:_____

IF THE CLIENT IS A MINOR

Mother's Name:_____ Home Phone No:_____

Date of Birth:_____ Social Security Number:_____

Cell Phone:_____ Work Phone:_____

Mother'sAddress:_____City:_____State/Zip_____

Mother's Employer:_____

Employer's Address:_____City:_____State/Zip_____

How long at this company?_____ Occupation:_____

Mother's Email:_____

Father's Name:_____ Home Phone No:_____

Date of Birth:_____ Social Security Number:_____

Cell Phone:_____ Work Phone:_____

Father's Address:_____City:_____State/Zip_____

Father's Employer:_____

Employer's Address:_____City:_____State/Zip_____

How long at this company?_____ Occupation:_____

Father's Email:_____

INSURANCE INFORMATION (IF YOU HAVE YOUR INSURANCE CARD WITH YOU, YOU CAN SKIP THIS SECTION)

Primary Insurance:_____ Effective Date:_____

Name of Policyholder:_____ Date of Birth:_____

Policy Number:_____ Group Number:_____

Secondary Insurance:_____ Effective Date:_____

Name of Policyholder:_____ Date of Birth:_____

Policy Number:_____ Group Number:_____

I give consent for my therapist to contact my physician, Dr._____Initial_____

Doctor's Phone: _____

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BILLING INFORMATION AND INSURANCE AUTHORIZATION

In order to control the cost of billing, it is requested that charges be paid at the time the service is rendered.

Authorization: I hereby authorize Marie W. Wood, Ph.D. and her office manager to furnish information to insurance carriers concerning my treatment, and I hereby irrevocably assign to Marie W. Wood, Ph.D., all payments for services rendered, when applicable. I understand that on occasion insurance companies may determine that services rendered were not reasonable or necessary despite the fact that they were prescribed and performed by a psychologist with my well being in mind. I understand that I am financially responsible for all charges whether or not covered by insurance. I authorize the release of pertinent information to my referring physician when appropriate

_____ _____

Signature of Client/Guardian Date

_____

Client/Guardian Name (printed)

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Treatment Agreement

In consideration of treatment by Dr. Marie W. Wood the undersigned agrees:

1. To pay the amount charged for all professional treatment and services to the undersigned, his/her family or other identified client. Client/guardian understands and agrees that regardless of insurance status, client/guardian is ultimately responsible for the balance on his/her account for any professional services rendered. Client/guardian has read and understands the fee policy statement and has had all questions regarding fees answered to his/her satisfaction. Further, client/guardian certifies that the information provided on the patient and insurance information form is true and correct.

2. Client agrees to give at least 24 hours notice in the event he/she is unable to make a scheduled appointment. Cancellations with less than 24 hours notice or no shows will be billed a $25.00 fee the first time and $50.00 thereafter.

3. A finance charge can be added of 1.5 percent per month on the unpaid balance over 30 days. This allows a minimum of 30 days from the date of services to pay the account.

4. In the event the account is turned over for collections, the collection and legal fees, including attorney fees and court costs shall be the financial responsibility of the client/guardian.

Authorization and Assignments of benefits

The undersigned hereby authorizes that payment under his/her medical insurance program be made to Dr. Marie W. Wood. It further authorizes Dr. Wood to furnish information concerning my illness and treatment of that of my minor child to my health insurance carriers or its agents for the purpose of determining the benefits payable or related purposes.

I permit a copy of this authorization to be used in place of the original.

_____ _____
Client/Guardian Name (printed) Date

_____ _____
Client/Guardian Signature Witness Signature

Marie W. Wood, Ph.D., Clinical Psychologist

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Informed Consent

Information: I will provide the best I have to offer in professional therapy services. If I cannot provide you with the servic e you need, I will refer you to another professional. If you need to contact me, please call 479 521-9696 and leave a message. In the event of an emergency, go to the nearest hospital emergency room. If you are seeing another mental health professional, let me know. Seeing more than one mental health professional at a time may lead to confusion in therapy.

Nature of Therapy: Psychotherapy may vary depending on the issue the client brings to therapy and the personality of the therapist. For therapy to be effective, it will require change. You must be prepared to take an active role and be willing to look at the problem from different points of view. I will take a history and gather information by interview or homework assignments, short asses sment tools or a psychological evaluation as needed.

Psychological Testing and Assessment: For psychological evaluations, I meet for an initial session and you can expect several more face-to-face sessions for clinical interviews and administration of s ome of the assessment instruments. I will give you protocols to complete in the office as part of the assessment. Following these appointments, I will set up a final meeting as an individual therapy session to go over the results of the psychological evaluation and answer any questions you might have.

Payment: The fee for Individual therapy sessions is $225.00. The initial interview is $250.00. Your payment or co-payment is due at the end of your 50 minute session. My fee for the psychological evaluation is generally $900 for the assessment and interpretation of the data. This amount may vary somewhat depending on the referral question. Payment for the psychological evaluation is due at the time of receipt.

Insurance: For testing and/or therapy, it is the clients' responsibility to talk to the front office staff to determine if their insurance company requires pre-authorization and to determine if I am on their provider panel. My office will file for insurance benefits, however you are responsible for your bill. Your signature gives consent to provide information to your insurance company.

Expert Witness: If you subpoena me as an expert witness in a court case, there will be a standard fee charge, plus travel and preparation time.

Confidentiality: I am bound by the same confidentiality privilege as Attorney and Client. Confidentiality will be honored with these exceptions for adults: If clients tell me they wish to hurt themselves or others or abuse of a child, elderly, or handicapped person is suspected. I am obligated to report these concerns. With minor clients, I make an agreement with the parents and guardians that what is said in the session is confidential

with the exception of minor clients informing me they want to hurt the mselves or others, or someone is hurting/abusing them. For these situations, I am obligated to report these concerns. For all other information, a signed release of information is required for me to release your records. For psychological evaluations, I can send them to other psychologists or release them to you and/or your legal representative at your written request.

Professional Disclosure: I abide by the ethical guidelines and standards of care of the American Psychological Association and the Arkansas Psychology Board. I am a licensed psychologist in the State of Arkansas. I have my Doctorate in Psychology. I am not a physician and do not prescribe medication

Records: Records will be kept for seven years. You may review them in my office. If there is a custody situation, I will protect the interest of the child and not release information or records unless ordered by the court.

Benefits and Risks/ Length of Treatment: Benefits include reductions of feelings of distress, improvement in relationships and resolution of specific problems. Feelings of relief, renewal and self-acceptance with behavior changes are goals and may happen quickly or take a long times. Risks may include uncomfortable feelings of regret, sadness, guilt, and frustration. You may end the therapeutic relationship at any point, but I would appreciate hearing from you. You are the significant decision-maker in the length of treatment. I will meet with you only as long as it is beneficial to you.

I have read the informed consent and give consent for treatment of myself and/or child.

_____ _____

Signature of Client/Guardian Date

_____

Client/Guardian Name (printed)

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215 N. East Ave., #203 · Fayetteville, Arkansas 72701 · (479) 521-9696

Credit Card Info

Date: _____

Name of Card Holder: _____

Visa ☐ Medical Flex CC ☐ MC ☐ Discover Card ☐ American Express ☐

Credit Card # _____CVVR:_____

Expiration Date: _____ Amount: _____

Address: Same as Credit Card Billing Address

Street:_____

City: _____ State: _____Zip:_____

Telephone: Same as Credit Card _____

Fax: _____Email Address: _____

Cardholder Signature:_____

Permission to Charge Card following each appointment (**initial**):_____

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HIPPA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this information carefully.

Protecting Your Personal Health Information
I value my relationship with you and I am committed to protecting the privacy of your personal and health information I want you to understand how I protect the confidentiality of your personal and health information as well as how I use and disclose it. I am required by state and federal laws to maintain the privacy of your personal and health information. Personal and health information includes and information that is identifiable to you as your personal information including information regarding your health care and treatment, and other identifiable factors such as name, age, address, income, or other financial information.

How I Protect Your Personal Information

- I treat all your personal information as confidential;
- I restrict access to your personal information to only those employees who need to know that information in order to provide services to you;
- I only disclose your personal information to the extent necessary for an insurance company to perform its function on our behalf, and under the condition that the company agrees to protect and maintain the confidentiality of your personal information; and
- I maintain physical, electronic, and procedural safeguards that are in compliance with federal and state regulations to ensure confidentiality of your personal information.

How I Use and Disclose Your Personal Information
When you receive care form my office, I may use your health information for treating you, billing for services, and conducting our normal business. I will only disclose your personal information when I am required or allowed by law, or in the event that you or your authorized representative gives us permission to do so. Uses and disclosures other than those listed below require your authorization. If there are other legal requirements under applicable state laws that further restricts my use or disclosure of your personal information, I will comply with those legal requirements as well. The following are the types of disclosures that I may make as allowed or required by law:

- **Treatment:** I may use and disclose your personal information for our treatments activities;
- **Payment/Billing:** I may use and disclose your personal information for billing and payment purposes such as claims to insurance companies or Medicaid;
- **Business Associates:** I may also share your personal information with third party business associates who may be contracted to perform certain activities for me. I ask these business associates to treat your information in a manner consistent with HIPPA laws;
- **To You or Your Authorized Representative:** Upon your request, I will disclose your personal information to you or your authorized representative. If you authorize me to do so, I may use your personal information or disclose it to the person or entity you name on your signed authorization. Once you provide me with an authorization, you may revoke it in writing at any time. Your revocation won't affect any use of disclosures permitted by your authorization while it was in effect. In certain situations, when disclosures of your information could be harmful to you or another person, we may limit the information available to you, or use an alternative means of meeting your request;
- **To Your Parent if You are a Minor:** Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and/or persons acting in a similar legal status. I will act consistently with the laws of the State of Arkansas, and will make disclosures consistent with such laws;

- **Your Family & Friends:** If you are unable to consent to the disclosure of your personal information, such as in a medical emergency, I may disclose your personal information to a family member or friend to the extent necessary to help with your health care. I will only do so in the event I feel the disclosure is in your best interest. With your approval, I may disclose/request your personal health information to designated family, friends, and others to assist that person in caring for you or in paying for services rendered to you;
- **Public Health and Safety:** I may disclose your personal information if I believe the disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. I may disclose your personal information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes;
- **Required by Law:** I must disclose your personal information when I am required to do so by law;
- **Process & Proceedings:** I may disclose your personal information in response to a court or administrative order, subpoena, discovery request, or other lawful process, and if required to government oversight agencies conducting the audits;
- **Law Enforcement:** I may disclose limited information to law enforcement officials; and
- **Military & National Security:** I may disclose to military authorities the personal information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials personal information required for lawful intelligence, counterintelligence, and other national security activities.

Your Rights Regarding Disclosure and Use of Your Personal Information

- **Access to Your Personal Information:** You have the right to review and receive a copy of your personal information. This right doesn't include the right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding; and protected health information that is subject o other state or federal laws that prohibit me to release such information. I may also limit your access to your personal information if I determine that providing the information could possibly harm you or another person. If I limit access based on the belief that it could harm you or another, you have the right to request a review of that decision;
- **Amendment:** You have the right to request that I amend your personal information. Your request must be in writing, and must identify the information that you think is incorrect and explain why the information should be emended. I may decline your request for a variety of reasons. If I decline your request to amend your records, I will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you want amended. If I accept your request to amend the information, I will make reasonable efforts to inform others of the amendment and to include the changes in any future disclosures of that information; and
- **Accounting of Disclosures:** You have the right to receive a report of instances in which I, or my business associates disclosed your personal information for purposes other than for treatment, payment, mental health service operations, and certain other activities. You are entitles to such an accounting for the six years prior to your request. I will provide you with the date of which I made a disclosure, the name of the person or entity to whom I disclosed your personal information, a description of the personal information I disclosed, and the reason for the disclosure. If you request this list more than one time in a 12 month period, I may charge you a reasonable fee for creating and sending these additional reports.

This notice takes effect January 28, 2008 and will remain in effect unless revised. I reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. I will notify you of any changes in regard to our privacy practices.

Marie W. Wood, Ph.D., Clinical Psychologist
215 N. East Ave, #203. · Sunbridge · Fayetteville, Arkansas 72701 · (479) 521-9696

Acknowledgement of Receipt of HIPPA Privacy Notice

Client Name:_____ Date:_____

I acknowledge that I have been given a copy of the HIPPA Privacy Notice. I have reviewed the HIPPA Privacy Notice and have had the opportunity to ask any questions I may have regarding the information presented in the notice. Such questions have been answered to my satisfaction. The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient.

Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Print

Print and bring to your first appointment. Please sign where indicated.