Coastal Bend Psychological Associates

R.C. Cramer, Psy. D, BCBA-D, LPC-S

4639 Corona Drive, Suite #34

Office (361)442-4024   FAX (361)853-7877

www.cb-ba.com

Client Information Form

Last Name____________________________ First Name __________________________MI_____

Address____

City__________________________________State______________________Zipcode__________

Phone Numbers:

Home______________________Work______________________Mobile______________________

Date of Birth ________________________________Referred By___________________________

Initial Appointment Date_______________________

Email address____

I understand that I am responsible for the payment of this bill, and that all fees, including COPAYS are due and payable at the time of the appointment. All appointments MUST be cancelled at least 24 hours in advance, or I will be charged for that appointment. I will be responsible for payment of missed visits as insurance does NOT pay for missed appointments or late cancellations. This office reserves the right to turn over unpaid accounts to its collection agency, and I will be responsible for the payment of any fees associated with the collection of a delinquent account.

I authorize the release of any medical or other information necessary to process the insurance claim. I authorize payment of medical benefits to the physician or supplier listed on my insurance claim form for the services listed on that form. I also request payment of government benefits to the party who accepts assignment on claim form.

____

(signature of client, or, if client is under 18 yrs. of age, signature of client's parent/guardian)

____   ____________________________

(printed name)   (Date)

Patient/Child Name:___________________________Therapist:_________________________________

Confidentiality Statement

Coastal Bend Psychological Associates

Welcome to Coastal Bend Psychological Associates. Entering into a therapeutic relationship is unique and is guided by professional governing ethical standards that we feel are important to share with you at this time.

Confidentiality: The therapeutic relationship is a privileged relationship and the content of all discussions, testing, notes and evaluations are protected. This information can only be released by your signed consent. In addition, written permission by all participating parties must be granted in order for recording devices to be utilized during counseling sessions.

Exceptions to Confidentiality: While the therapeutic relationship is confidential, the professional standards require these exceptions:

A) When physical harm is threatened against another person,
B) When physical harm is threatened against one's self
C) When physical abuse or neglect is directed at a child or adult.
D) When records are subpoenaed by a local, state or federal court.

Safety Policy: The use and/or possession of drugs, alcohol, firearms and weapons of any kind are strictly prohibited on any location where therapy sessions are being conducted through Coastal Bend Psychological Associates.

I have read, understand and agree to the policies of Coastal Bend Psychological Associates provided in this document as they relate to confidentiality, exceptions to confidentiality, fees, cancellation and safety policies

Client Signature______________________________________ Date________________________

(Client or Parent/Guardian if minor/Personal Representative)

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AUTHORIZATION OF DISCLOSURE

RELEASE OF INFORMATION &GENERAL CONSENT

Client Name_____________________________________ Date of Birth__________________

AUTHORIZE THE RELEASE, DISCLOSURE AND DISCUSSION OF INFORMATION

BETWEEN THE FOLLOWING TWO PARTIES:

(1.) COASTAL BEND PSYCHOLOGICAL ASSOCIATES & R.C. CRAMER, PSY.D, BCBA-D

(2.) ____

THIS AUTHORIZATION IS RELEVANT FOR THE FOLLOWING INFORMATION

☐ DIAGNOSTIC EVALUATION &ASSESSMENT, HISTORY & PHYSICAL, DIAGNOSIS, MEDICATION HISTORY

☐ARD NOTES, PSYCHOEDUCATIONAL/PSYCHOLGICAL TESTING & EVALUATION, IEP, BEHAVIORAL CONCERNS, MODIFICATION IMPACT, GRADES, SPECIAL EDUCATIONAL RECORDS

☐CPS CASE FILES, RECORDS OF REMOVAL, INFO ON CURRENT GUARDIAN

☐OTHER____

ADDITIONALLY, I WOULD AUTHORIZE COASTAL BEND PSYCHOLGOICAL ASSOCIATES TO MEET WITH AND/OR PROVIDE COUNSELING SERVICES TO MY CHILD (____) WHILE AT: ______________________(SCHOOL). INTIAL OF PARENT/GUARDIAN_____________

THE CONSENT TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME EXCEPT TO THE EXTEND THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON.

SIGNATURE OF CLIENT___________________________________DATE_______________

SIGNATURE OF PARENT__________________________________DATE_________________

WITNESS____DATE_________________

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Patient Name: ______________________________________

Date of Birth______________________________

Due to high volume of patients needing our specialized services, our clinic has established the following guidelines regarding cancellation, no shows or late arrivals.

The policy is as follows:

Cancellations & No Shows

1. Please notify Costal Bend Psychological Associates (361) 442-4024 of cancellations at least 24 hours before scheduled appointment time. This allows the office to schedule another patient in need of an appointment.
2. Appointments not cancelled within 24 hours or failure to show up for a scheduled appointment will be considered a "**no show**".
3. Patients with **Three**(3) "**no show**" appointments within a 12 month period are subject to be dismissed from the practice.
4. **Two** (2) "**no show**" appointments for Initial Evaluations will result in the dismissal of the patient's referral.

Late Arrivals

1. Patients who arrive 10 minutes after their scheduled appointment time will be considered late. At the discretion of the provider patients may be seen with a reduced visit time or have to reschedule their appointment.

Thank you in advance and we appreciate your cooperation!

I understand the above statements.

Signature ____ **Date**______________________________