

Carol Terry Psychological Services, P.C.  
Carol Terry, Ph.D., Licensed Psychologist  
1006 24<sup>th</sup> Ave N.W., Suite 100  
Norman, OK 73069  
Phone: (405) 321-0303 Fax: (405) 801-2846

**NEW PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Who referred you to my office: \_\_\_\_\_  
Please list the main reasons for seeking psychological services:  
\_\_\_\_\_  
\_\_\_\_\_

**IF PATIENT IS A MINOR PLEASE COMPLETE THE SECTION BELOW:**

Legal Guardian Name(s) \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Legal Guardian Mailing Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Contact Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
If parents are separated or divorced, OR you are not the parent, please provide the name of the other parent/guardian(s) not listed above and their contact information:  
Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

**ALL PATIENTS MUST COMPLETE THE FOLLOWING SECTION**

Please indicate the preferred contact number or if you prefer another method of communication:

May we leave messages for you on your voicemail? (e.g., reminder calls, cancellations, etc.) Yes / No

**BILLING INFORMATION:**

Person responsible for the Bill: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Phone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Insurance ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PLEASE COMPLETE SECTION BELOW FOR ANY SECONDARY INSURANCE**

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Insurance ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*Carol Terry Psychological Services, P.C.*  
Carol Terry, Ph.D., Licensed Psychologist  
Aurora Professional Center  
1006 24<sup>th</sup> Ave, NW, Suite 100, Norman, OK 73069  
Phone: (405) 321-0303 Fax: (405) 801-2846  
[www.normanpsychology.com](http://www.normanpsychology.com)

**Psychologist-Client Services Agreement  
Business Policies and Procedures (1/1/2018)**

Welcome to my practice. I appreciate your seeking services at my office and hope that this policy answers your questions about the services and costs associated with your evaluation or treatment here. The following guide explains the policies concerning my qualifications, services, fees, appointments, insurance, and confidentiality. Please review it carefully. If you have any questions, please discuss them with Dr. Terry. In addition to this document, you also need to review the Notice of Privacy Policies Document located at my office and on the website.

**Please arrive 15 to 20 minutes early for your first appointment and bring all paperwork and insurance card(s) if we are filing insurance for you or your child.**

**We have a small waiting room. Please don't bring more than 2 family members with you in addition to the patient who is scheduled.**

**Services and Qualifications**

A variety of services are provided at this practice, including Clinical Diagnostic Evaluations, Individual, Family, and Couples Therapy, and Clinical Psychological Testing for adults, adolescents, and children. It is important that you understand what service you or your child will be receiving at my office. I do not provide court-related or forensic services. *I do not provide court testimony, forensic assessment, custody evaluations, letters to attorneys, or any other services for court or legal purposes.* My services are limited only to enhancing the health and functioning of my clients.

I earned my doctorate in Clinical Psychology from the University of North Carolina at Chapel Hill in 1988 and I have been a Licensed Psychologist since 1990. I am a member of the American Psychological Association as well as a variety of other professional organizations. I periodically teach in the Psychology Department at the University of Oklahoma and have served on a variety of board of directors for several professional organizations and community agencies.

**Psychotherapy Services**

If you are seeking psychotherapy services for yourself or a family member, I typically will conduct an initial evaluation session that lasts an hour followed by about 1 to 2 additional 55 minute sessions in order to develop a treatment plan and to decide if I can provide the services that you or your child requires. This evaluation typically involves taking a detailed history, including the current difficulties that brought you here. Sometimes, I will also recommend psychological testing, which is an additional service I can provide. During the initial evaluation period, we can both decide if I am the best person to provide the services you or your child needs in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 55 minute session per week at a time we agree on, although sessions may be longer or less frequent, depending on the patient needs. Further, I want you to be aware there are both risks and benefits associated with psychotherapy. While the goal of psychotherapy generally is to find solutions to problems and reductions in feelings of distress, the process of psychotherapy also can involve the experience of uncomfortable feelings like sadness, guilt, anger, or frustration. But there are no guarantees of what will be experienced in therapy. By the end of the initial evaluation period, I will offer you some initial impressions of what our work together will include if you decide to proceed with therapy. If you have questions about my procedures, we should discuss them whenever they arise.

**Clinical Psychological Evaluation Services**

Clinical psychological evaluations are not the same as psychotherapy services, although they are typically conducted to assist in treatment planning, which may include recommendations for certain types of therapeutic interventions. They are clinical in nature in that they may assist with diagnostic evaluation and treatment planning. I do not conduct psychological evaluations for forensic or court purposes. Psychological evaluations vary in length and cost depending on the type of testing required. Given that psychological evaluations involve several components that include interviews, test administration, scoring and interpretation of tests, and written reports, they require several hours to complete. The amount of time needed to complete an evaluation varies depending on the goals for the evaluation but typically ranges from 4 to 12 hours. If you are being referred by another professional for a psychological evaluation (such as a physician or therapist), it is very helpful to have that professional fax me a brief note indicating what the purpose of the evaluation is before I see you or your child.

Typically, for a very young child's first appointment (6 years and younger), my preference is to first meet with the parents alone for the first appointment, a diagnostic interview, during which I gather information about the problems the child is having as well as conduct a thorough developmental history. Then I will meet with the young child at a separate appointment followed by an additional appointment with the parents when I review my findings and recommendations.

For elementary age children (6 to 12 years old) and adolescents (13 to 17), I will meet first with the parent(s) and child for a one hour interview and then for a separate appointment for about 2 to 4 hours to conduct the testing. Additional testing may also be scheduled depending on the reasons for the evaluation. For example, testing for learning disabilities may require more than one testing session. After the testing is completed, a separate feedback appointment will also be scheduled to review the test results and recommendations. A written report of testing findings and recommendations will be prepared.

An adult's first testing appointment is an hour interview. A separate appointment to conduct the testing can range from about 2 to 4 hours, depending on the nature of the testing. After the testing is completed, a separate feedback appointment will also be scheduled to review the test results and recommendations. A written report of testing findings and recommendations will be prepared.

Finally, psychological evaluations are not always covered by insurance at the same benefit as psychotherapy services and sometimes require preauthorization. While my billing company will attempt to check this benefit and obtain prior authorization for insurance that I am a provider for, it is ultimately your responsibility to know your insurance policy benefits and insure that any needed authorizations are obtained prior to my conducting the evaluation. The CPT code for psychological testing is 96101; you can call your insurance company to check what your policy will pay for testing, if you have to meet a deductible before insurance will pay, if authorization is needed, and if there are any diagnostic conditions that are excluded from your testing benefit.

#### **Fees and Payment Procedures**

A current fee schedule is attached to this guide. However, fees may be different depending on your insurance plan. Payments are due at the end of each visit, unless other arrangements are made beforehand. Please make checks payable to "Carol Terry Psychological Services, PC." Credit Cards and Debit Cards are also accepted for payment.

For minors, it is my policy that the parent or guardian who initiates therapy or testing for a child is the party responsible for payment at the time that services are rendered. Shared financial arrangements between parents should be worked out between the parents involved.

#### **Medical Insurance**

Services provided are covered under most health insurance policies under outpatient psychiatric treatment, behavioral health, or psychological testing. However, some companies reimburse mental health services at a different rate from other medical services. Some policies have annual deductibles that have to be met by individuals or the family; some set annual limits in dollars or numbers of visits allowed per year. Since benefits are so varied, each client should review his or her policy carefully and be aware of the benefits or limitations involved. We will also have our billing service (Sharlabo) check your benefits upon scheduling your first appointment. In addition, we will file insurance claims for you, unless otherwise directed by you.

#### **Insurance Plans for which I am an in-network provider:**

1. Blue Cross Blue Shield Plans
2. Healthchoice
3. Coventry/FirstHealth

Note: While I am not currently a Cigna provider, I do provide a 10% discount off my rates listed below to clients with Cigna.

If you have one of the insurance plans listed above, your company will probably reimburse me at a higher rate than if you go to an out-of-network provider. If your company is not on this list, we can usually still file claims with them and will check your insurance's out-of-network benefit for you. Exceptions to this are if your insurance plan is Soonercare, Tricare, or an HMO; these policies will not reimburse me for services; you certainly have the option to self-pay for services.

#### **Appointments**

**For your first appointment, please complete the appropriate paper for new patients from my website: [www.normanpsychology.com](http://www.normanpsychology.com). Please arrive at least 20 minutes before your scheduled appointment time so that you can check in at the receptionist desk, review my Notice of Privacy Policies and Practices, and complete any additional forms. If you are using insurance, please bring your insurance card with you.**

When an appointment is made, that time is set aside and cannot be given to any other client. It is very important that appointments be kept. If an appointment time needs to be rescheduled or canceled, please call the office so that the time may be made available to someone else. There will be a charge of **\$ 65.00** for **any missed appointment** unless notice of cancellation is received **24 hours in advance** or unless the last-minute cancellation is made necessary by a **genuine emergency**. **Insurance will not pay for missed appointments** and the client or their guardian is solely responsible for paying for this fee. Appointments may be canceled by leaving a message on my confidential voicemail or letting my secretary know during regular office hours.

Payments for missed appointments are due with the regular fee at the next visit. Missed appointments are not reimbursed by insurance.

**Phone Sessions**

A phone session occurs when the therapist and client (or family member) carry on a conversation of a therapeutic, problem-solving, or information-exchanging nature or when the guardian of a child agrees for me to conduct a professional consultation with other individuals pertinent to the child's treatment or evaluation (e.g., teacher, physician, therapist). Short phone calls (under 5 minutes) are not considered sessions. Longer phone calls, however, will be charged as a telephone consultation and will be charged at the rate for individual therapy. The fee for a phone session will be due at the next scheduled visit. Phone sessions will be indicated as such and are not reimbursed by insurance.

**Confidentiality and Privacy Information**

Records of your service activities are confidential and will not be released without the client's (or guardian's) specific written consent, except under the exceptions listed below. We may use or disclose your Protected Health Information (i.e., information in your health care record that may identify you) for treatment, payment and health care operations purposes *with your consent*. You may revoke such consent in writing at any time. You may not revoke an authorization to the extent that (1) We have taken action in reliance on the 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. The exceptions to confidentiality are listed below:

1. If the therapist suspects that child abuse or neglect has occurred or that a vulnerable adult has been abused or neglected, the law requires that it be reported to the proper authorities. This includes suspected mental or emotional abuse of a child who has witnessed domestic violence.
2. If the therapist believes that you are a clear and imminent danger to yourself or another person, the therapist may notify appropriate others to prevent that occurrence. (Examples, statements of suicidal or homicidal intent).
3. If it becomes necessary to contact an attorney or a collection agency, then your name, identifying information about how to reach you, and amount owed will become available to these agents.
4. In legal proceedings, patient/therapist communications are privileged with the following exceptions. A judge's court order is required for such information to be released or the patient's written release for the information. Examples of when a judge might subpoena your record include:
  - A. If your mental status is an issue for the court;
  - B. The judge feels that communications are necessary to the proper administration of justice.

**MINORS AND PARENTS**

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment and evaluation records. Both custodial and noncustodial parents are accorded this right to medical records under Oklahoma law. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I generally recommend that parents consent to give up their access to their child's therapy record. If parents agree to this during therapy, I will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. With young children, I typically do have frequent collateral meetings with parents given that treatment typically involves assistance from their parents (e.g., when behavior therapy is the primary type of therapy) and documentation of such meetings are also recorded in the child's medical record. Family meetings may be recommended when I believe that they would be helpful in a child's treatment too. If I feel that the child is in danger or is a danger to someone else, I will notify the parent/guardian of my concern. If I am conducting a psychological evaluation of a child, I typically send the report to the child's parents or legal guardian.

**COURT TESTIMONY AND LEGAL INVOLVEMENT**

As noted above, I do not provide court testimony, forensic assessment, custody evaluations, letters to attorneys, or any other services for court or legal purposes. My services are limited only to enhancing the health and functioning of my clients. If you are seeking a psychologist who can testify on your behalf, such as in a custody or criminal case, I will be happy to refer you to other psychologists who do provide that service. By signing this agreement and beginning either your or your child's evaluation or treatment with me, you agree that none of our conversations, treatment, diagnoses, etc. can be used for any legal purposes, and that my records and/or oral testimony cannot be compelled in any case. If a subpoena is issued requiring my appearance or for my records and/or oral testimony, you will then be billed for any attorney fees, costs and/or expenses incurred for the time required to comply with or quash the subpoena, and for my time related to dealing with the subpoena. Because of the difficulty of legal involvement, I charge \$350.00 per hour of time spent in preparation, travel, consultation, appearance, etc. and require that a retainer be paid in advance.

**Psychologist's Duties under HIPAA**

You are required under HIPAA to review my Notice of Privacy Practices which is a document in addition to this one. This notice is always located in the binder on the front reception desk so that you can review it at any time and on my website [www.normanpsychology.com](http://www.normanpsychology.com). You can also request a copy of that Notice in writing from my secretaries. We are required by law to maintain the privacy of your Personal Health Information and to provide you with a notice of our legal duties and privacy practices with respect to your record. We will abide by the terms in this policy, unless we notify you of changes. You will be provided with copies of new policies or procedures. Further, you should be aware that pursuant to HIPAA and professional ethics code, I keep professional records containing your Protected Health Information in parts of your file.

**Impairment from Alcohol or Other Substances**

I respectfully request that you be free of alcohol or other intoxicants prior to coming in for an evaluation or therapy so that we can have the best chance of being successful in our work together. If, during a session, I come to believe that you are impaired in some way because of substances, then I will address that concern to determine if we can continue. If in fact you are "intoxicated" for whatever reason, then we will stop the session and I will make arrangements for you to get back to your residence "safe and sound." This may involve calling a friend, relative, or calling a cab. Then too, I will request your car keys so that you will not be tempted to continue driving while impaired. If, for some reason, you refuse to cooperate, then I could be forced to call the authorities to insure your safety and the safety of others. While such a circumstance has only happened one time in my years of practice, you need to be informed about what could happen if you were to come to therapy "impaired" in this way.

**Emergencies:** Please call Dr. Terry on her cellular phone at (405) 202-3323 in case of an emergency or in the case of a life-threatening emergency call 911 or proceed to the nearest emergency room. Please do not text me. If it is before 5 p.m., first call my office (321-0303); leave a message with the secretary or on the voicemail if there is no answer. If your call is not returned promptly during business hours, you can call Dr. Terry's cellular phone number. You can also go to your nearest emergency room for assistance. When I am on vacation or otherwise unavailable, I will leave the name and phone number of the professional covering for me on my voicemail and with my secretary. My policies will be in effect for that coverage as well.

**FEE SCHEDULE\*\***

Initial Diagnostic Interview, 60 minutes.....	\$190.00
Individual Therapy, per 55 minute session.....	\$ 140.00
Couples or Family Therapy, per 55 minute session.....	\$ 140.00
Psychological Evaluation, per hour.....	\$ 140.00
For each hour spent administering tests, there is typically an additional hour charged to score, interpret, and prepare the report.	
Telephone Consultations longer than 5 minutes, per quarter hour or any portion thereof.....	\$ 35.00
Any additional consultation or services performed on behalf of the client other than court-related/legal matters, per hour.....	\$ 140.00
No Shows or appointments cancelled less than 24 hours ahead of time.....	\$ 65.00
Forensic/Court-Related Services (As noted above, I do not do court-related services except when someone has broken this agreement with me and I am compelled by the court to become involved with court related matters) (e.g. testifying in court under subpoena, participating in a deposition, preparing for court services, consulting with my personal attorney due to being compelled to be involved in court-related matters)	
<u>Fee per hour: \$350.00</u>	

\*\* Please note that your fee may differ slightly from those listed for evaluation, therapy or testing services if you are a client with one of the insurance companies Dr. Terry contracts with.

**LATE CANCELLATIONS OR MISSED APPOINTMENTS:** If you are unable to keep an appointment kindly give us 24 hours notice, otherwise a charge of \$65.00 will be due. Insurance will not pay this fee. The client or their guardian is responsible for the payment of this fee.

Unless other arrangements are made beforehand, services will be discontinued for missing payments with no notice or for no payment on 2 consecutive sessions. Finance charges are also added if you do not make a payment within 30 days. Late charges are computed at 1.5% monthly (18% annually) for any balance over 30 days old. Final payment is expected on behalf of the client before reports, including psychological evaluations, are released. Accounts that are over 90 days past due are turned over to a collection agency.

A \$25.00 charge is added for any returned checks.

**Practice Statement:** My office is located in the Aurora Professional Center, a building with several other mental health professionals. This group is an association of independently practicing professionals, which shares certain expenses and administrative functions. While the members share office space and expenses, I want you to know that my practice is completely independent in providing you with clinical services and I am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission or in the case of emergency coverage during my absence which you request. You should be aware that I employ office staff to assist me with running my practice and I also contract with a billing service to provide billing services. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling and billing. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member. I may occasionally find it helpful to consult other health and mental health professionals about a case in order to provide optimal care to my patients. During such consultations, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't

object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your clinical record.

**Breach Notification Addendum to Policies and Procedures: As Required under the 9/2013 Privacy Rule of HIPAA, I must notify you of the following Breach Notification Policy. A "breach" is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule.**

1. When the Practice becomes aware of or suspects a breach in your PHI, the Practice will conduct a Risk Assessment and will keep a written record of that Risk Assessment. This will include reviewing the nature and extent of the PHI involved, to whom the PHI may have been disclosed, whether the PHI was actually acquired or viewed, and the extent to which the risk to the PHI has been mitigated.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the practice will give notice of the breach as described in the breach notification overview in my Privacy Notice.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

Your signature on this form indicates that you have read the information in this agreement and agree to its terms. This also serves as an acknowledgement that you have reviewed the HIPAA Privacy Notice form described herein. If you are the guardian of a minor child who is the patient, you are giving legal consent for services for that minor and attest that you have the legal authorization to give consent for the clinical evaluation or treatment for that child.

X  
\_\_\_\_\_  
Signature of Adult Patient/Guardian      Print Name of Adult Patient/Guardian      Date

\_\_\_\_\_  
Print Name of Minor of Patient  
if Patient is a Child      Date of Birth of Child: \_\_\_\_\_

I also give permission for Dr. Terry, her staff, or her medical billing company to release medical information to my or my child's (if the patient is a child), insurance company or a managed care company contracted by the insurance company to manage my or my child's medical care if necessary in order for the insurance company to pay their portion of services provided at this office. I further agree to pay for anything that the insurance will not pay for.

\_\_\_\_\_  
Signature of Adult Patient/Guardian      Print Name of Adult Patient/Guardian      Date

If you have any questions about your privacy rights or this business policy and agreement, please direct them to Dr. Carol Terry at 1006 24th<sup>h</sup> Ave, NW, Suite 100, Norman, OK 73069. 405-321-0303.