Victoria Anderson, Ph.D. ◇ LICENSED PSYCHOLOGIST

INFORMATION for PATIENTS

Dear New Patient:

Please read all of the following information. It gives helpful explanations about therapy, laws, policies, etc.

About Therapy: In general, counseling is a process to assist people with problems in their individual, family, or interpersonal living. Such problems have often been building up for some time. When entering therapy it is helpful to realize that close personal examination of feelings and relationships may be emotionally difficult.

Therapy, like all learning, takes some time. You will need to test and practice what you are learning in therapy. There will be ups and downs but I will do everything I can to help you continue progressing toward your goals. Please share with me any concerns or questions that may develop during therapy, no matter what they are. Even if they are painful they may be related to the issues you need to deal with. Attending sessions consistently will make therapy more effective than a hit and miss approach. While most people benefit from psychotherapy there is no guarantee that you, or your family member, will be helped. Your openness and commitment will be major factors.

About Your Therapist: I am a licensed psychologist. I hold a doctoral degree in counseling psychology from Brigham Young University. In addition to this therapy office I also work in another state as a psychologist. I am the mother of one son and one daughter and I enjoy travel, outdoor activities, kayaking, and gardening.

About Confidentiality: You should know that whatever you say in counseling or whatever information you provide will be kept confidential, with the following exceptions.

1. When you wish to have information released to another agency, hospital, school, or other qualified persons. In such a case you will need to sign a legal release.
2. When a proper court order requesting information is made.
3. When it appears that you may be a danger to yourself or others, or you give information that another person is in the same situation.
4. When information is obtained suggesting child abuse or neglect. I am required by Utah law to report such information to Child Protective Services or the police.
5. In the case of minors where information is gained which parents have a clear need to know. However, to maintain therapeutic rapport and progress with minors, I will use discretion in sharing information.

Confidentiality, privacy, and privilege, are ethical and legal concepts governed by professional ethical guidelines and specific state and federal laws such as the HIPAA Privacy Rule. Copies of federal HIPAA policies are available.

About Fees & Insurance: The fee for my services is $140 per 40 minute session and $170 per 55 minute session for outpatient individual or family therapy. *I may have a contract with your specific insurance company for a different rate and if so that rate may apply.* If you do not have medical insurance please talk to me about a cash fee. Psychological evaluations and testing are also billed at a rate of $150 per hour of testing, scoring, writing and reporting. Outside the office services (home, hospital, court appearances, etc.) are billed at $150 per hour including travel time. Where possible I will take telephone calls outside the office if there is an emergency or pressing issue. I do not charge for brief phone consultations but calls of more than 10 minutes will be charged at $40 per 15 minutes.

Many health insurance plans include mental health benefits. We are happy to provide the service of billing your insurance company. However, health insurance is a contract between you and the insurance company and you are ultimately responsible for any charges you incur. A charge of $70 will made for appointments not cancelled at least 24 hours in advance. You will be responsible for the full no-show fee, as this charge may not be billed to your insurance company. The billing for my services may be assigned to Alpine Counseling Center or other billing and collection services.

A Final Note: Again, please share with me any concerns you have at any time during your therapy. Thank you for your trust. I look forward to working with you.

Please read both sides of this document, then sign it to verify that you have read it in its entirety and agree to the conditions outlined. You will be provided a copy if you desire.

Patient Information

Full Patient Name _____ Age _____ Gender M ☐ F ☐

Primary Contact Phone _____ ☐Home ☐Cell ☐Work Date of Birth_____

Secondary Contact Phone _____ ☐Home ☐Cell ☐Work Email_____

What method do you prefer our office use to make appointment reminders? (We do not guarantee a reminder will be made.)
☐ Primary ☐ Secondary

Mailing Address _____
Street City State Zip

Parent Name(s) (for minors) _____

In case of emergency, who should we contact?

Name _____ Phone _____ Relationship _____

Primary Care Physician: Name _____ City _____

Insurance Information

You may provide a copy of your insurance card and skip this section if you prefer. If your insurance requires pre-authorization, please provide the authorization number here: _____ *# of Sessions* _____

Primary Insurance Company _____ Policy # _____ Group # _____

Address _____ Phone _____
Street City State Zip

Subscriber Name_____ Subscriber Date of Birth _____

Secondary Insurance Company _____ Policy # _____ Group # _____

Address _____ Phone _____
Street City State Zip

Subscriber Name_____ Subscriber Date of Birth _____

Professional Services Agreement

Consent: By signing this form you consent to treatment and to the policies and procedures listed on both sides of this form. You acknowledge that emergency services may not be available at all times and that Dr. Anderson is not responsible for your actions.

Agreement to Pay: By signing this form you acknowledge that this is a contract that you are undertaking and that you will be responsible for all charges as noted herein, including the prior page. If your insurance company makes any payments, these will be credited to your account. You further agree to make, at the time of your appointment, any co-payment required by your insurance. A $10.00 service fee will be made for sessions where a co-payment is not made. You agree to provide my office with valid contact information until such time as your account is paid in full. If your account is not paid as agreed or becomes delinquent past 90 days, you agree to pay a collection fee of 33% of your unpaid balance in addition to the account balance. In the event that it is necessary to commence legal action to collect your bill, you agree to pay reasonable attorney's fees and court costs.

Consumer Rights & Privacy: Dr. Anderson subscribes to all current legal requirements and ethical guidelines for a psychological practice as outlined here and as contained in the Alpine Counseling Center Privacy Practices and Consumer Rights Policies and Procedures. By signing here you acknowledge that you have read this form and received a copy of the ACC privacy practices.

Reviewed and agreed: _____ _____
Signature Date