Margaret M. Tripp, Ph.D.

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ADULT CONSENT FOR EVALUATION/TREATMENT

Patient Name: _____ **Date of Birth:** _____-_____-_____

I hereby give full consent to receive services of Margaret M. Tripp, Ph.D. I understand my first session with Dr. Tripp is an initial consultation for evaluation of my mental health and that formal treatment is not initiated until Dr. Tripp and I agree to do so. I authorize Dr. Tripp to carry out the psychological evaluations and treatment that are advisable during my psychotherapy. I understand that while the evaluation and treatment are designed to be beneficial, they may at times be difficult and uncomfortable. There is an expectation that I will benefit from treatment, but there is no guarantee.

CONFIDENTIALITY

I understand that any information I provide to Margaret M. Tripp, Ph.D. is confidential and generally will not be released to others without my written consent. However, I understand that professional ethical obligations, state and/or federal law might require Margaret M. Tripp, Ph.D. to disclose confidential information without my consent in the following circumstances:

1. If the therapy session reveals any information concerning the abuse of a child, elder or disabled person, Dr. Tripp is mandated by law to make a report to the proper authorities. By signing this document, I acknowledge my awareness of this fact.
2. If the course of therapy reveals any intent to harm either myself or others, Dr. Tripp has my irrevocable permission to prevent me from accomplishing harm. I specifically give my irrevocable permission for Dr. Tripp to warn police or law enforcement authorities about parties she feels may be harmed.
3. If I request Dr. Tripp provide session receipts, I am aware information about my health status and treatment will be disclosed. As a billing submission requirement of the insurance company, I understand Dr. Tripp will be required to provide a mental health diagnosis for me, and may be required to provide the company with detailed treatment needs or complete copy of the treatment records. Once treatment records are in the possession of insurance company, Dr. Tripp cannot guarantee their continued confidentiality.
4. If a lawsuit is filed by me against Dr. Tripp for breach of duty; or if a court order, legal proceeding, statute, or regulation requires disclosure of records, I understand legal obligations require the release of my therapy records.

TREATMENT RECORDS

It is stated law that psychologists maintain a record of the treatment given to me. This record will contain the information that will allow Margaret M. Tripp, Ph.D. to chart the course of therapy. This record is used for only that purpose and it is Dr. Tripp's intent that my file remains private.

1. I understand I may get a copy of my treatment records by providing her with a signed release of information request.
2. I agree I will pay in advance for copying cost of the actual record or time required for the preparation of the treatment summary if required. This includes providing copies or reports to any court or legal representative.
3. If the therapy sessions contain more than one person, only the identified patient may obtain the complete treatment file.
4. In the event that Dr. Tripp becomes incapacitated or dies, it will become necessary for another provider to take possession of each patient's files and records. I give consent to allow another licensed mental health professional to take possession of my records and provide me with copies upon request, or to deliver them to a therapist of my choice.

COMMUNICATION POLICY

Continuous effort is made to provide secure communication between patient and staff by phone, email, and fax. These forms of communication are subject to use and monitoring by trained office staff only, however, cannot be guaranteed secure. Margaret M. Tripp, Ph.D. and her staff do not use messaging on social networking sites to communicate with patients. In accepting services from Dr. Tripp, and authorizing communication with her office, patient agrees to knowledge of limitations/restrictions of online communication and agrees to hold harmless Dr. Tripp and her staff for information loss due to technical failure or cyber occurrence.

Telehealth services are offered by Dr. Tripp when deemed appropriate. In order to engage in phone or video-conferencing services, I agree to the following: 1) risks to patient confidentiality are higher over phone/video-

conference, 2) session will occur over a secure internet connection rather than public Wi-Fi, 3) alternate phone number/email and emergency contact will be provided for use in the event of a crisis, 4) insurance company may not reimburse for telehealth services, 5) Dr. Tripp may determine that telehealth services are no longer appropriate and require in-person therapy resume.

PAYMENT POLICY

Payment is due at the time of service. My consent to treatment includes an electronic payment permission, authorizing Margaret M. Tripp, Ph.D. and her staff to deduct service fees from my designated account. It is my responsibility to file and collect my own insurance claims. I understand if I do not uphold my responsibility to pay for services, this may result in the termination of treatment with Dr. Tripp and referral for appropriate treatment services elsewhere. Payment after the date of service will include a late payment charge of $25.

FEE SCHEDULE

Initial Evaluation/New Patient	**$215 per 60 minute session**
Treatment/Psychotherapy Session	**$195 per 50 minute session**
No Show or Late Cancel Fee (<24 hours)	**FULL Session Fee**
Late Payment Fee-charged day after service	**$25**
Letter Writing or Treatment Summary	**$100 per 30 mins**
Forensic or Court Involvement	**$400/60 mins, $100/15 mins**
Consultation/Class Fee	**$215 initial 60 minutes, $195 each additional 60 mins**

12 months between visits = New Patient, New Consent Form

MISSED SESSION POLICY

If I need to cancel a session with Margaret M. Tripp, Ph.D., I agree to provide at least 24 hours notice.

1. **24 hours notice** of cancellation is required, and 48 hours is preferred. I understand that my appointment time is reserved for me. Dr. Tripp does not double book patients and therefore, if I fail to show up and/or provide appropriate notice of cancellation, she is unable to fill my appointment time with someone who can use that time instead.
2. **Cancellation with less than 24 hours notice or no show will result in a charge of FULL session fee**. This policy applies to all reasons for cancellations, including illness or work/school conflicts. I understand and agree that the credit card on file with the office will be charged the cancellation fee whether I choose to return for follow-up services.

I understand I am responsible for coming to my session on time, and if I am late, the appointment will still conclude at the scheduled end time.

PRIVACY POLICY & CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

As described in detail in the Notice of Privacy Practices, Dr. Tripp requests my consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. By signing consent, I: (1) Acknowledge that a copy of the Notice of Privacy Practices (Eff. 02/2005, Rev. 09/2021) is available to me; and (2) Consent to provider use and disclosure of my health information for treatment, payment, or health care operations. I have the right to revoke consent to use or disclosure in writing any time, except where practice has already used or disclosed my health information in reliance upon this consent.

TERMINATION OF TREATMENT

I understand the length of time and frequency of sessions required for therapy will be determined by my personal situation. Margaret M. Tripp, Ph.D. will do her best to fulfill my therapeutic needs and to provide me with her best professional care. There is no guarantee of a cure. Any break in treatment for more than 12 months will require reinitiating treatment with Dr. Tripp as a new patient, with no guarantee of Dr. Tripp's availability at that time.

My signature on this consent form verifies that I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that my questions were answered to my satisfaction by Dr. Tripp, and that I give my consent for treatment. I understand that I have the right to withdraw my consent for treatment at any time.

_____ _____ _____

Patient's Signature **Printed Name of Patient** **Date**

ADULT PERSONAL HISTORY QUESTIONNAIRE

CONTACT INFORMATION			
PATIENT Full Name :		**Today's Date:**	
PATIENT Date of Birth:	**CURRENT** Age:		
Primary Address:			
City, State:	Zip:		
Alternate Address (school):			
City, State:	Zip:		
Phone Contact Numbers		Can I leave a message on this line?	
Cell		YES ☐ NO ☐	
Work		YES ☐ NO ☐	
Home		YES ☐ NO ☐	
Emergency Contact (Name, Number, Relationship):			

Dr. Tripp provides the option of communicating or sending appointment reminders by email. Please be aware that email is not a 100% secure form of communication and thus privacy cannot be guaranteed. Email will not be used for treatment or intervention. By listing email addresses below, you are acknowledging your understanding of these statements.

EMAIL ADDRESS: _____

Signature for permission to communicate through email: _____

REASON FOR SEEKING THERAPY
How did you find out about Dr. Tripp?
What has you seeking therapy at this time?
How long ago, or at what stage of life was the issue/concern first noticed?
What are you hoping to achieve with therapy?

EDUCATION/EMPLOYMENT
Highest Level of Education Completed:
Current Employment Status: (employed, student, not working, current position)
Are you content with your current status? Content with current schooling or employment?

Are there specific issues or concerns related to your work/school environment or performance?

FAMILY INFORMATION

Please list all family members who live in the home:

Name	Relationship	Age

Are there any family members who live elsewhere? If so, list their names, ages, and reasons for moving out:

Has there been a divorce in the family? If so, when? And if applicable, what are the custody arrangements?

Are there other individuals who are actively involved in your life?

SOCIAL/RECREATIONAL INVOLVEMENT

How do you spend 'free' or unscheduled time?

What are your favorite hobbies and interests?

How much exercise do you get?

Do you belong to or regularly attend any community group or congregation (church, club, etc.)?

What social media applications do you utilize for communication, networking, or entertainment?

RECENT STRESSORS

☐	Death in Family	☐	Child left home
☐	Death Close Friend	☐	Move to New Home
☐	Serious illness/injury, Self	☐	Conflict with In-laws
☐	Serious illness/injury, loved one	☐	Change in Job- new position, laid off
☐	Family Fighting	☐	Change in financial status
☐	Marital Problems	☐	Change in daily responsibilities
☐	Separation/Divorce	☐	Change in Social Network
☐	New Marriage in Family	☐	Outstanding Personal Achievements
☐	Problems with Child Rearing	☐	Other:

MEDICAL HEALTH

Do you have any of the following medical problems?

Current	Past		Current	Past	
☐	☐	Heart Problems	☐	☐	Head Injury
☐	☐	Digestive Problems	☐	☐	Surgeries
☐	☐	Hypothyroidism	☐	☐	Tics
☐	☐	Hyperthyroidism	☐	☐	High Blood Pressure
☐	☐	Diabetes, Type I	☐	☐	Unexplained Pains
☐	☐	Diabetes, Type II	☐	☐	PMS Symptoms
☐	☐	Overweight	☐	☐	Muscle Tension
☐	☐	Underweight	☐	☐	Headaches
☐	☐	Back or Neck Pain	☐	☐	Cancer
☐	☐	Alcohol use/abuse	☐	☐	Drug use/abuse

If you checked any of the boxes above, please describe the health problem:

Are there any other medical problems not listed above that you experience?

Primary Physician: Phone Number:

Are you currently taking any medications? If so, please list

EMOTIONAL HEALTH

How would you describe your overall mood and emotional state?

Have you sought psychotherapy before? If so, what were the circumstances?
Did you find therapy helpful?
If you are taking medication for emotional or psychological struggles, who is the prescribing physician?
Is the medication helpful?

SYMPTOMS

Have you or your family members struggled with any of the following problems?

	Myself, Current	Myself, Past	My Parent	My Sibling	My Child	My Partner
Depression, Sadness						
Anxiety						
Excessive Worry						
Panic Attacks						
Obsessions						
Compulsions						
Suicidal Thoughts						
Attempted Suicide						
Nervous Breakdown						
Problems with Anger						
Problems with Assertiveness						
Oppositionality/Defiance						
Attention Deficit						
Hyperactivity						
Learning Disabilities						
Schizophrenia or Psychosis						
Eating Disorder						
Excessive eating						
Alcohol Use/Abuse						
Drug Use/Abuse						
Abused in any way						
Other:						

Additional Details

Is there anything else you would like to make sure I know?_____

_____

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