Emily C. Engel, Psy.D., PLLC
Licensed Psychologist
3111 Springbank Lane, Suite G
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CONSENT FOR PSYCHOLOGICAL SERVICES – ADULT

Thank you for seeking my services. This document covers important information about my professional practices and business policies. Please review it carefully and ask me any questions that you may have.

Please check which services you consent to receive:

_____ Initial Consultation (1-4 sessions)
_____ Psychotherapy
_____ Other – Describe: _____

The Nature of Psychological Services

- **Initial Consultation:** During our initial sessions, I will conduct an assessment of your needs and goals and then provide you with my initial impressions and recommendations for treatment. After the initial consultation, you are free to decide if you would like to begin treatment with me, or if we determine that I am not the best fit for you, I will be happy to provide an appropriate referral.
- **Communication:** The therapist-client relationship is unique. I have a legal and ethical obligation to keep what you share with me private and confidential, to promote candid and complete communication between us. I am only able to provide you with truly beneficial services if I am aware of all information that might be relevant to your care. If you have questions or concerns about my services, please let me know.
- **Outcome:** Psychotherapy varies depending on the therapist, client, and particular circumstances. In general, the purpose is to provide a safe and supportive context to improve your life and relationships. While research shows that psychotherapy is effective in reducing distress and facilitating growth and change, risks include emotional distress, relationship challenges and issues previously unknown. Like any professional service, results cannot be guaranteed. Even so, many people find that therapy is worth the discomfort they might feel.
- **Termination:** Ideally, therapy concludes when the therapist and client agree that treatment goals are met. However, you are free to discontinue therapy at any time. I do strongly encourage you to speak with me first as this can be a helpful learning experience and I can also provide you with referrals to other services if needed.
- **Session Timing:** Session time includes transition to/from the office, payment and scheduling of future services. I will make every effort to stay on time. Please help me by having your payment and scheduling information ready ahead of time. Thank you for your cooperation and courtesy toward other clients.
- **Office Disclaimer:** I am a clinical psychologist in independent private practice. Though I am renting office space at South Charlotte Clinical Associates, please note that I, and the other providers at that location, are solely tenants and not in any other formal professional relationship. Each provider maintains their own practice, policies and procedures.

Contact

- **Emergencies:** If you are experiencing an emergency, please call 911, go to the nearest hospital emergency room, or call CMC's Behavioral Health Center (available 24/7) at 704-444-2400. Please also call me and let me know the nature of your situation as soon as you are able.
- **Telephone:** I am often not immediately available by telephone, but do have a confidential voicemail. I return calls as soon as I am able and make every effort to return your call within one business day. Please note, I do not communicate via text message.

- **Email:** The privacy and security of information sent by email cannot be guaranteed. You are welcome to contact me via email for routine matters, but sensitive information should be communicated via a confidential voicemail or phone consultation. Please do not communicate urgent or emergency information via email – please follow the above emergency procedures.

Confidentiality

The law and professional ethics require me to keep client information confidential. This means that, generally, I cannot share your health information without your written authorization and I will strive to protect your privacy.

Exceptions to Confidentiality:

- If I believe you are threatening serious bodily harm to another, I am required to take protective action. This may include notifying the potential victim, contacting the police, or seeking hospitalization for you.
- If I believe you are at risk of causing severe harm to yourself, I may be obliged to seek hospitalization for you, or to contact family members or others who can help provide protection.
- If I have reasonable suspicion that any child, elderly person, or incompetent person is being abused or neglected, the law requires that I report this to the appropriate county agency.
- If a court of law orders me to release information, I am required to provide that to the court.
- If you are or become involved in any kind of lawsuit or administrative procedure where the issue of your mental health is involved, you may not be able to keep your records private in court.
- In order to provide you the best treatment, I may seek consultation from another licensed mental health professional. In these consultations, I make every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential, although the exceptions to confidentiality apply to them as well. Similarly, when I am away or unavailable, my practice is covered by a licensed therapist. I may inform the on-call therapist about your situation to facilitate your getting appropriate support should you need it in my absence.

Payment

- **Payment:** Payment is due at the time services are rendered, and the cost of services is your responsibility. I accept payment by cash, check or credit/debit card (Mastercard, Visa, Discover & American Express accepted), and I request that you keep a credit card securely on file to facilitate payment (see Credit Card Consent Form).
- **Fees:** The fee for the initial 60 minute session is $200. Subsequent 45 minute psychotherapy sessions are $150 and 60 minute sessions are $175 (allowing for notetaking, scheduling and billing time). Please also note that I may charge $150/hour for other professional services you may need, billed in 15-minute increments if the service provided is less than one hour. Such services include consultation with other professionals, report writing, telephone conversations lasting 15 minutes or longer, attendance at a meeting you have authorized, preparation of records, travel time, and the time spent performing any other service provided in the interest of an established individual client.
- **Insurance:** I strive to keep my practice client-focused rather than driven by managed care so do not participate on insurance panels. If you wish to use your "out-of-network" benefits, I will be happy to provide you with a statement that you may submit to your insurance company for reimbursement. The advantage of using health insurance benefits is that you may be reimbursed a portion of the fee. However, I will be required to provide a psychiatric diagnosis, you may need permission ("authorization") for treatment, a third party (the insurance company) may have access to your records, and reimbursement may be terminated before your treatment needs are met. If your employer offers a Health Care Flexible Spending Account, you may use this for payment. I encourage you to investigate your health insurance benefits prior to beginning treatment.
- **Payment Difficulties.** I aim to help you access important psychological services. If you are having difficulty paying your fee, please discuss this with me as soon as possible. I offer a sliding scale for eligible families and can assist you in accessing appropriate services either with me or another provider.

- **Legal Fees:** If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

Cancellations and Missed Appointments

Your appointment time is reserved exclusively for you. When you cannot keep your appointment, please call and give as much notice as possible. If an appointment is missed or cancelled with less than 24 hours' notice, you will be responsible for the full session fee. Monday appointments must be cancelled by noon the preceding Friday to avoid a charge.

ACKNOWLEDGMENT AND CONSENT

I voluntarily agree to receive psychological services from Emily C. Engel, Psy.D., PLLC. I understand and agree that I will participate in the planning of my care and that I may discontinue treatment at any time.

By signing this Consent for Psychological Services – Adult form, I, the undersigned patient, acknowledge that I have both read and understood all terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Printed Name of Patient	Patient's Date of Birth
Signature of Patient or Patient's Representative	Date
Printed Name of Representative (if applicable)	Relationship to Patient
Witnessed by (Signature)	Date

Form Revised 4.19.16

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NOTICE OF PRIVACY PRACTICES
Health Information Portability & Accountability Act (HIPAA) Law

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, ASK ME ANY QUESTIONS YOU HAVE, AND KEEP THIS FORM FOR YOUR RECORDS.

DISCLOSURE OF INFORMATION: This office is committed to and practices the following guidelines to protect the privacy of your Protected Health Information (PHI). I am required by law, as well as by professional standards, to keep your health information private, to give you this notice of my privacy practices, and to let you know if I make any changes in them. I consider all information about our work to be confidential. Your signature on the "Receipt and Acknowledgement Form", stating that you have received and reviewed this notice, gives me your consent to use and/or disclose your PHI for purposes of payment and business practices (as needed for billing, insurance claims, collections, and maintenance of your medical record). For treatment coordination and consultation, health care operations and other cases, I will ask for your authorization for use and/or disclosure of your PHI. I may not disclose your PHI without your informed and voluntary consent or authorization. Whenever your PHI is released or obtained, only the minimum information necessary will be communicated.

DISCLOSURES WITHOUT AUTHORIZATION: There are some situations in which the release of information without authorization is required and/or permitted by law and professional ethics. While I am required to take such action, I will do my best to communicate my disclosures with you in a timely manner. These include:

- Emergencies
- Reporting suspected abuse or neglect of a child, elderly person or incompetent person
- Disclosures required by court order
- Disclosures necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public

YOUR RIGHTS REGARDING PRIVACY: By law, you have certain rights regarding the health information that I collect and maintain about you. These include the rights to:

- Request to inspect and obtain a copy of your medical record. Note, there may be a charge for printing/copying records. Additionally, due to the sensitive nature of professional clinical records, I may offer to have you review them in my presence so that I can answer any questions you might have.
- Request an amendment of any section of your medical record.
- Request restriction of disclosure of your PHI for the purposes of treatment, payment and healthcare operations.
- Request an accounting of the disclosures that your provider makes of your health care information.
- Receive a copy of this notice.
- Refuse to acknowledge receipt of this notice. However, if you chose not to accept these practices, I cannot treat you.

QUESTIONS AND/OR EXERCISING YOUR RIGHTS: If you have any further questions and/or concerns about this notice please contact me. In order to exercise any of your rights described above or if you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to my office. You may also contact the Secretary of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC, 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. I cannot and will not make you waive your right to file a complaint as a condition of receiving care from me, or penalize you for filing a complaint. I reserve the right to amend the terms of this notice.

Form Revised 4.19.16

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule, the federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice regarding the protection of their private health care information. The law further mandates that patients must sign an acknowledgement attesting that they have received the notice.

Your signature below indicates that you have been provided the Privacy Notice as required by the federal government's HIPAA legislation and your signature acknowledges this to be an agreement between you and your provider.

_____	_____
Signature of Patient or Patient's Representative	Date
_____	_____
Printed Name of Patient	Printed Name of Patient's Representative

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CREDIT CARD CONSENT FORM

Client Name: _____ Date of Birth: _____

With this Consent, Emily C. Engel, Psy.D. agrees to keep your credit card information securely on file and apply fees to it under the following conditions:

___ (Initial) I understand that by signing this agreement, I authorize Emily C. Engel, Psy.D. to apply fees for psychological services to my credit card.

___ (Initial) I authorize Emily C. Engel, Psy.D. to apply a full fee for missed appointments and/or appointments not cancelled according to Dr. Engel's 24-hour cancellation policy.

___ (Initial) I authorize Emily C. Engel, Psy.D. to apply any outstanding fees that are unpaid after 30 days.

___ (Initial) I understand that I may revoke this agreement at any time.

NAME _____

CARD TYPE _____ BILLING ZIP CODE_____

CARD NUMBER _____

EXPIRATION DATE _____

SECURITY NUMBER (on back of card) _____

NAME ON CARD _____

SIGNATURE _____

DATE AUTHORIZED _____

DAYTIME CONTACT NUMBER _____

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PATIENT INFORMATION FORM: ADULT

Please complete the following information:

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street City State Zip

Phone: Home: _____ Message OK? Y / N
Cell: _____ Message OK? Y / N
Work: _____ Message OK? Y / N

Email: _____Would you like to receive appointment reminders via email? Y/N

Occupation: _____ Employer: _____

Education Level: _____

Relationship Status: □ Married □ Partnered □ Single □ Separated □ Divorced □ Widowed

Race/Ethnicity: _____ Gender: _____ Religion: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Referred by: _____ May I contact him/her? Y / N

Person responsible for the patient's payment: Self _____ Other _____

If Other, Name: _____ Relationship: _____

Phone: _____ Billing address, if different than above:

_____
Street City State Zip

Reason for Current Inquiry

Please describe your current concerns: _____
_____
_____
_____
_____

Describe your goals in seeking services: _____
_____
_____
_____

Psychological/Psychiatric History

Have you ever been diagnosed with a psychological/psychiatric condition? If yes, describe: _____
_____
_____
_____

Have you had any psychological testing or participated in treatment for the above? If yes, describe:
_____
_____

Has anyone in your family been diagnosed or suspected to have a psychological/psychiatric condition? If yes, describe: _____
_____

Have you or a family member ever made a suicide attempt? Y / N

Please indicate if you have experienced any of the following:

Concern	Past Y/N	Current Y/N	Concern	Past Y/N	Current Y/N
Anxiety, worry, panic attacks			Suicidal feelings/thoughts		
Obsessive thoughts			Feelings of hopelessness		
Repetitive behaviors/compulsions			Easily upset		
Restlessness			Grief/death issues		
Sadness			Irritability		
Loss of interest in activities			Excessive energy		
Sexual concerns			Mood swings		
Low self-esteem			Excessive bodily concerns		
Fatigue, low energy			Distressing memories		
Sleep difficulties			Job stress		
Eating/appetite difficulties			Self-harm thoughts		
Uncontrollable crying			Concentration difficulties		
Substance abuse			Aggression – Verbal/Physical		

Family Status

Please list the people residing in your home:

Name	Relation to you	Age	Highest grade completed	Occupation

Please list any other significant family members (i.e., child living out of home)

Name	Current age	Other information

Medical History

Primary Care Provider: _____ Phone: _____

Date of last exam: _____

Please list any past or current medical conditions: _____

_____

_____

List current medications:

Medication Name	Dosage/Frequency	Prescribing Provider

Please list your personal strengths: _____

_____

_____ _____

Signature Date

Form Revised 4.19.16