

**MARGARET BERTON, Ph.D.**

**Licensed Psychologist.....**

**21 Lynn Batts Lane, Suite 11**

**San Antonio, Texas 78218-3017**

**Phone: (210) 829-1994 Fax: (210) 829-8788**

### **BARIATRIC SURGERY QUESTIONNAIRE**

*As part of your pre-surgical evaluation, there are questions that need to be addressed. It would be most helpful if you would complete this questionnaire in order to expedite your interview. Thank you!*

**YOUR NAME:** \_\_\_\_\_

1. What is the main reason you wish to have bariatric surgery?
  
2. How long have you considered this step?
  
3. What other means have you tried to lose weight? *(Check all that apply)*  

<input type="checkbox"/> Calorie restriction	<input type="checkbox"/> Exercise
<input type="checkbox"/> Weight Watchers	<input type="checkbox"/> Low-carbohydrate or low-fat diets
<input type="checkbox"/> L.A. Weight Loss	<input type="checkbox"/> Jenny Craig
<input type="checkbox"/> Other	Describe your results with these attempts:

\_\_\_\_\_  
\_\_\_\_\_

4. What health problems are you experiencing due to your weight?  

<input type="checkbox"/> Hypertension (High BP)	<input type="checkbox"/> Arthritis	<input type="checkbox"/> GERD (Reflux)
<input type="checkbox"/> Diabetes / Pre-diabetes (circle one)	<input type="checkbox"/> Joint pain	
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Shortness of breath	
<input type="checkbox"/> Other (Please describe):	_____	

Your Name: \_\_\_\_\_

Have you ever purged in an attempt to lose weight (e.g., using laxatives or making yourself vomit after eating)?  Yes  No

If yes, please when and for how long?

Were you treated for an eating disorder?

5. Have you ever been dependent upon alcohol or other drugs?  Yes  No

6. Have you ever experienced: (Please indicate yes or no)

Depression

Anxiety

Psychosis (i.e., losing touch with reality)

If you responded with yes, please explain:

7. Have you ever been treated for nerves or a mental or emotional disorder?

8. What are your plans for coping with the lifestyle changes that will be required of you post-surgically?

9. Do you have anyone available for support during your recovery?

**Margaret Berton, Ph.D.**

**Licensed Psychologist, Licensed Specialist in School Psychology 21 Lynn Batts Lane, Suite 11, San Antonio, Texas 78218 210/829-1994**

**INFORMATION ABOUT MY BUSINESS POLICIES & PROCEDURES**

**Welcome!** This document contains important information about my practice. My goal is to be as helpful to you as possible, and to conduct my practice in an ethical and professional manner. One way that I try to do this is to be very straightforward about my business policies and procedures. If you have questions about any of these policies, please let me know so that I can discuss them with you.

**FEES:** My fee for most outpatient services is \$175 for an initial evaluation session and \$150 per 50-minute session thereafter. The standard “50-minute hour” gives me some time to take notes between sessions so that I stay well informed about what we are working on. I also charge this same hourly rate for school observations, consultations, or other off-site services which I may provide on your behalf. I generally do not charge for commute time for off-site visits, or for phone calls of 10' or less, unless they occur frequently, or become a scheduled part of treatment. Frequent phone consultations of over 10' in length are billed at a prorated rate of \$2.50 per minute. These fees may vary as mandated by contracts I hold as a provider for your insurance company. In that case, my fee is regulated by the insurance company, as is the co-pay for which you are responsible. All fees are payable at the time of service unless other arrangements have been made. Forensic evaluations and legal services are billed at \$175.00 per hour.

**MISSED APPOINTMENTS:** Appointments are times that I set aside just for you. If you need to cancel or reschedule an appointment, please do so at least 24 hours in advance. **Appointments which are missed or cancelled with less than 24-hour notice are billed at the full fee rate unless I am able to fill the time with another client.** Because insurance companies will not pay for missed or late-cancelled appointments, this is likely to be a significant out-of-pocket expense for you.

This policy is not designed to be punitive. First, therapy requires your active participation and commitment to be effective, including timely attendance. Second, since my appointments run at least 50 minutes, each appointment constitutes a significant portion of my daily schedule. Third, frequently others would like to come in for an appointment if you do need to cancel or reschedule. Twenty-four hours is the minimum time that I need to make these arrangements.

**PAYMENT FOR SERVICES:** Payment (or copayment) for services is handled by Therapy Partner Corporation by electronically processing fees at the time of service. Checking account information or a credit card number will be captured using the *Electronic Payment Authorization* form. Session fees will then be deducted from the designated account after each clinical session. You will receive a monthly statement via email attended within a calendar month. You can also log on to Therapy Partner’s website to access printable billing statements if needed. Please direct billing inquiries directly to Therapy Partner Corporation by phone (toll free 877-232-9847) or by email: [info@therapypartner.com](mailto:info@therapypartner.com). [Your account can be confidentially accessed at www.therapypartner.com.](http://www.therapypartner.com)

**CONFIDENTIALITY:** The information which you share with me is confidential. Usually, information about you is shared only with your prior written consent. Exceptions to this general policy include: 1) cases of abuse or neglect of minors, or the elderly; 2) for reasons of safety and protection, if there is a serious suicide, self-injury, or injury to other parties; and 3) confidential information can, in some cases be subpoenaed by a court. If you have any questions about confidentiality or any other issues relating to your therapy, please let me know.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Name (Printed)

**CONFIDENTIAL INFORMATION (Please Print)**

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Education: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #'s" Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

e-mail address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

You were referred by? \_\_\_\_\_ May I contact him/her? \_\_\_\_\_

Reason for your visit? \_\_\_\_\_

Previous mental health contacts or evaluations: \_\_\_\_\_

May I contact him/ her/ that agency? \_\_\_\_\_

Family physician? \_\_\_\_\_

May I contact him/her? \_\_\_\_\_ Approximate date of last visit: \_\_\_\_\_

Chronic Health Conditions: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Please list all Members of the Household (including yourself):

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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*I understand that full payment is expected at the time of service unless other arrangements have been made in advance with the therapist. I accept financial responsibility for this account regardless of insurance coverage. Co-payments (or session fees applicable toward insurance deductibles) are due at the time of service.*

*I understand that I am financially liable for the full fee if I fail to cancel my appointment at least 24 hours in advance. Exceptions may be made in emergency situations.*

*My signature below indicates my authorization for my treatment and my agreement to the business policies and procedures of this provider as outlined herein and in the more detailed explanation of Business Policies & Procedures provided to me.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MARGARET BERTON, Ph.D., Psychologist**

21 Lynn Batts Lane, Suite 11

San Antonio, Texas 78218-3017

Phone: (210) 829-1994 Fax: (210) 829-8788

Dear Client,

Welcome to the practice of Dr. Margaret Berton. This letter is intended to inform you of current billing procedures. Therapy Partner Corporation manages all billing matters on behalf of the practice by electronically processing session fees from clients at the time of service.

This system allows clients or patients to pay for treatment at the time of service without having to bring physical payment to their session. Checking account information or a credit card number will be captured using the *Electronic Payment Authorization* form at your initial consultation. Session fees will then be deducted from the designated account each time you receive treatment.

Clients will receive a monthly statement via email for any treatment sessions attended within a calendar month. Clients can also log on to Therapy Partner's website to access printable billing statements if needed. All statements generated by Therapy Partner are insurance-ready for easy reimbursement.

Feel free to contact Therapy Partner regarding any billing activity related to your treatment in the following manner.

Therapy Partner Corporation

Email: [info@therapypartner.com](mailto:info@therapypartner.com)

ACCOUNT VIEW: [WWW.THERAPYPARTNER.COM](http://WWW.THERAPYPARTNER.COM)

Phone: (303) 782-5555

Toll Free: (877) 232-9847

Billing is handled in this way to allow me to focus on therapeutic care during our time together. I look forward to working with you and /or your family member.

Sincerely,

Margaret Berton, Ph.D.

## ELECTRONIC PAYMENT AUTHORIZATION FORM

This form should serve as a reminder to all clientele that this provider uses a third party billing agency, Therapy Partner Corporation, to manage all billing and administrative functions.

This service allows your payment for treatment to be electronically deducted from a designated checking/savings account, or credit card. Checks, Visa, Mastercard, and Discover cards will be accepted. The billing information provided below will be registered with Therapy Partner Corporation and will be used to process your payment for treatment.

**Please review and complete all relevant sections.**

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Social Security Number** (Responsible Party): \_\_\_\_\_

**Responsible Billing Party Name** (as shown on Credit Card/Account): \_\_\_\_\_

**Billing Address** (as registered with Credit Card Company/Bank):  
\_\_\_\_\_  
\_\_\_\_\_

**Mobile Number:** \_\_\_\_\_ **Home Phone Number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Check One:** Debit Card: \_\_\_\_\_ Credit Card: \_\_\_\_\_

-OR-

**Card Type** (Visa, Mastercard, or Discover): \_\_\_\_\_

**Card#:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

Please return this completed form to Dr. Berton

**Do you have other health insurance besides Tricare? If so, If NOT, skip this page.....>>**

**If you are using other insurance besides Tricare, before your first visit.....**

Please contact your insurance company and request authorization for your visits. You will need to call the "800" number on the back of your insurance card, and be certain that I am a provider for your plan.

I will need to know the following information when you come for your visit:

Insurance plan name: \_\_\_\_\_

Insurance company (if different): \_\_\_\_\_

Policy holders' name: \_\_\_\_\_

ID#: \_\_\_\_\_

Social Sec #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Your relationship to the policy holder: \_\_\_\_\_

Is this insurance primary? (with Tricare secondary?) YES / NO (Circle one)

I will also need a copy of your insurance card, front and back, so that I have contact information, and address to which claims are to be sent. You may provide me with that copy when you come, or I will copy your card for you.

*That's it..... I am looking forward to being of assistance to you..... Dr. Berton*

**PATIENT ACKNOWLEDGMENT  
OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge receipt of the following document(s):

- Notice of Privacy Practices: Summary (the next three pages --->)
- Notice of Privacy Practices: Complete Document

Patient's Name: \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT, LEGAL  
REPRESENTATIVE \_\_\_\_\_

PRINTED NAME \_\_\_\_\_  
(NOTE: IF REPRESENTATIVE SIGNS FORMS, COPIES OF LEGAL DOCUMENTATION MUST BE  
ATTACHED OR ON FILE.)

DATE: \_\_\_\_\_

**21 LYNN BATTS LANE, SUITE 11, SAN ANTONIO, TEXAS 78218**

# Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Medical and Mental Healthcare Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

## I Uses and Disclosures for Treatment, Payment, and Health Care Operations

I MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI), FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PURPOSES WITH YOUR CONSENT. TO HELP CLARIFY THESE TERMS, HERE ARE SOME DEFINITIONS:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”  
Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician, psychiatrist or another psychologist.  
Payment is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer or managed care organization to obtain reimbursement for your health care or to determine eligibility or coverage.  
Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.  
“DISCLOSURE” APPLIES TO ACTIVITIES OUTSIDE OF MY OFFICE, SUCH AS RELEASING, TRANSFERRING, OR PROVIDING ACCESS TO INFORMATION ABOUT YOU TO OTHER PARTIES.

## II Uses and Disclosures Requiring Authorization

I MAY USE OR DISCLOSE PHI FOR PURPOSES OUTSIDE OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS WHEN YOUR APPROPRIATE AUTHORIZATION IS OBTAINED. AN “AUTHORIZATION” IS WRITTEN PERMISSION ABOVE AND BEYOND THE GENERAL CONSENT THAT PERMITS ONLY SPECIFIC DISCLOSURES. IN THOSE INSTANCES WHEN I AM ASKED FOR INFORMATION FOR PURPOSES OUTSIDE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, I WILL OBTAIN AN AUTHORIZATION FROM YOU BEFORE RELEASING THIS INFORMATION. I WILL ALSO NEED TO OBTAIN AN AUTHORIZATION BEFORE RELEASING YOUR PSYCHOTHERAPY NOTES. “PSYCHOTHERAPY NOTES” ARE NOTES I HAVE MADE ABOUT OUR CONVERSATION DURING A PRIVATE, GROUP, JOINT, OR FAMILY COUNSELING SESSION, WHICH I HAVE KEPT SEPARATE FROM THE REST OF YOUR MEDICAL RECORD. THESE NOTES ARE GIVEN A GREATER DEGREE OF PROTECTION THAN PHI.

YOU MAY REVOKE ALL SUCH AUTHORIZATIONS (OF PHI OR PSYCHOTHERAPY NOTES) AT ANY TIME, PROVIDED EACH REVOCATION IS IN WRITING. YOU MAY NOT REVOKE AN AUTHORIZATION TO THE EXTENT THAT (1) I HAVE RELIED ON THAT AUTHORIZATION; OR (2) IF THE AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE, AND THE LAW PROVIDES THE INSURER THE RIGHT TO CONTEST THE CLAIM UNDER THE POLICY.

## III Uses and Disclosures with Neither Consent nor Authorization

I MAY USE OR DISCLOSE PHI WITHOUT YOUR CONSENT OR AUTHORIZATION IN THE FOLLOWING CIRCUMSTANCES:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and

Regulatory Services.

- **Health Oversight:** If a complaint is filed against me with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

#### IV Patient's Rights and Psychologist's Duties

##### Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.  
I RESERVE THE RIGHT TO CHANGE THE PRIVACY POLICIES AND PRACTICES DESCRIBED IN THIS NOTICE. UNLESS I NOTIFY YOU OF SUCH CHANGES, HOWEVER, I AM REQUIRED TO ABIDE BY THE TERMS CURRENTLY IN EFFECT.

V Complaints

IF YOU ARE CONCERNED THAT I HAVE VIOLATED YOUR PRIVACY RIGHTS, OR YOU DISAGREE WITH A DECISION I MADE ABOUT ACCESS TO YOUR RECORDS, YOU MAY CONTACT ME AS THE PRIVACY MANAGER OF MY PRACTICE, 21 LYNN BATTS LANE, SUITE 11, SAN ANTONIO, TEXAS 78218 (210) 829-1994, FAX (210) 829-8788.

YOU MAY ALSO SEND A WRITTEN COMPLAINT TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, 1301 YOUNG STREET #1169, DALLAS, TEXAS 75202, (214) 767-4056, FAX (214) 767-0432, TDD (214) 767-8940.

VI Effective Date, Restrictions and Changes to Privacy Policy

THIS NOTICE WILL GO INTO EFFECT ON APRIL 14, 2003.