TRIANGLE AREA PSYCHOLOGY CLINIC

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Background Information & History

Welcome! Please complete the following information. All responses should pertain to the adult patient to be treated.

Patient's Name_____ Date _____

Person completing this form _____

Patient Demographic Information:

Permanent Address: _____
City _____State _____ Zip _____

Temporary Address (for college students or others temporarily in the area)
Street Address: _____
City _____State _____ Zip _____

Primary Phone Number: _____

Additional Phone Number: _____ Email: _____

Age _____ Date of Birth _____ /_____ /_____

Gender: Male _____ Female _____ Non-binary_____ Prefer not to respond_____

Prefer to self-describe _____

How did you hear about the TAP Clinic? _____

Emergency Contact Information

Contact Name: _____ Phone number: _____

Relationship to Patient: _____

Patient Background Information
Current Relationship Status:
___Single
___Married / permanent partner (how long? _____)
___Separated (how long? _____)
___Divorced (how long? _____)
___Widowed (how long? _____)

Who lives in the home with patient?

_____

_____

Does patient have children? Yes_____ No _____
If yes, what are their ages? _____

Patient Employment/Educational Status:
___Employed, full-time ___Employed, part-time ___Self-Employed ___ Retired
___Student ___Homemaker ___Unemployed

Has the patient ever been hospitalized for mental health concerns and/or required emergency psychiatric services (e.g., ER visit, mobile crisis unit, suicide hotlines)? ___Yes ___ No

If yes, please describe further:

Type of service (e.g, ER)	Date(s) of Service	Presenting problem (e.g., suicidality)

Has the patient received previous non-emergency mental health treatment? (e.g. therapy or psychiatric services) ___Yes ___ No
If yes, please describe further:

Type of service (e.g., outpatient)	Date(s) of service	Presenting problem (e.g., depression)

Are you aware of any mental health diagnoses that the patient has received? If so, what are they?

_____

_____

Will patient be needing invoices to submit to insurance for any out of network benefits?
___Yes ___No Name of Insurance _____

Does the patient have Medicare or Medicaid as a primary or secondary insurance?
___Yes ___No

Is the patient currently prescribed any medication?
___Yes ___No
If yes, please list the current medications (psychiatric and other):

Medication name and dosage	Prescriber name	Reason prescribed	Date prescribed

What would you/the patient like to work on in treatment?

_____

_____

_____

Please check any of the following areas that you would like to focus on in treatment:

_____ Depression
_____ Anxiety
_____ Panic attacks
_____ Eating or body image concerns
_____ Substance use
_____ Self-esteem/self-worth
_____ Schoolwork/employment difficulties
_____ Relationship difficulties
_____ Trauma
_____ Anger management
_____ Emotion regulation difficulties
_____ Parenting difficulties

Does the patient have any current or past legal difficulties or pending court cases (including custody/divorce proceedings, immigration proceedings, criminal or civil litigation)? _____Yes _____No

Please describe:_____

_____

_____

_____

_____

Please read the checklist and *check whether you/the patient are currently, in your history, or have never experienced* these symptoms/behaviors. For any item that you/the patient are currently experiencing or have experienced in the past, please provide additional detail in the space below.

Do you/the patient have the following symptoms, behaviors, or experiences?	**Yes, at present**	**In the past only**	**Never**
Suicidal thoughts, urges, or behaviors			
Self-harm or self-injury (e.g., cutting or burning)			
Aggression towards others (includes physical aggression, throwing objects, or threatening physical harm)			
Hearing, seeing, smelling, tasting, or feeling things that others do not seem to experience			
Substance use (e.g., alcohol, marijuana, cocaine) or misuse of prescription medication (e.g., Xanax) to the point that your use required treatment, was concerning to others, or concerned you			

Please provide any additional detail below:

_____

_____

_____

_____

OUTPATIENT SERVICES CONTRACT FOR PRACTICUM STUDENT THERAPISTS

Welcome to The Triangle Area Psychology Clinic! This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so you can discuss them with your therapist. Your signature at the end of this document signifies an agreement between you, your therapist, and the TAP Clinic.

SUPERVISION AND TRAINING

You are being offered services that will be provided by a graduate student therapist who is under the direct supervision of a Licensed Psychologist at the TAP Clinic. Student therapists at The TAP Clinic are supervised individually on a weekly and as-needed basis by their supervisor. Practicum students in the DBT Practicum also take part in our DBT Consultation Team meeting, in which they receive consultation from approximately 5 licensed clinical psychologists (names of other therapists are available on request). If you ever have questions or concerns about your therapist or your therapy that you would like to address, please contact your therapist's supervisor.

One of the main purposes of supervision and training is to assist our therapists in providing the best possible services to their clients. As such, it is standard procedure for sessions to be audio or videotaped for supervision and educational purposes. A separate audio/video consent form will be provided.

We offer a sliding fee scale for patients seen as part of our training clinic. Your therapist will review the sliding scale with you to determine your fee. Please note that this fee is generally not reimbursable by your insurance company, as most insurances will not reimburse for services provided by a trainee. Upon request, we will provide you with forms that you can submit to your insurance company; however, you should call your insurance company in advance to find out if they will reimburse for these services.

PSYCHOLOGICAL SERVICES

The TAP Clinic offers a range of psychotherapy services for adolescents and adults. The psychotherapy that you receive will consist of meeting with a provider who will assist you in setting and working towards goals for desirable changes.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress; however, there are no guarantees as to what you will experience.

In your first few sessions, your therapist will evaluate your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what your work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with the therapist. At the end of the evaluation, your therapist will notify you if s/he believes that s/he is not the right therapist for you and, if so, s/he will give you referrals to other practitioners whom we believe are better suited to help you. **Please be aware that an intake is not considered an agreement for treatment.**

MEETINGS

We typically conduct evaluations that last from 2 to 4 sessions. During this time, you and your therapist can decide if there is a good fit between you. If you and your therapist agree to begin psychotherapy, individual sessions will generally occur once per week for 50 minutes or on a schedule mutually agreeable to you and your clinician. Every effort will be made to begin and end sessions on time. If your clinician is

late beginning a session, then when possible, the session will be extended to allow for the full session time. If a client is late for a session, then the session will usually have to end on time.

PROFESSIONAL FEES

Our hourly fees for practicum students are outlined in the attached Sliding Fee Schedule. If you and your therapist meet for more than the usual time, or if your case requires more out of session contact or case management than is typical, you may be charged accordingly. Examples of this type of service include report writing, telephone conversations (with you or with other people or professionals associated with your case) lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request. You will not be charged for any supervision that is provided for your case. If you become involved in legal proceedings that require your therapist's supervisor's participation, you will be expected to pay for any professional time the supervisor spends on your legal matter, even if the request comes from another party. In addition, if you elect to transfer services to a licensed TAP provider, your fee will be set based on the fee schedule for licensed TAP clinicians (see attached Fee Schedule for licensed TAP clinicians).

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless you and your therapist agree otherwise. Payment schedules for other professional services (e.g., report writing) will be agreed to when such services are requested. We accept cash, check, and credit cards. Checks are made payable to TAP Clinic, PLLC. Credit card processing is handled by Square, Inc. If for any reason an account balance has been accrued, the balance is due within 10 days of the statement/invoice date. If for some reason payment is not received for as many as two sessions, then further services will be discontinued until all unpaid charges are paid; however, in the case of an emergency, we will make the necessary exceptions.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

LATE CANCELLATIONS AND MISSED SESSION POLICY

Cancellation/rescheduling of appointments must be done **24 business hours** in advance or the fee will be charged for the session. Please note that sessions scheduled on Mondays require cancellation on or before the previous Friday in order to comply with the 24 business hour policy. Cancellations can be made via phone call, voice mail, or email correspondence; however, you should not consider your session cancelled until you have received confirmation from your therapist that s/he has received your message. Note that insurance cannot be billed for a missed or late appointment, so you will be responsible for the entire charge of the reserved time.

INSURANCE REIMBURSEMENT

All TAP Clinic providers are out of network for all insurance policies. In addition, insurance companies do not typically reimburse for services provided by a trainee. To set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. You (not your insurance company) are responsible for full payment of our fees, and you are responsible for finding out exactly what mental health services your insurance policy covers. You should call your insurance company before beginning treatment to determine whether you will receive insurance benefits for services

provided by a trainee. *Please note that Dr. Ritschel cannot see or supervise cases for patients who have Medicare as primary or secondary insurance. Patients who see Dr. Ritschel or one of her supervisees are also not able to submit invoices to Medicare for reimbursement.*

Please note that insurance companies do not always reimburse for multiple sessions on the same day (e.g., if you attend an individual and a group therapy session), so please be sure to ask your insurance company about this when you verify your benefits. You should also be aware that most insurance companies require that you provide them with your clinical diagnosis. Sometimes we have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. Your signature on this document authorizes the TAP Clinic to speak with your insurance company if needed and to release such information as requested. We will do our best to keep that information limited to the minimum necessary.

RECORDING

Your sessions will not be audio or videotaped without your prior written consent. Similarly, we expect that clients will not record sessions conducted at the TAP Clinic without the consent of the therapist, and that you will not take photos or video of other clients or staff members without consent. Violations of this policy may be grounds for termination of treatment.

CONFIDENTIALITY [for adult patients; please see addendum for minor patients]

In general, the privacy of all communications between a patient and a psychologist is protected by law, and we can only release information about our work to others with your written permission; however, there are a few exceptions.

In most legal proceedings, you have the right to prevent your therapist from providing any information about your treatment; however, in some legal proceedings, a judge may order a therapist's testimony if s/he determines that the issues demand it, and we must comply with that court order.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if your therapist believes that a child or elderly person is being abused or has been abused, we may be required to make a report to the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, your therapist will make reasonable efforts to fully discuss it with you before taking any action.

Your therapist may occasionally find it helpful to consult other professionals about a case. TAP clinicians regularly meet for the purpose of case consultation with the goal of providing wraparound care. Consultation with relevant experts is considered an integral part of excellent clinical care and helps ensure that you are receiving the best possible treatment. During a consultation, the consultant is legally bound to keep the information confidential. Ordinarily, your therapist will not tell you about these consultations unless s/he believes that it is important to your work together. Your signature on this document allows TAP Clinic therapists to communicate with each other without additional consent from you.

If you are entering our DBT program, confidential information is shared among the DBT Team for the purpose of adherent treatment and coordination of care. The DBT consultation team is a mandatory component to comprehensive DBT programs; as such, all TAP Clinic DBT therapists participate on our DBT team. At times, DBT therapists from practices outside of the TAP Clinic may be on our consultation team, and you are welcome to request a current list of DBT team members at any time. Your signature on this document provides consent for your DBT therapist to discuss your care on team without having to obtain a release of information from you.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that you discuss any questions or concerns that you may have with your therapist. However, if you need specific clarification or advice that we are unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex.

ASSESSMENTS

As a standard part of our practice, we gather electronic assessment measures to evaluate symptoms and behaviors. We utilize a HIPAA-compliant, encrypted, online platform called Psych Surveys, which administers, scores, and graphs assessment data. Please indicate how you would prefer to complete these assessments (note: if you elect to receive an email about this, please be sure to indicate your consent to be contacted by email on the Communications Consent document later in this packet):

_____ Send me an email; I'll go to the website to complete the measures

_____ Send me an email; I'll download the Psych Surveys app and complete the measures on my smart phone

_____ I'll come to the clinic and complete the measures before or after my session on a TAP tablet

_____ I'd prefer to complete measures on paper

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) and the Notice of Privacy Practices is a federal law that provides additional privacy protection and explains your rights regarding the release of any Protected Health Information (PHI). The law requires your signature stating you have read or have been offered a copy of The TAP Clinic's Privacy Practices Agreement. You may request a Notice of Privacy Practices from the office at any time, and a copy is available on our website.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Patient printed name _____ Date _____

Patient signature_____ Date _____

Method of Communications Information and Consent

As there are now many means by which clinicians, staff, and clients can communicate, we would like to go over policies for each method of communication and get your consent for each form of communication.

Phone and Voicemail:

____ I consent to communication by phone, including leaving detailed voicemails on these numbers. My preferred telephone number for TAP clinic contact is: _____
Type (e.g., home, cell, work): _____

The TAP Clinic may also use the following number(s) as back-up methods of communication *and may leave detailed voicemail messages on any of these lines*:

Phone number: _____ Type (e.g., home, cell, work): _____
Phone number: _____ Type (e.g., home, cell, work): _____

Email and Text Messages:

We realize that email and text communication have become easy, efficient ways to communicate. However, there are inherent risks associated with email and texting and we would like to make sure that you are aware of these risks. Please review the risks and considerations, and then indicate your consent by signing below.

Email address: _____

Risks and Considerations for Email and Text Communication:

We use email communication and text messaging only with your permission and only for administrative purposes unless you have made another agreement with your therapist. That means that email exchanges and text messages with our office should be limited to things like setting and changing appointments, billing matters, and other related issues. Please do not email your therapist about clinical matters, because email is not a secure method of communication. If you need to discuss a clinical matter with your therapist, please make arrangements either to discuss the matter by phone or during your next therapy session.

There are risks associated with e-mail and text messaging as outlined below. Please be aware of the following:

- E-mail and text messaging are not completely confidential, including but not limited to the following:
  - E-mails and text messages are retained in the logs of the e-mail/phone/internet service provider. Although under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers.
  - Copies of e-mails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
  - E-mails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Emails and text messaging are subject to human error by TAP clinic employees or external third parties, which may include, but are not limited to:
  - E-mail and text senders can misaddress an e-mail or text.
  - E-mail and text senders may unintentionally send or attach private or confidential information to an undesired recipient.

Conditions for the use of email and texts with TAP clinicians:

- Clinicians cannot guarantee but will use reasonable means to maintain the security and confidentiality of e-mail and text information sent and received. This includes but is not limited to a passcode lock on phones and password-protected computers.
- E-mail and texting are not appropriate for urgent or emergency situations. Your clinician cannot guarantee that any particular e-mail and/or text will be read and responded to within any particular period of time.
- E-mail and texts should be concise. Unless you and your clinician have agreed to a specific exception, sensitive or complex situations should be discussed in a phone call or during a scheduled appointment, not via e-mail or text.
- If texts or e-mails contain information relevant to your treatment, they may be retained in your medical record, or a summary of the content may be included in a clinical note in your record.
- If you choose to use e-mail or text messaging, you agree that your clinician may reply to your email and text messages, and that your clinician may include any information that they deem appropriate, including information that would otherwise be considered confidential.
- You agree that if you do not receive a timely response from an e-mail or text message to your clinician, that you will follow up with a phone call to them or contact emergency services.
- If you choose to use e-mail or text messaging, you agree not to hold the TAP Clinic or your clinician liable for improper disclosure of confidential information that is caused by you, a third party, or TAP clinician error.

By signing here, I agree that I have read and understood the telephone, email, and text messaging policy and risks.

Print client name: _____ Date: _____

Client signature:_____ Date:_____

For clients under age 18:
Print parent/guardian name: _____ Date: _____

Parent/guardian signature:_____ Date:_____

Specific options for email and text communication should be selected on the next page.

Please choose one option for **email consent**:

____ I **decline** to be contacted by members of the TAP Clinic by email for any reason. I understand that if I email the clinic, providers will be unable to respond to me other than to say that there is no consent on file. Until the Clinic is in possession of a signed consent to return my email, my questions and or concerns will not be addressed via email.

____ I **consent** to unrestricted email contact. I agree that the TAP Clinic can communicate with me via email regarding session times, scheduling concerns, assessment measures, and that clinicians may respond to emails in ways that may include protected health information. I also understand that my provider(s) may decline to respond to my email requests if the provider deems that the content requested is not appropriate for email and requires a phone call or session to address concerns. In addition, I understand that **highly confidential or private information (e.g., insurance invoicing, treatment summaries, etc.) will not be sent over email** unless there are truly exceptional circumstances.

Please choose one option for **text messaging consent**:
____ I **decline** contact by text message. I agree not to contact providers by text and understand that my provider will not respond to or initiate texts regarding my care.

____ (For non-DBT clients) I **consent to limited** text messaging, restricted to basic scheduling, rescheduling, or alerting my provider that I am running late. I agree that neither my provider nor I will communicate by text on more complicated matters, such as symptom assessment, treatment recommendations, or questions that require more than a quick, concise response.

____ (For DBT Clients only) I agree to abide by the phone coaching agreement with respect to my texting behavior.

CONSENT TO AUDIO OR VIDEOTAPE

Video and/or audio tapes are valuable tools that are sometimes used at the TAP Clinic as aids in the therapy of clients and effective training of therapists. Therapists may use session tapes to review session content or as a way to get consultation from other therapists. In addition, therapists who are on the DBT team at the TAP Clinic may use session tapes as a way to work toward adherence to the DBT treatment model. Session tapes are also required by the DBT-L Certification Board for those therapists who are applying for DBT Certification. This process is considered very important to the training and certification of DBT practitioners and is intended to improve quality of client care. Regardless of whether you are a DBT client or not, the taping of sessions is focused on the clinician and their efficacy or as a tool to aid in the assessment and treatment of the client. It is important for you to understand the purpose and use of these recordings and to obtain your written consent to use these electronic sources.

I understand that session recordings may be used for one or more of the following purposes:
- The recordings may be used by my therapist for purposes of evaluation of my treatment and my therapist's delivery of treatment offered at the TAP Clinic.
- The recordings may be used for purposes of education of or consultation with other professional staff within the TAP Clinic.

Any session recordings for the following purposes will require an *additional* release form and signature:
- Recordings used for purposes of obtaining consultation from experts outside of the TAP Clinic.
- Recordings used for purposes of education of professional persons outside the TAP Clinic.
- Recordings of treatment sessions sent to the DBT-L Certification Board for review to determine eligibility for DBT Certification (i.e., if therapist is applying for certification).

I understand that this consent is good for the duration of my treatment at the TAP Clinic unless other agreements have been made, or until such time that it is revoked by me. I understand that I may revoke this authorization at any time by written notification to the TAP Clinic, and I retain my right to have any recording electronically erased in my presence. I understand that material discussed in this audio/video tape will be treated as confidential by those viewing the session and that the tapes will be kept in a secured, locked place.

Unless I am seeing a practicum student or postdoctoral fellow, I am aware that I may elect not to participate in session taping and that if I choose not to participate, doing so would not adversely affect my treatment at the TAP Clinic. **However, services provided by unlicensed individuals practicing under a supervisor are expected to be taped in order for the supervisor to provide the best possible supervision.**

_____ _____
Print Name of Client Date

_____ _____
Signature: Client Date

Authorization to Release and/or Obtain Information

From: The TAP Clinic, PLLC (includes all TAP Clinic employees and practicum students)

To: _____
Person/Entity
_____
Contact information

To: _____
Person/Entity
_____
Contact information

To: _____
Person/Entity
_____
Contact information

Concerning:
Client: _____
Date of birth: _____

Information to be disclosed: _____
_____

I hereby authorize The TAP Clinic to obtain the information described above regarding myself or my dependent. In addition, I authorize the above named to release the above information regarding myself or my dependent to the TAP Clinic. This release is limited to the parties noted in this document and is authorized within the constraints of confidentiality applicable to all parties.

This authorization is valid for the duration of my treatment at the TAP Clinic and is subject to revocation, in writing, at any time.

Printed name of Client/Guardian_____ Date _____

Signature of Client/Guardian _____ Date _____

Sliding Fee Scale Guidelines and Fee Schedule

The TAP Clinic offers a psychology practicum training opportunity for outstanding doctoral candidates in the Child Clinical Psychology program at UNC Chapel Hill. Practicum students are supervised weekly by licensed psychologists at the TAP Clinic, and they attend the weekly consultation team meeting if they are in the DBT rotation. All individual sessions conducted by practicum students are billed on a sliding scale as outlined below. Please let your therapist know your annual income, which will determine your session rate. Note that sessions conducted by trainees may not be reimbursed by your insurance provider.

Printed Name: _____ Date: _____
Client Signature: _____

Initial Assessment/90 minute appointments	
Income	**Fee**
$0-$40,000	$45.00
$40,001-$50,000	$60.00
$50,001-$60,000	$75.00
$60,001-$70,000	$90.00
$70,001-$80,000	$105.00
Above $80,000	$120.00

Individual Therapy/50 minute appointments	
Income	**Fee**
$0-$40,000	$30.00
$40,001-$50,000	$40.00
$50,001-$60,000	$50.00
$60,001-$70,000	$60.00
$70,001-$80,000	$70.00
Above $80,000	$80.00

****Please note that the group therapy rate is only available when we are offering a sliding scale group****

Group Therapy/90 minute appointments	
Income	**Fee**
$0-$40,000	$25.00
$40,001-$50,000	$30.00
$50,001-$60,000	$35.00
$60,001-$70,000	$40.00
$70,001-$80,000	$45.00
Above $80,000	$50.00

Debit / Credit Card Information

As a courtesy, we are able to place your credit or debit card on file to process session fees. Credit cards are processed and stored through Square, Inc., which is HIPAA compliant and password protected. If you do *not* want your credit card information stored in Square, please notify your therapist. Square requires that you provide a valid email address in order for us to create your account. Once your account is created, we will delete your address from your Square file with us, and thus you will *not* receive an emailed receipt when we run transactions. The TAP Clinic is happy to provide you with an invoice of services on request.

Please read the information below, fill out the necessary information, and sign at the bottom of this page if you agree to the credit and debit card policy listed below.

Your debit or credit card can be billed for the following purposes:

1. Full payment of attended session(s) for myself or for a family member.

2. Full payment of late cancellations (less than 24 business hours) or missed sessions.

3. Full payment for group session(s) that are billed by the month (i.e., adult DBT groups).

Card Information

- Card #: _____
- Expiration Date: _____
- Security Code: _____
- Full name on Card: _____
- Billing Zip Code: _____
- Email address for Square account:_____

I have read the above information in its entirety and acknowledge my understanding of the content. I authorize The TAP Clinic to bill my card for the reasons listed above.

Printed name: _____Date: _____

Signature:_____