Gregory M. Crow, Ph.D.
Psychologist

NEW PATIENT INFORMATION

DATE _____

LAST NAME OF PATIENT _____ FIRST NAME _____

I do not have any form of Medicare coverage, whether it be disability or otherwise. _____ (Please Initial)

PATIENT STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

MARITAL STATUS: _____ S=single M=married Se=separated D=divorce W=widowed

BIRTHDATE _____ AGE _____ SEX: [ ]M [ ]F Email _____

HOME TELEPHONE (_____)_____ CELL TELEPHONE (_____)_____

EMPLOYER _____ WORK TELEPHONE _____ x_____

WHO REFERRED YOU? _____

I AUTHORIZE A ***THANK YOU FOR REFERRING LETTER*** TO BE MAILED (PLEASE INITIAL) _____

PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICES ARE RENDERED
SEE PAGE 3 FOR ITEMIZED CHARGES

INFORMATION PERTAINING TO SPOUSE, PARTNER OR GUARDIAN

LAST NAME _____ FIRST NAME _____

I do not have any form of Medicare coverage, whether it be disability or otherwise. _____ (Please Initial)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ AGE _____ SEX: [ ]M [ ]F Email _____

HOME TELEPHONE (_____)_____ CELL TELEPHONE (_____)_____

EMPLOYER _____ WORK TELEPHONE _____ x_____

INFORMATION PERTAINING TO PATIENT'S CHILDREN

	NAME	BIRTHDAY	AGE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

7510 East Angus Drive
Scottsdale, Arizona 85251
480-947-1989
Appts 623 -572-4128
Fax 480 -941-0280

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TREATMENT AGREEMENT

PLEASE REVIEW AND ASK ABOUT ANYTHING YOU DO NOT FULLY UNDERSTAND.
PLEASE INITIAL AND SIGN WHERE INDICATED AFTER THOROUGHLY READING.

BENEFITS AND EMOTIONAL RISKS: Most people who come in for treatment are seeking help to improve significant relationships and/or receive relief and education related to mental and emotional problems they are experiencing. When you first come into therapy we will mutually establish a treatment plan for you and review it together as we proceed. You may refuse any treatment that I recommend and/or withdraw informed consent in writing at anytime. Revocation of informed consent will be binding on me unless I have taken action in reliance on it. Refusal of counseling treatment or withdrawal from counseling may have potential consequences such as not reaching your counseling goals, and/or uncomfortable emotions such as sadness, guilt, and helplessness. There are no guarantees of what you will or will not experience. Once obtaining psychological services, the majority of individuals and family benefit from the process. Self-exploration, learning new skills and ventilating difficult feelings are generally quite helpful. Some risks do exist. As counseling starts, please understand that examining issues may produce strong feelings of unhappiness, anger or frustration, or shame. These and other feelings are a difficult, but natural part of the psychotherapeutic process and often provide the basis for needed change. Also, important personal decisions are often an outcome of counseling. Changes in behavior in the work place, at home and in one's family of origin produce new opportunities as well as challenges. Decisions made by one family member may be viewed negatively by another. Do not be hesitant to discuss treatment goals, procedures, or your impressions of the services that are being provided.

CONFIDENTIALITY: A client's confidentiality is important and is legally protected. There are circumstances where that privileged communication is limited: 1) We are required to report suspected child or elder abuse or neglect and are obligated to take steps to inform others if a client is a danger to self or others. 2) Confidentiality may be waived if a client sues the psychologist or in the event of a court order or other legal proceeding. 3) When a clinician is out of town another professional will cover crisis calls and that person may be advised of issues that might arise on your case. 4) If a health plan is expected to pay for some portion of the cost of services, it must be understood that some communication of same information regarding diagnosis, course of treatment and prognosis may be shared. 5) In the event that group counseling services are provided, it is acknowledged that the doctor or practice cannot be held responsible for a breach of confidentiality on the part of a peer group member (see group rules sheet).

In accordance with Arizona Revised Statute (A.R.S.) § 12-2293, with your written request of access to or copies of your client records, I shall promptly provide your client records to you or the person that you designate in writing (for example, another health professional or your legal representative) unless I determine and notify you that access to your client records is contraindicated. Also, I am exempt from making available raw test data and psychometric testing materials. There may also be additional limitations on access to your records not mentioned here but found in the Arizona Revised Statutes that apply. If I determine that you should not have access to your client records, I shall note this determination in your client record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence. In the event of my extended unavailability, a protocol has been developed providing for your access to your records.

COUPLES' COUNSELING: At times one or both individuals may have history of or be presently involved in activities that their partner does not know about. In many cases, keeping significant information secret is not in the best interest of the relationship. Please raise these issues privately with me as soon as possible and if, in my opinion, these issues need to be brought into counseling I will support ways to accomplish that. If we do not have agreement going forward, I will terminate our couples' work and suggest other alternatives for you.

REPRESSED MEMORY: I understand from the beginning of treatment with Dr. Crow that he cannot confirm or deny my memories – whether they be "repressed" memories or not. Dr. Crow will help me process the resulting feelings and issues that may surface as a result of any memories. I understand that the reliability of repressed memory is controversial and that the decision whether or not to confront the "perpetrator" is controversial due to it's potential ill effects on me and my family. I understand the risks and challenges and potential ramifications (both ways) of this very difficult issue and that Dr. Crow will support my decision either way.

INITIAL _____

INITIAL _____ **(SPOUSE, SIGNIFICANT OTHER)**

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Fax 480 -941-0280

RELEASE OF INFORMATION: In order to provide the most efficient and appropriate care, it is important that we obtain records from previous care givers. Please complete one *Release of Information* form for each professional you wish us to communicate with.

HOURS/AVAILABILITY: Appointments are scheduled weekdays between the hours of 8:00am and 4:00pm and are for a counseling hour, 60 minutes in length. To set an appointment, call Sandy at 623-572-4128 during the hours of 8am-12pm Monday through Friday. You may leave a message for Dr. Crow any time by calling 480-947-1989. For emergencies during non-office hours, please call your family physician, 911, or go to an emergency room.

CANCELLATIONS: It is my policy to charge for appointments not canceled as follows:

"ONE hour" session a minimum of 24 hours cancellation notice
"TWO hour" session a minimum of 72 hours cancellation notice

To assist in your compliance with this policy, you may leave a message at 623-572-4128 24 hours a day. I understand that it is my responsibility to call a minimum of **24 hours** prior to a scheduled appointment to cancel a "one hour" appointment regardless of the reason. By not complying, I am responsible for the full amount of $215, which cannot and will not be billed to insurance. I understand that a minimum of **72 hours (3 days)** is required to cancel a "two hour" appointment regardless of the reason. By not complying, I am responsible for the full amount of $430, which cannot and will not be billed to insurance.

EMERGENCIES: In the event of an emergency or crisis and Dr. Crow is unavailable, call your primary care physician, a crisis intervention service or go to an emergency room.

CASE PREPARATION: There will be times that I will be required to gather information from prior therapists, family, acquaintances, complete paperwork, etc. The majority of the time this is expected and simply part of the process and there is no additional charge. Should an occasion arise that requires a greater amount of time than usual gathering information or a crisis intervention resulting in the cancellation of a scheduled appointment(s), there will be an additional charge.

PAYMENT: It is expected that clients PAY FOR EACH VISIT AT THE TIME OF THE SESSION.

INSURANCE: I do not accept insurance with the exception of Blue Cross Blue Shield (non-managed care). I do not accept Medicare. You will receive a receipt at the time of the session that you may file either to your insurance company or submit to a flex plan or medical savings account. **It is your responsibility to know what your health plan will and will not cover.** Benefit information obtained from your insurance company does not guarantee payment. Actual amounts may differ as the benefit determination of claim payment is made at the point the claim is processed. **I understand that at times my insurance company may contact the provider for information regarding a claim I have submitted. In such case(s), I authorize the release of any medical or other information necessary to process the claim.** Some insurance carriers are now requiring case management for out-of-network benefits even though I am not a contracted provider. If this is your situation, you may not have coverage. If you have any questions please call Sandy for assistance.

CHARGES: The following standard charges apply:

INITIAL CONSULTATION	$240.00
INDIVIDUAL THERAPY	$215.00 /60 minute session
GROUP PSYCHOTHERAPY	$ 70.00 /90 min
PSYCHOLOGICAL TESTING	$215.00 /hour
CASE PREPARATION and CRISIS INTERVENTION	$215.00 /hour
FORENSIC FEES – charges are from portal to portal when not at Dr. Crow's office	
	$250 /20-30 minutes
	$300 /30-60 minutes
Deposition	$300 /per half hour by phone
	$1,500/per half day in person
Court Appearance	$3,000/per day
	$1,500/per half day
Cancellation – Dr. Crow may charge a cancellation fee when a scheduled deposition or court appearance is cancelled less than 72-hours in advance. The cancellation fee will be based on the number of hours cancelled.	
RETURNED CHECKS	$ 25.00
MONTHLY PROCESSING FEE	**1.0% of balance**

No payment or contact to our office in 120 days constitutes the account as delinquent and may be referred for collections.

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INITIAL _____

INITIAL _____ (SPOUSE, SIGNIFICANT OTHER)

I have initialed each page of this Treatment Agreement indicating that I have read and reviewed the information contained herein. I have had the opportunity to ask any questions and they have been answered to my satisfaction. I accept these understandings and agree to have my self/son/daughter/family participate in treatment.

_____ _____

SIGNATURE of client or parent if client is a minor **DATE**

_____ _____

SIGNATURE (Spouse/Significant Other) **DATE**

I have received the Notice of Privacy Policy.

_____ _____

SIGNATURE of client or parent if client is a minor **DATE**

_____ _____

SIGNATURE (Spouse/Significant Other) **DATE**

Gregory M. Crow, Ph.D.
Psychologist

AUTHORIZATION FOR INFORMATION RELEASE

TO:_____
COUNSELOR, AGENCY, DOCTOR OR HOSPITAL

_____
ADDRESS PHONE

RE: _____ DOB: _____

I authorize Dr. Crow and the agency or individual stated above to discuss and/or exchange information and/or reports as initialed below. It is understood that this release is granted to assist the staff at each agency/office. It is further understood that this information once obtained, it will not be released to any other agency or individual.

INITIAL ON THE LINE(S) BELOW

_____ Social history/intake

_____ Psychological exam

_____ Thank-you for referral letter

_____ Other (Specify) _____

_____ Treatment notes

_____ Hospitalization records

_____ Testing results

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be released or disclosed without my written permission unless otherwise provided for in the law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. **This consent (unless revoked earlier) expires one year subsequent to the signing of this release.**

NAME_____ _____

ADDRESS_____

SIGNATURE_____DATE_____
(PARENT/GUARDIAN IF MINOR)

WITNESS_____DATE_____
(IF RELATIVE, STATE RELATIONSHIP)

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Notice of Privacy Policy

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.

Effective Date: April 14, 2003

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by federal and state law to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information for different purposes. We will not use your confidential information or disclose ir to others without your authorization, except for the following purposes. The examples below are provided to illustrate the types of uses and disclosures we are permitted to make without your authorization. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians/therapists/counselors who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician/therapist/counselor to whom you have been referred to ensure that the physician/therapist/counselor has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider or facility (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your doctor.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a therapy session may require that your relevant protected health information be disclosed to the health plan to obtain approval for the session.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your doctor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Others Involved in Your Healthcare: There will be times that your doctor will be required to gather information of prior therapists, family, acquaintances, complete paperwork, employers, etc. You will b e required to sign an Authorization for Information Release for every person(s) to be contacted. Unless you object, by not signing the release form, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in crisis intervention efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your doctor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your doctor is required by law to treat you and the doctor has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the

public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or elder abuse or neglect and are obligated to take steps to inform others if a client is a danger to self or others. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process. You will be contacted if such a request for records is requested and you will be required to sign an Authorization for Information Release. You have the right to refuse to the doctor to comply with a subpoena. Your records are confidential and protected by the psychologist-client privilege. Your records contain information that was received by reason of the confidential nature of the relationship. Be it known a court may order you to comply and records would be released at that time.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

USES AND DISCLOSURES WITH YOUR WRITTEN AUTHORIZATION

We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice, without your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your doctor or the doctor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR INDIVIDUAL RIGHTS

Right to Inspect and Copy you Confidential Information. You may ask to inspect or to obtain a copy of your confidential information that is included in certain records we maintain.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; psychological test data and reports; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Right to Request Additional Restrictions. You may request restrictions on our use and disclosure any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. While we consider all restrictions carefully, we are not required to agree to a requested restriction.

Right to Receive Confidential Communications. You may ask to receive communications of your confidential information from us by alternative means of communication or at alternate locations. While we will consider reasonable requests carefully, we are not required to agree to all requests.

Right to Amend your Records. You have the right to ask us to amend your confidential information that is contained in our records. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your doctor or another person created the information that you want to change, you should ask that person to amend the information.

Right to Receive and Accounting of Disclosures. Be it known that no information will be released from this office either by phone or in writing without your signed consent on an Authorization for Information Release form from our office. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

If you wish to make any of the requests listed above under "Individual Rights," you must complete and mail us the appropriate form. To obtain the form please contact Sandy at 480-951-8817. After we receive your signed, completed form, we will respond to your request.