LICENSED OKLAHOMA STATE
BOARD OF EXAMINERS
OF PSYCHOLOGISTS

CLINICAL PSYCHOLOGY

B. TODD GRAYBILL, Ph.D., P.L.L.C.
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918-683-8827
FAX: 918-686-0902
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CLIENT INFORMATION QUESTIONNAIRE

NAME:_____ Today's Date:_____

Age:_____ Birthdate:_____ Gender: Male Female

Address:_____ Home Phone: ( )_____

City:_____ State:_____ Zip Code:_____

Occupation:_____ Cell or Pager:_____

Employer:_____ Business Phone: ( )_____

Address:_____ City:_____ State:_____

Education:_____ SSN:_____

Marital Status: Single Married Divorced Separated Widowed

Date of present Marriage:_____

Spouse's Name:_____ Age:_____ Date of Birth:_____

Occupation:_____ SSN:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Business Phone:_____

Spouse's Education:_____

CHILDREN:

Name	Age	Living at Home?

Dates of Previous marriages:_____ to _____

_____ to _____

(Go to next page, please...)

Name of person, other than spouse, to contact in case of an Emergency:

_____

Address: _____

Phone: _____

Who Referred You Here? _____

Briefly Describe Your Reason For Seeking Help: _____

_____

_____

When Did These Problems First Begin? _____

Have You Ever Received Psychological or Psychiatric Help of Any Kind Before? _____

If Yes, Please List the Name of the Professional and the Dates: _____

_____

List Any Major Health Problems for Which You Are Currently, or Have Recently, Received Treatment:

_____

_____

_____

List All Medications You Are Now Taking and the Dosage: _____

_____

_____

Do You Plan To Use Insurance To Cover a Portion of Your Treatment Here? _____

If So, Please Complete the Following:

Name of Insurance Company: _____

Name Insurance Coverage Is In: _____

ID Number: _____

Group or Policy Number: _____

_____

Signature of Person Responsible for Payment

(Go to next page, please...)

Please Circle Any of the Following Problems Which Pertain to You.

NERVOUSNESS	DEPRESSION	FEARS
SHYNESS	SEXUAL PROBLEMS	SUICIDAL THOUGHTS
SEPARATION	DIVORCE	FINANCES
DRUG USE	ALCOHOL USE	FRIENDS
ANGER	SELF-CONTROL	UNHAPPINESS
SLEEP	STRESS	WORK
RELAXATION	HEADACHES	TIREDNESS
NATURAL DISASTERS	MEMORY	AMBITION
LEGAL MATTERS	LEARNING DISABILITY	BOYFRIEND/GIRLFRIEND
SCHOOL	INSOMNIA	MAKING DECISIONS
ENERGY	INFERIORITY FEELINGS	CONCENTRATION
LONELINESS	CAREER CHOICES	HEALTH PROBLEMS
EDUCATION	NIGHTMARES	MARRIAGE
TEMPER	APPETITE	STOMACH TROUBLES
CHILDREN	BEING A PARENT	DISTURBING THOUGHTS
BOWEL TROUBLES	TENSION	ANXIETY
MOODINESS	UNUSUAL EXPERIENCES	CONFUSION
EXCESSIVE WORRY	CHILD ABUSE	DEATH
FAMILY	IRRITABILITY	BOREDOM

Thank You For Completing This Questionnaire.

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CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I understand that as part of my health and medical care, B. Todd Graybill, Ph.D. originates and maintains medical and health records describing my health history, symptoms, evaluation and test results, diagnosis, treatment, and any plans for future care and treatment. I further understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means for a third-party payer to verify that services were billed as actually provided.
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand that I have been provided with a **NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **NOTICE** prior to signing this consent. I understand that I must revoke this consent in writing, except to the extent the organization has already taken in reliance there on.

By Oklahoma Law we are required to notify you…**that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

(Over)

Information may be released to the following individuals/organizations for the indicated purpose:

Name: _____

_____

Purpose: Healthcare decisions and/or information

****

I request the following restrictions to the use and/or disclosure of my health information:

_____

_____

****

You may ____, may not ____ leave appointment reminders or medical information with any message service, answering machine, or voice mail.

You may____, may not ____ leave appointment reminders or medical information with my spouse or other family members.

X_____ _____

Signature of Patient or Legal Representative Date Notice Effective

****

B. Todd Graybill, Ph.D. ____ accepts, ____ denies, ____ accepts conditionally the restrictions imposed on release of information stated above.

X_____ _____

Signature/Title Date

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OFFICE POLICIES

Appointments

Clients are seen on an appointment basis. Each appointment is normally 60 minutes, and that time has been specifically reserved for you. A normal session actually varies from 35 to 55 minutes. Please be prompt. If you are late, you will be seen only for the time remaining in your scheduled appointment. If I am late, I will see you for the entire 60 minutes. If you cannot make your scheduled appointment, please call at least 24 hours in advance to reschedule. **THE FULL FEE WILL BE CHARGED FOR ALL APPOINTMENTS MISSED OR CANCELED WITHOUT 24 HOUR NOTICE.**

Fees

Charges for services are set in accordance with the accepted standards of the profession. My fee is $160.00 per 60 minute session. Payment is due when services are rendered. If this is not possible, please discuss this with me during your session. The fee for the Initial Consultation is $200.00, and the fee for Marital or Family sessions is $165.00 per 60 minute session. Fees for Testing available upon request.

Insurance

All charges are your responsibility whether your insurance pays or not. Not all services and diagnoses are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

If you plan to use your health insurance to reimburse a portion of my fee, please give your insurance information to my secretary. Insurance is filed as a courtesy to you at no extra charge and does not relieve you of the responsibility of your bill. Payment of fees to me is your responsibility, and you are responsible for collecting reimbursement for yourself from your insurance company. I will be happy to assist you with any insurance problems.

(Over)

Therapeutic Policies

I will provide you with a comprehensive assessment of your problem. I will make explicit goals of your therapy or evaluation. I invite you to discuss your progress with me as we go along. I will keep you informed as to the progress I perceive, and I will discontinue therapy as soon as maximum benefits have been achieved. I ask that you terminate your therapy with me during a scheduled appointment.

Telephone/Emergency Service

My receptionist works Monday-Thursday 8:00 a.m. to 1:00 p.m. At other times, if I am with an appointment or out of the office, my answering machine will be on. Please leave your message, and I will return your call as soon as possible. I have chosen an answering machine rather than an answering service to ensure confidentiality. My home phone is 682-8924. Please call me at home only for extreme crisis or emergency. In those rare instances in which there is a crisis and I cannot be contacted, you may contact the Muskogee Regional Medical Center Emergency Room or the Green Country Mental Health Crisis Line.

Informed Consent

Your signature indicates that you have read and understand the above Office Policies and consent is given to provide services to you and/or your child.

X_____ _____ _____

Signature of Patient or Parent/Guardian Date Relationship if Patient is a Minor

Please discuss with me any questions or concerns that you have about these policies. Thank you for reading through this, and you may take a copy with you for future reference.

B. Todd Graybill, Ph.D., P.L.L.C
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INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me now if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time.
Telepsychology, however, requires technical competence of both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

Risks to confidentiality. Because telepsychology sessions take place outside of the clinician's private office, there is potential for other people to overhear session if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only when in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or storied data could be accessed by unauthorized people or companies.

Crisis management and intervention. Usually, I will not engage in telepsychology with consumers who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some clinicians believe that something is lost by not being in the same room. For example, there is debate about a clinician's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communicate between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matter, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicate by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by office phone. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of your telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Office Polices and Consent to Use and Disclose Health Information still apply to telepsychology. Please let me know if you have any questions about the exceptions to confidentiality.

Appropriateness of Telepsychology

I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling, or referrals to another professional in your location who can provide appropriate services.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover session that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire feel of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person session in accordance with my policies.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign an authorization allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, call GCBHS Crisis Hotline for Adults at 918-682-8407 or for youth at 918-441-1315, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on my office phone (918-683-8827).

If there is a technological failure and we are unable to resume the connection, you will only be charged the appropriate prorate amount of actual session time.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions. *Note: At least one parent or guardian must consent for any minor children.*

I authorize to receive email and text message correspondence from clinician regarding telepsychology and invoices/receipts for payment.

_____ _____

Email Cell Phone

I give my permission for clinician to speak to the person listed below in case of an emergency.

_____ _____ _____

Contact Person Relationship Phone Number

_____ DOB: _____/_____/_____

Client Name (Print)

_____ _____

Client Signature Date

_____ _____

Parent Guardian Signature Date

_____ _____

Clinician Signature Date