Christy M. Stammen, Ph.D.
1700 Alma Drive, Suite 205
Plano, TX 75075
(972)-509-2611 X3

OFFICE POLICIES INFORMATION SHEET

Welcome to the psychology offices of Christy M. Stammen, Ph.D. This office offers a variety of individual, marital/relationship, and family psychotherapies for adults as well as for children and teens. In response to frequently asked questions and to insure your understanding of our office policies, we ask that you read the following information and sign your name to indicate your understanding. Should you have any questions, please feel free to ask your doctor.

1. Therapy sessions begin by appointment and are 45-50 minutes in length. The time and length of evaluation sessions are arranged on an individual basis.

2. The fee for the initial therapy session is $200. Subsequent therapy sessions are $175. Evaluation fees are determined on an individual basis. Special fee schedules apply if you are part of a PPO or other managed health care group.

3. Full payment for each session is requested at the time services are rendered unless prior arrangements have been made. Pre-payments are accepted. A $35 fee will be charged for any returned checks.

4. Your session time is reserved for you. If you are unable to be there for your appointment, you are asked to notify our office at least 24 hours in advance so that someone else may utilize this time (you may notify us by email or phone). In the absence of your notification, you will be billed for the missed session. Insurance is not responsible for this bill, so you will be billed for the full fee amount. Further, if you miss a session and do not call to reschedule, we will assume that you have terminated therapy.

5. If you are filing your own insurance and would like a receipt for payment, please let us know. We can also provide end of year statements.

6. No outstanding fees of over $290 for which arrangements for payment have not been made will be allowed. You are responsible for payment. If your financial status prohibits further treatment with us, we will be happy to refer you to alternate agencies.

7. All delinquent accounts for which full payment has not been received (nor alternate arrangements for payments have been made) may be turned over to a collection agency. Persons who fall into this category will be responsible to pay all costs incurred in the collection process.

8. The benefits obtained from psychological services are dependent on many factors, and no guarantees regarding the effectiveness or outcome of these services are offered. The therapeutic process involves both the commitments of you as the patient and your doctor.

9. Psychological services are confidential in most circumstances. Please be aware, however, that you or your family records are NOT confidential in the following circumstances: child custody disputes, civil law suits where psychological functioning is part of the claim, criminal lawsuits where records are subpoenaed, situations where child or elderly safety is of concern, or an impending act is planned by you or a family member that could cause harm to persons known or unknown. If insurance is paying some of all of your bill, be aware that your diagnosis, dates of service, and other information will be provided to the insurance company to secure payment if you authorize us to do so. Please ask your doctor any questions you might have about this information.

10. All patients give consent for the psychologists and staff in this office to consult with each other as needed to provide the best possible services. In an emergency, the psychologists and staff in this office have permission to contact you as needed.

    I have read, understand, and agree to abide by the above Office Policies Information Sheet. I have received a copy of the Texas Notice Form.

_____ _____

Signature Date

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CLIENT INFORMATION

Name_____ Preferred Name_____
Date of Birth_____Age_____ Preferred Pronoun_____
Home Address_____ Employer_____
City_____State_____Zip_____ Office Address_____
Cell Phone _____ City_____State_____Zip_____
Other Phone _____ Business Phone _____
Number you prefer to be reached at?_____
Can we leave you a message at this number?_____
Can we contact you by e-mail?_____ If yes, e-mail address:_____
*if you choose to communicate by e-mail, please read and sign addendum page titled "e-mail notice"

Family Physician_____ Phone_____

Emergency Contact_____ Relationship to Client_____
Phone _____

Who is financially responsible for services?_____
Relationship to Client_____ Employer_____
Address_____ Business Address_____
City_____State_____Zip_____ City_____State_____Zip_____
Cell Phone _____ Business Phone _____
Date of Birth_____Age_____

If we are filing insurance for you, please complete and sign the following:

Health Insurance Company Name_____
Claims Address_____
City_____State_____Zip_____
Subscriber ID#_____ Group#_____

I hereby assign all medical benefits, to include major medical benefits to which I am entitled including private insurance and other health plans to: Christy M. Stammen, Ph.D. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid for by said insurance. I hereby authorize assignee to release all information necessary to secure the payment.

Signed_____ Date_____

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INTAKE SHEET

Brief statement of problem or services requested: _____

_____

Who referred you? _____

For each person currently living with the client (INCLUDING THE CLIENT), please list the following information:

Name	Birthdate/ Age	Client/Relation to Client	Years of Education	Occupation	Marital Status/Years Married

For the CLIENT ONLY, please list all prescription and nonprescription medications:

Medication	Amount	Condition Being Treated	Prescribing Doctor

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APPOINTMENT REMINDERS

I utilize a computer system where you can receive an appointment reminder to your email address, your cell phone (via a text message), or through a computer generated voice message to your home or cell phone. You will receive a message the day before your scheduled appointments (including Sundays if your appointment is on Monday). I need the following information from you in order to establish your account.

Client Name:_____

Parent Name (if client is a minor):_____

Where would you like to receive appointment reminders?

(**CHECK AND COMPLETE ONLY ONE CHOICE**)

_____ Via a text message on my cell phone (normal text message rates will apply)
Your cell phone number: _____

_____ Via an email message to the address listed below
Your email address: _____
*if you choose to communicate by e-mail, please read and sign addendum page titled "email notice"

_____ Via a voice message on my cell or home phone (normal cell phone rates apply)
Your phone number:_____

_____ None of the above. I'll remember my appointments on my own.
(missed appointment fees will still apply)

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ADDENDUM: EMAIL NOTICE

It is important to be aware that e-mail communication can be relatively easily accessed by unauthorized people, and therefore can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to unauthorized access due to the fact that servers have unlimited and direct access to all e-mail messages that go through them. Unencrypted e-mails are even more vulnerable to unauthorized access. Please be aware that all email communication with Dr. Stammen is unencrypted.

Please notify Dr. Stammen immediately if you decide to avoid or limit in any way the use of e-mail. Please do NOT use e-mail for emergencies.

It is important that you understand that Dr. Stammen does not provide professional advice through e-mail. If you choose to send personal information via e-mail that you feel relates to your therapy or that you think is important for Dr. Stammen to know, it will be discussed in your next therapy session, not through e-mail.

By signing below, I acknowledge that I have read and understood this e-mail notice. I give consent for Dr. Stammen to contact me through e-mail.

_____ _____

Signature Date

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INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting telepsychological services, we discussed and agreed to the following:

- There are potential benefits and risks of phone and/or video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the phone and/or video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and thus recommend that you utilize in-person sessions.

Patient Name:_____

Signature of Patient/Patient's Legal Representative: _____

Date: _____