Victor N. Hirsch, PhD
Licensed Clinical Psychologist
1025 E Main Suite 100
League City, TX 77573
Phone # (281)332-3852
Fax # (281)557-7518

Patient Name:_____ Appointment date:_____

DOB: _____ Married_____ Single____ Widowed ____ Divorced_____

Address:_____City_____State_____Zip_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____Email:_____
Please select 1 method to receive you appointment reminders: Home_____Cell_____Work_____email_____

Employer and/or School:_____ How did you hear about us?_____

Reason for Visit:_____
Is there a court order that affects the parent-child relationship? YES____ NO____
If yes, which conservator has the right to consent to psychological treatment? _____

Medication name	Dosage	Frequency (How often)	Prescriber (Doctor name)

If additional space is necessary, please write on back

Primary Care Physician name _____Phone # _____
Medical Conditions: _____

Risk of Injury to self or others? Suicide Risk: **Yes**_____ **No** _____ Assault Risk: **Yes** _____ **No** _____
Substance abuse: **Yes** _____ **No** ___ Attend AA/NA meetings? **Yes** _____ **No** _____Domestic Violence: **Yes** ____ **No** ____

Primary Insurance:_____ Policy/ID #_____

Group#_____ Benefit phone#_____

Secondary Insurance:_____ Policy/ID #_____
Group#_____ Benefit phone#_____

Insured's Name_____
(if different from patient)
DOB_____Employer:_____
Relationship to patient self _____ spouse _____ child _____ other _____, explain_____

Responsible Party: _____
(**if different** from patient, *this must be filled out if patient is **a child***)
Address:_____City_____State_____Zip_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____Email:_____
Employer:_____School:_____

In Case of Emergency, notify: _____Phone #: _____

(Please provide a copy of insurance card and valid form of identification)
WE REQUIRE 24 HOURS CANCELATION NOTICE or pay NO-SHOW fee of $70.00

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Psychological Testing Report Writing Costs

The year 2019 brought many changes to how insurance companies pay for Psychological Testing and report writing. Most insurance companies moved psychological testing to the medical side instead of mental health. The insurance companies reasoning for that is because they say it is a diagnostic tool. Our office staff will verify your benefits prior to your appointment, however, please be aware that verification of benefits is not a guarantee of payment.

Some insurance companies/policies require that the provider office get authorization before we can start testing. In these cases we schedule an initial appointment and gather the patient's information, put it on a form and submit to the insurance company. Then your insurance will determine the number of hours they will pay or they may deny testing because they deem it "not medically necessary". Some policies pay for report writing and others do not cover these services or the cost goes to the deductible. **If for some reason your insurance company does not pay benefits, you will be responsible for payment in full.**

We will bill your insurance **one time** to try to collect the money, if they do not pay YOU are responsible for the balance before the report/letter is released.

If you choose not to pay for a report and would just like to go over test results with the provider please call and make an appointment. Results will NOT be discussed over the phone.

We offer self-pay report writing rates:

1.) Summary letter (1page) with dates of service and a diagnosis for $200.00

2.) Basic report, with background history, list of test and diagnosis. $600.00-800.00

3.) Comprehensive report -includes details-background history, diagnosis, recommendations, test scores. $900.00 – 1500.00

We do not release **typed reports** without payment of Psychological Testing and Report writing.

_____ _____
Printed name of patient/guardian Date

_____
Signature of responsible party

Hirsch & Associates

1025 E Main St, Ste 100
League City, TX 77573

INSURANCE PAYMENT RELEASE (Assign Benefits)

I hereby authorize release of information necessary access benefits, to file a claim **AND** an appeal with my insurance company,

_____ and **ASSIGN BENEFITS**
(NAME OF INSURANCE COMPANY)
OTHERWISE PAYABLE TO ME TO VICTOR N. HIRSCH, PhD AKA HIRSCH & ASSOCIATES INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not covered by my insurance carrier unless otherwise talked over with Hirsch & Associates and approved by Victor N. Hirsch, Ph.D.
By signing this I authorized Hirsch & Associates to treat me accordingly.

_____ _____
PATIENTS SIGNATURE DATE

MEDICAID AGREEMENT /COMMERCIAL INSURANCE (sign only if you have Medicaid)

" I understand that, in the opinion of Hirsch & Associates, the services or items that I have requested to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

_____ _____
PATIENTS SIGNATURE DATE

CANCELLATION POLICY

By signing this I authorize Hirsch & Associates to assess me a fee for **NOT CANCELING AN APPOINTMENT WITHIN 24 HOURS** of my appointment time. I will be responsible for a partial fee of the session of $70.00. I agree that my credit card will be charged for the price of that appointment which is reserved for you. I also agree that if my credit card information should change that I will inform Hirsch & Associates at my next scheduled appointment. OR BY SIGNING BELOW I AGREE THAT I **DO NOT HAVE A CREDIT CARD** BUT I WILL PAY THE $70.00 FEE ***BEFORE*** SCHEDULING ANOTHER APPOINTMENT.

Debit Card **Credit** VISA____ M/C ____ AMEX ____ Discover ____

Credit Card #_____Expiration date:_____
3 digits # on back of card_____

_____ _____
PATIENT'S SIGNATURE DATE

Hirsch & Associates

1025 E Main St, Ste 100
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NOTICE OF PRIVACY PRACTICES

This notice describes how health 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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described in this notice while it is in effect. This notice takes effect 4/1/03, and will remain in effect until we replace it.

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

USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operation. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing you with treatment.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, i.e. insurance and electronic filing of insurance.

Healthcare Operation: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: In the event of your incapacity or emergency circumstance, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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

PATIENT RIGHTS

Access: You have the right to look at or request copies of your health information, with limited exception. You must make a request **in writing** to obtain access to your health information. You may obtain a form to request access by the contact information listed at the end of this notice.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLIANTS

If you want more information about our privacy practices or have questions, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with the decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information. You may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the US DEPARTMENT OF HEALTH AND HUMAN SERVICES. We will provide you with the address to file with, upon request.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Depart of Health and Human Services.

Privacy Officer: Victor N. Hirsch, Ph.D
Telephone: 281-332-3852
Address: 1025 E Main St, Ste 100, League City, TX 77573

I have read the above statement and asked any necessary questions. I agree to these arrangements and give my consent for treatment.

_____ _____

Patient Signature – ***ONLY IF 18 years or older)*** Date

_____

PATIENT PRINTED NAME

_____ _____

Parent/Guardian Date

_____

Printed name

Hirsch & Associates
1025 East Main, Ste 100
League City, TX 77573

INFORMATION AND CONSENT FOR SERVICES

Welcome to your initial session. We look forward to working with you. This document contains important information about by professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information. You may revoke this agreement in writing at any time. I am a licensed Psychologist with a PhD in Clinical Psychology. My license is through the Texas State Board of Examiners of Psychologists, who regulates the private practices of Psychologists and process any complaints.

Most individuals initiate treatment because of problem areas in their lives. Both evaluation and treatment services are offered through this office. Evaluation is sometimes performed to provide information about you and clarify current problems in order to determine appropriate treatment and service. Evaluation consists of interviews that cover both your background and description of the problems and conditions that caused you to seek services. It may involve various tests given to assist in documenting your current situation.

Treatment begins with a treatment plan. During the first session we will identify the issues that will be discussed, the goals of treatment and methods used to meet these goals, as well as alternative services. This will be done in collaboration with you. We anticipate that we will discuss with each other our work together. Please let us know if you are dissatisfied so we can work to resolve it. Sometimes this process results in discomfort and distress. Should this happen, it is important that this is communicated.

Progress occurs at different rates for different people. Managed Care plans or others who referred you may only offer you a certain number of sessions. Termination ideally occurs when we both agree that our work is complete and our goals are met. This can take anywhere from a few sessions to a number of months. If you need to withdraw from therapy before completion, we ask that you have at least one final session where we will review progress to date and consider any follow up recommendations or referrals that might meet you needs.

Keeping your records confidential is the highest priority. You have a right to access your record, and any part of your record. It will only be released by your written permission or by someone with legal authority to give such permission. We are legally bound to keep our discussion private, with certain exceptions. The most frequent exceptions to the confidentiality of records are: 1. If you threaten to harm yourself or another person, relevant information may be released at that time. 2. If you say that you are abusing a child, elderly person, or disabled individual who may be the victim of abuse. 3. If records or testimony as a therapist are subpoenaed by the court, such as in cases of child custody.

Since we reserve a scheduled time for you **please give 24 hours notice** if you cannot make the appointment. If 24 hours is not given, there will be **a $70.00 charge for the missed appointment, which is not covered by insurance**. My session fee is $135.00 for each 45-50 minute therapy session unless otherwise negotiated. In addition to weekly appointments, there may be **charges for other professional services you may need. I will break down the hourly cost if I work for periods of less than one hour**. Other services include report writing, telephone conversations lasting longer than **10 minutes**, consulting with other professionals with your permission, preparation of records or treatment summaries and the time spent performing any other service you may request of me. We request that payment be made in full at each session unless we agree upon other payment arrangements. Failure of insurance companies or other third parties not paying as expected is disappointing, however; the ultimate **responsibility for payment remains with the client.**

We hope that this information helps to promote good working relationship. Please feel free to ask about all issues at any time during treatment. We look forward to working with you.

I have read the above, asked any questions and agree to these arrangements.

_____	_____	_____
Printed Name	Signature	Date

HIRSCH & ASSOCIATES
1025 E Main St, Ste 100,
League City, TX 77573

We reserve a scheduled time for you **please give 24 hours notice** if you cannot make the appointment. If 24 hours is not given, there will be **a $70.00 charge for the missed appointment,** which is not covered by insurance.

We request that payment be made in full at each session unless we agree upon other payment arrangements. Failure of insurance companies or other third parties not paying as expected is disappointing, however; the ultimate **responsibility for payment remains with the client.**

There may be charges for other professional services you may need **THAT ARE NOT COVERED BY INSURANCE.**

Other services:

*REPORT WRITING ***We will bill insurance, but if the claim is denied the patient will be responsible for payment before the provider will release the report**. ***
*Letter writing
*Telephone conversations lasting longer than **10 minutes**, billed as minimum of one hour
*Consulting with other professionals, with your permission, outside of your appointment time.
*Preparation and coping of patient records. (We must have a written request signed and dated.)
*Treatment summaries
*Completing forms outside your therapy session
*And the time spent performing any other service you may request of me, that is not covered by insurance.

_____
Patient printed name

_____
Patient signature and Date (if under 18 must be signed by parent or guardian)

Victor Hirsch, Ph.D

Clinical Psychologist

1025 E Main St, Ste 100
League City, TX 77573
Phone # 281.332.3852

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____, _____ authorize **Hirsch & Associates**
Printed patient name DOB Provider

to disclose to_____
(Name of facility/person for which information is to be disclosed)

Address:_____
Street or mailing address, City State Zip Code

Phone # _____ Fax # _____

my (or that of my minor child) personal health information/records for the purpose related to my evaluation and treatment.

I understand that this is a required consent and I must voluntarily and knowingly sign this authorization before any records may be released, and that I may refuse to sign, but if I do not sign this forms the records will not be released.

I further release Victor N. Hirsch, PhD from any liability arising from the release of information to the individual(s)/agency designed herein.

This authorization shall remain in force 30 months following the date of my signature below, and copy is as valid as the original. I understand that I have the right to revoke this authorization at any time in writing.

_____ _____
Patient's Signature Date:

Printed name:_____

_____ _____
Signature of patient's Parent/Authorized representative Date:

Printed name:_____

Describe relationship to patient_____

Hirsch & Associates

1025 East Main, Ste 100
League City, TX 77573

Patient Name: _____ Medical Record No: _____

1. I understand that my mental health care provider may provide an option for me to engage in a telepsychology session under particular circumstances when I am unable to attend my session face to face.
2. My mental health care provider has explained to me how the telephone and teleconferencing technology will be used to affect such a session will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to the use of the telephone and/or technology, including interruptions, unauthorized access and technical difficulties. I understand that my mental health care provider or I can discontinue the telepsychology session/visit if it is felt that the telephone and teleconferencing connections are not adequate for the situation.
4. I understand that my mental healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the session other than my mental health care provider and consulting mental health care provider in order to operate the telephone and teleconferencing equipment as necessary. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and thus will have the right to request the following: (1) omit specific details of my mental health/ medical history/ psychological examination that are personally sensitive to me; (2) ask non-psychological personnel to leave the telepsychology examination room: and or (3) terminate the session at any time.
5. I have had the alternatives to a telepsychology session explained to me, and in choosing to participate in a telepsychology session, I understand that some parts of the visit involving psychological tests may not be conducted by individuals at my remote location and must be done under the direction of the mental health care provider.
6. In an emergent session, I understand that the responsibility of the telepsychology consulting specialist is to advise my mental healthcare provider and that the specialist's responsibility will conclude upon the termination of the telephone and teleconferencing connection.
7. I understand that billing will occur from both my mental healthcare provider and any additional fees that may be incurred by my telephone/ service provider to facilitate the telephone and teleconferencing session.
8. I have had a direct conversation with my psychologist, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Patient's/parent/guardian signature Date Time

Hirsch & Associates

Name of person filling out form: _____Relationship_____

Patient Name: _____ Date:_____

Date of Birth: _____Age_____

PCP:_____ Phone #_____

Psychiatrist:_____Phone:_____

Main complaint: (What brought you here today?)

_____

_____

_____

_____

Treatment

Have you ever received psychological, psychiatric, or counseling services before? Yes _____ No _____

When? Dr/Counselor name For what

_____

_____

_____

Have you ever had psychological testing? Yes _____ No _____ If yes, when?_____

Have you taken medications for psychiatric or emotional problems in the **past**? Yes _____ No _____

If yes, what psych medications have you taken **in the past?** _____

_____

Are you currently on medications? Yes ____ No ___If yes, list **ALL** medications including medical conditions

Name of Drug Dosage For What Condition

_____

_____

_____

Have you ever been hospitalized for mental illness? Yes _____ No _____ If Yes, when and for how long?

_____

Are you suicidal now? Yes _____ No _____ Have you been suicidal in the past? Yes _____ No _____

Sleep

Do you sleep well? Yes _____ No _____ If no, do you take medication (either over the counter or prescription) to help you sleep? Yes _____ No _____ If yes, what do you take and how often?_____

_____

Appetite

Do you feel you have a healthy appetite? Yes_____ No _____

Do you feel like you have an eating disorder such as over eating or excessive dieting etc.?Yes _____ No_____

Family Relationships

Parents:

Relationship with Mother: Good: _____ Strained: _____ Difficult: _____ Violent: _____

Relationship with Father: Good: _____ Strained: _____ Difficult: _____ Violent: _____

Have physical health problems? Yes _____ No _____ If yes explain: _____

_____

Use alcohol? Yes _____ No _____

Use recreational drugs? Yes _____ No _____ If yes, which ones: _____

_____

Mental or emotional difficulties: Yes _____ No _____

Are both parents still living? Yes _____ No _____

Siblings:

Do you have siblings? Yes _____ No _____ How many? _____

Do you get along with your brothers and sisters? Yes ____ No _____ **IF NO**, explain:

_____

Do any of your siblings have drug or alcohol abuse problems? Yes _____ No _____

Are all of your siblings still living? Yes _____ No _____ IF NO, how long ago/cause

_____

Abuse History

Have you ever been abused? Yes_____ No _____ see next page……

If yes, using letters please explain: **E**motional, such as told worthless, belittled etc, **P**hysical, such as beatings; **S**exual, such as touching/molesting, fondling, intercourse; **N**eglect, such as failure to feed, shelter or protect you

Kind of Abuse Your age By Whom

Present Relationships

Single _____ Married _____ Divorced _____ Widowed _____ Live together _____

Do you get along with your present spouse or partner? Yes _____ No _____

Do you have children? Yes _____ No _____

If yes,how many? Male _____ Ages _____ Female _____ Ages _____

Do you get along with your children? Yes _____ No _____ IF NO, short explanation:_____

Substance Abuse

Have you ever felt the need to cut down on your drinking? Yes _____ No _____

Have you ever felt guilty about your drinking? Yes _____ No _____

Have you ever taken a morning "eye opener"? Yes _____ No _____

Do you drink daily? Yes _____ No _____ If yes, how much? _____

Weekly? Yes _____ No _____ Social Only Yes _____ No _____

Do you currently use recreational/street drugs? Yes _____ No _____ If yes, which drug/drugs

What drugs recreational/street drugs have you used in the past 10 years? _____

Do you smoke cigarettes? Yes _____ No _____ Chew/Snuff Yes _____ No _____