Valley
Psychological Associates
1045 S. Cedar Crest Boulevard
Allentown, Pa 18103-5443

CLIENT DEMOGRAPHIC INFORMATION FORM

Initial Appointment Date: _____ Clinician: _____

Client Name: _____ • M / F DOB: ___/___/___

Partner's Name (if couple): _____ • M / F DOB: ___/___/___

Home Address_____

City_____ State_____ Zip_____

Home phone _____-_____-_____ Messages Okay? ☐ Yes ☐ No

Cell phone _____-_____-_____ Messages Okay? ☐ Yes ☐ No

Social Security #: _____

E-mail address _____

May we contact you by email? ☐ Yes ☐ No

In Case Of Emergency, Notify:

NAME_____

RELATIONSHIP _____

Cell/Home phone _____-_____-_____

How did you learn about Valley Psychological Associates?

___ Website ___ Relative/ friend ___ *Physician ___ Yellow Pages/Website ___ Insurance Company

___ Internet Search engine (please circle: Google, Yahoo, Bing, MSN, Other) Search words used: _____

* If there is a referring physician, may we have your permission to thank the referral source? ☐ Yes ☐ No

Insurance Information

No insurance, self-pay: _____ Primary Care Physician: _____ Phone: _____

If you have Insurance please provide the following information:

Name of insured: _____ Employer: _____

Insurance Company: _____ ID # (on card): _____ Group #: _____

Date of Birth of the insured person _____ 1-800 Number on Card _____

Client's Relationship to insured: ____self _____spouse ____son/daughter

Do you have secondary insurance? Y / N Date of Birth of the insured person _____

Name of insured: _____ Employer: _____

Insurance Company: _____ ID # (on card): _____ Group #: _____

Patient's Signature and Release: I authorize Valley Psychological Associates to provide my insurance company with any information necessary to process my claims. I understand that my signature below is my written permission for insurance payments for services rendered to be paid directly to the provider for services.

CLIENT SIGNATURE_____ DATE _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Use And Disclosure Of Health Information

This notice of HIPAA Privacy Rules includes information we are required to give you regarding our privacy practices. We use and disclose health information about you for treatment, payment, and health care operations. For example:

Payment: We may use and disclose your health information to obtain payment for services we provide you. We may also disclose your health information to another health care provider or entity that is subject to the Feceral Privacy Rules for its payment activities.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

For Your Safety and the Safety of Others: If we determine that you are a danger to yourself or others, we will take all necessary steps to protect those at risk, including informing the Police and Crisis Intervention.

Our Legal Duty

Federal and state law requires us to maintain the privacy of your health information. The law also requires us to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices as described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information we maintain, including health information we created or received before we made the changes. Prior to making any significant changes in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of your notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us at any time.

Acknowledgement of Receipt of Notice of Privacy Practices

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate your acknowledging your receipt of our policy by signing below.

I, _____ acknowledge that I have received the notice of privacy practices from Tyson Davis, Psy.D.

_____ _____

Patient Signature(s) Date

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Psychotherapy Agreement

Tyson Davis, Psy.D.

About Me

I am a licensed clinical psychologist in the state of Pennsylvania. I earned my Doctor of Psychology (Psy.D.) at Rosemead School of Psychology at Biola University. Although I have the experience and training to provide therapy and assessment for all ages and for many types of problems, I specialize in working with adults and couples. I work from a psychodynamic perspective, which focuses not only on resolving problems but achieving greater insight into them to effect changes that are lasting. I view the therapeutic relationship as the vehicle through which you may better understand your unique history, identify problematic ways you have learned to be in the world, and experiment with new ways of being and relating. By unmasking hidden aspects of yourself and patterns in your relationships, therapy provides a meaningful relationship where you may become known as you truly are and experience the possibility for transformation, healing, and restoration.

Confidentiality

Confidentiality is one of the most important aspects of the psychotherapeutic relationship. Confidentiality fosters trust and safety, so that people are better able to share their happiest, saddest, scariest, darkest, most secretive parts of their emotional experiences. Since trust and safety are so important, everything that you share with me will remain confidential. I will not disclose anything that we discuss to anyone unless I have your verbal and written permission. While I do maintain records of our appointments and content of our meetings, I make every effort to keep these secure and confidential.

In all but a few situations, state law and the rules of my profession protect your confidentiality. The following are the most common cases in which confidentiality is *not* protected:

- If you make a serious threat to harm yourself or others, the law allows me to try to protect you or a potential victim. This usually means telling others about the threat and helping you seek appropriate help.
- If I have cause to believe a child, disabled person, or an elderly person has been or will be abused, neglected, or exploited, I am legally required to report this to the proper authorities.
- If I am court-ordered to provide testimony regarding my knowledge and experience of you, I will then testify truthfully and honestly.

At times, I may also discuss various cases with supervisors and consultants as a way to enhance my clinical work with my patients. You can rest assured that these individuals are bound by the same confidentiality standards as outlined above.

Appointments

During our first few appointments, we will discuss what brings you to treatment. This will be a time for us to gather more information, gain a better "feel" for one another, and decide together what may be the best course of treatment for you. If we do not feel we would be a good fit to continue working together, or if you would prefer to meet with someone different, I would be happy to make a referral to another

trusted therapist who might better meet your goals or fit your preferences. Should we both decide to continue working together, we will set up regular appointments at a frequency of *at least* once per week with the possibility of meeting at a greater frequency. Increasing frequency of appointments often allows for a deepening of the therapeutic process and provides greater potential for long-lasting change. Once we decide on mutually agreeable time(s) and day(s) for your appointment(s), this time will be considered solely "yours" on a consistent, reliable basis. I will not schedule other patients during your time.

Fees

My fees are listed below. I am considered "in-network" with several insurance companies, so the fee schedule below may not accurately reflect the actual out-of-pocket costs for which you will be responsible.

Initial Consultation Appointment	$140
Individual Psychotherapy Appointment	$130
Couples Psychotherapy Appointment	$130
Testing (per hour)	$100

Insurance

I am an "in-network" provider with the following insurance companies:

- Highmark
- Blue Cross Blue Shield (multiple plans)
- Capital Blue

If you would like to use one of these companies to supplement the cost of your treatment, your actual out-of-pocket costs (co-payment) will be based on your particular plan, amount of coinsurance, and amount of deductible to be met (if any).

If you do not have one of the above types of insurance, and you would like to use your insurance to help pay for your treatment, I would be considered an "out-of-network" provider for you. If I am out of network for you, I will not submit a bill to your insurance company; however, I would be happy to provide you with an invoice with the amount you have paid for treatment. You may then submit this invoice to your insurance company to obtain partial reimbursement for the costs of treatment.

Billing

I accept all major credit cards as well as health and flexible savings accounts. Payment for appointments is due at the beginning or end of each visit. I will provide you with a monthly invoice reflecting the total amount paid for the month and any outstanding balance. If your account is chronically past-due, we may discuss a payment plan for you to be able to continue treatment. There may be cases where an outstanding balance may interrupt your ability to continue in treatment, but we will discuss this as the occasion arises. A fee of $30.00 will be assessed when checks are returned due to insufficient funds.

Cancellation and Late Arrival Policy

Out of respect for you and other patients, I will try to always begin and end on time. Because your appointment time is solely yours and will not be filled with any other patients, you will be charged the

full appointment fee for missed appointments and late cancellations (less than 24 hours notice). I will make exceptions to this policy on certain occasions such as accidents, emergencies, poor weather conditions, etc. If you are late for appointments, you will be charged the full appointment fee.

Financial Responsibilities of Patients

It is important for you to know that you are financially responsible for all payment of services whether or not you are using your insurance. In cases where your insurance payment is denied or your benefits have been exhausted, you will retain responsibility for payment of services. I will do my best to inform you of any unexpected changes in your coverage of which I might become aware. If your treatment is discontinued and an outstanding balance has been incurred, I will try to negotiate a repayment plan with you. If your account remains seriously past due and a repayment plan has been unsuccessful, you may be referred to a collection agency.

Courtroom and Other Legal Testimony

As a patient of mine, you agree you will not call on me for any legal or forensic proceedings. In these scenarios, I would be seen as a biased witness and this could interfere with our therapeutic relationship. If you are in need of a referral for any kind of forensic work, I am happy to provide names of colleagues with this specialty who can assist you with this type of evaluation.

Potential Risks of Therapy

Psychotherapy may involve risks. These may include recollection of unpleasant events that can arouse intense emotions of fear and anger. Feelings of discomfort, anxiety, sadness, frustration, loneliness, or helplessness may also be aroused but frequently abate during the course of treatment. If you are coming for couple's therapy, you may experience increased conflict and tension in your relationship as personal growth is often painful and adjustments in your personal relationships are often required. While these adjustments can be difficult and painful, many people find the interpersonal rewards of change to be well worth the effort.

Urgent Situations and Emergencies

During the course of psychotherapy, *urgent situations* sometimes arise between appointment times. I will try to help you through these times to the best of my abilities, and additional appointments may be recommended. In the event of an emergency, please contact your physician, hospital emergency room, community crisis line, or 911.

Summary

Finally, I am honored that you chose to work with me in psychotherapy. I recognize that this is not an easy decision and requires a significant commitment of time, energy, and financial resources. I am looking forward to getting to know you better and am hopeful you will find our time together meaningful and beneficial. I invite any and all questions or comments you might have about our work together or any aspect of your treatment.

* Please retain this for your own reference.

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Consent to Treatment & Fee Policy Agreement

I have read pages 1-3 of "Psychotherapy Agreement" for Tyson Davis, Psy.D. and have received a copy for my own reference. I agree that Tyson Davis, Psy.D. has explained the nature and types of treatment that may be provided. I understand that I have the right to terminate treatment at any time, and that I am responsible for payment in full of services received and missed appointments. I will pay by check, cash, or credit/debit card at the beginning or end of each appointment.

My signature below attests to my acceptance of and consent to the described treatment policies/procedures and financial obligations outlined on pages 1-3 of the "Psychotherapy Agreement."

_____	_____	_____
Patient Printed Name(s)	Patient Signature(s)	Date

_____	_____
Tyson Davis, Psy.D.	Date

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COUPLES THERAPY
INITIAL EVALUATION

The purpose of this questionnaire is to obtain a comprehensive picture of your background. If you are uncomfortable with completing any items, please leave them blank and we can discuss your concerns during our appointment.

Name: _____ Date: _____
Name of Partner/Spouse: _____

What brings you to therapy at this time?
_____
_____
_____
_____

Relationship Status: (Check all that apply)
☐ Married ☐ Separated ☐ Divorced (# of times ____) ☐ Dating ☐ Living together ☐ Living apart

Length of time in current relationship: _____

Do you have children from your **current** relationship? ☐ Yes ☐ No
Do you have children from a **previous** relationship? ☐ Yes ☐ No

Have you received prior **couples** therapy? ☐ Yes ☐ No
If "yes," When? _____ Where? _____
For What Issues?
_____
With whom? _____ Length of treatment?_____
What was your experience of therapy like?
_____

Have you received prior **individual** therapy? ☐ Yes ☐ No
If so, give a brief summary of concerns that you addressed. _____
_____
_____
_____

What do you hope to accomplish through therapy? _____
_____
_____

What have you already done to deal with the difficulties? _____
_____
_____

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Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does: _____

_____

_____

Is there a history of infidelity in your relationship? ☐ Yes ☐ No
If "yes," by whom and when?

_____

Is alcohol/substance use a point of contention in your relationship? ☐ Yes ☐ No
If "yes," how often and what drugs or alcohol?

_____

Has conflict ever escalated to the point of physical violence in the relationship? ☐ Yes ☐ No
If "yes," how often and what happened?

_____

_____

Have either of you threatened to separate or divorce (if married) as a result of the current relationship problem(s)? ☐ Yes ☐ No
If "yes," who? ☐ Me ☐ Partner ☐ Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?
☐ Yes ☐ No
If yes, which of you has withdrawn? ☐ Me ☐ Partner ☐ Both of us

How satisfied are you with your **sexual** relationship? (Circle one)
1 2 3 4 5 6 7 8 9 10
(Extremely Unsatisfied) (Extremely Satisfied)

What is your current **level of stress** in the **relationship**? (Circle one)
1 2 3 4 5 6 7 8 9 10
(No Stress) (High Stress)

What is your current level of stress **overall**? (Circle one)
1 2 3 4 5 6 7 8 9 10
(No Stress) (High Stress)

Please rate your current level of happiness in your relationship.
1 2 3 4 5 6 7 8 9 10
(Extremely Unhappy) (Extremely Happy)

What are your biggest strengths as a couple? _____

_____

_____

Please use the space below to include any additional information that may be important:

_____

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