

**Margaret Berton, Ph.D.
Licensed Psychologist**

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INFORMATION FOR NEW PATIENTS

Please read over this information, then sign and date the Informed Consent for Treatment. Keep this information for your records.

Forms to complete begin on page 3.

Thank you for choosing me as your psychologist. I appreciate the importance of your confidence. I will do all that I can to ensure your continuing trust. The following is information regarding office policies and procedures and should answer common questions. My goal is to ensure a comfortable, productive and fully informed professional relationship.

Privacy of Information: The information you share with me is kept confidential. I do not discuss personal information about clients with other people. Only with your written consent can information about you be shared. It is often helpful to me to communicate with the professional who referred you, with your family doctor, or, in the case of children, with school teachers or counselors. Insurance companies also frequently request information to verify that services you are receiving are reimbursable under the terms of your health insurance policy. You have complete control over whether or not information about you will be released. You can authorize the release of some information but request that other information remain confidential.

Exceptions: There are some rare exceptions to the general policy prohibiting the release of information without your specific authorization. If you are involved in a court matter that involves the best interest of a child, the court can subpoena my records and my testimony and I may be compelled to release the information even if you object.

A second, unlikely exception to the general right of confidentiality would occur if I believe that releasing some information about you is vitally necessary to protect you or others. If I have good reason to believe that suicide or injury to another person is an imminent danger, I am obliged to take action to protect you or others. If a teenager's behavior creates extreme personal risk which could be prevented by disclosing confidential information to the parents, I am obliged to do so.

Lastly, I am required by law - as a licensed professional with the State of Texas - to notify authorities if I believe or suspect that a child or elderly person is being abused.

There are two situations in which I might talk about you with a colleague. When I am away from the office for an extended period of time, I have a trusted colleague take emergency calls for my clients. This person will be available to you in emergencies. Therefore, he or she needs to know enough about you to be helpful. Generally, I will tell my colleague only what he or she would need to know for an emergency. Of course, my colleague is bound by the same laws and rules as I am regarding the confidentiality of information.

I sometimes consult with other doctors and mental health professionals about my clients. This helps me in providing the best possible treatment for you or your child. The people I consult are also required to keep your information private. I do not discuss clients by name and I disclose only what is necessary for my colleague to understand the situation.

Fees: Please pay for my services at each session. Unless otherwise dictated by your insurance plan, my fee for an initial evaluation is \$175.00, and \$150.00 for regular psychotherapy sessions. Sessions are 50 minutes long. Fees also apply to computer-administered psychological tests, data analysis, report-writing, case-related correspondence, telephone consultation (longer than 10 minutes), and duplication of records. When I participate in a school meeting or court appearance on your behalf, my hourly fees apply to these activities, and are not covered by your health insurance plan. Payments can be made by cash, check, and debit or credit cards (Visa and MasterCard). I am happy to provide detailed statements of your account on request. If I am an out-of-network provider for your insurance plan, you will need this statement to submit for reimbursement. Payment of co-payments or deductibles are to be paid to me at each session. You may leave a credit or debit card on file with me for your convenience.

Appointment Times and Scheduling: Your appointment times are reserved especially for you. For this reason, it is important that you keep all scheduled appointments, or cancel according to these policies. If you must cancel or reschedule an appointment, please notify me at least 24 hours in advance so I can assign your appointment time to another client. *I make a charge for appointments which are not cancelled with 24 hours notice.* Exceptions are made for emergency situations. The first missed or late-cancelled appointment is \$50. Subsequent missed or late-cancelled appointments are billed at the allowable rate according to the terms of your health insurance policy, or at a full-session fee. *Please note that insurance companies will not reimburse you for fees for missed or late-cancelled appointments. Thus, missed appointment fees are **your** responsibility.*

Appointments are generally 50-minutes long. I try to begin within 10 minutes of our scheduled appointment time. Please try to arrive promptly to insure that you have a full therapy session. Ten minutes between sessions is the minimum I need to record notes in your record, return phone calls, or tend to other administrative business.

Emergency Availability: To contact me, please call the office number, 210-829-1994, and press 4. You may press 4 to bypass the outgoing message. However, if I am out of the office, the outgoing message may contain instructions for how to direct your call. When I am with clients, the telephone ringer is off so you will be connected to my voicemail where you can leave me a message. If you *must* reach me immediately in an emergency, or if you are calling to cancel a scheduled appointment within 24 hours of the appointment, please text or call 210-430-5199. In emergency situations, I will return your call as soon as possible. If I am unavailable (out of town or ill), I will arrange coverage with one of the other providers with whom I office. Dr. Madeleine Reichert, Donald McCann, Robert Zachary or Jay Vargas-Zachary usually provide emergency back-up for me.

Information about Me: I am aware of the importance of training, experience and professionalism in the treatment of emotional and life-adjustment difficulties. I welcome your questions about my background, training, experience and my treatment philosophy and procedures. You can also access more information about me at www.drberton.com.

Margaret Berton, Ph.D.
January 4, 2018

CONFIDENTIAL INFORMATION (Please Print)

Name: _____

Age: _____ Birth Date: _____ Gender: _____

Home Address: _____ City/State/Zip _____

Telephone #'s

Home: _____ Work: _____ Mobile: _____

e-mail address: _____

Occupation: _____ Education _____

Employer or School: _____

You were referred by? _____

May I contact him/her? _____ Reason for your visit?

Please list all the people living in the home with you?

Name	Age	Relationship
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Previous mental health contacts or evaluations:

Professional's Name

Dates (from...to)

Problem or Concern

May I contact anyone listed above? Yes / No (circle one)

Family physician? _____

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

THE SPACE BELOW IS AVAILABLE FOR PROVIDING ME WITH FURTHER INFORMATION ABOUT YOU OR YOUR FAMILY WHICH YOU FEEL IS IMPORTANT FOR ME TO KNOW:

INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

I have read Dr. Berton's 2-page Information for New Clients document. I agree to the policies therein with regard to confidentiality, fees, appointment times, scheduling and canceling appointments, and emergency coverage. My signature below indicates that I have been fully informed of these policies, I agree to comply with these policies and I consent to treatment by Dr. Berton.

Signature

Date

PATIENT CONTACT INFORMATION

Email is not secure. That is, email can be like a postcard that anyone can read. Federal regulation requires that your health information be protected. You may send an email message to Dr. Berton that is encrypted (and therefore secure) via www.drberton.com. With email you may request an appointment time in the event you are unable to schedule online. You may also ask brief questions, or provide Dr. Berton with information relevant to an upcoming session or our work together. **EMAIL SHOULD NEVER BE USED FOR EMERGENCIES.**

_____ (initial) I understand the Email Policy

This office may find it necessary to leave a message on your personal answering machine or voice mail if you are unavailable. These messages may contain confidential information, for instance, the fact that you are a patient (e.g., returning your call). These messages may be heard by people other than you. If it is acceptable to leave a message on your answering machine, please initial below.

_____ Yes _____ No

At times there may be a need to send or receive information concerning your treatment to or from another office, school, clinic, or hospital. Please initial below if it is acceptable to use FAX communication.

_____ Yes _____ No

To expedite your health care and in the interest of convenience, Dr. Berton may use mobile and/ or cordless telephones to discuss your care with you or other providers, clinics, hospitals, schools, etc. Therein exists the possibility that unauthorized persons may intercept or overhear such conversations; however, this is not routinely anticipated. The policy of this office is to occasionally use a mobile or cordless device. If this is acceptable to you, initial below.

_____ Yes _____ No

I have read the two Policy documents (Information for New Clients and Informed Consent and Authorization for Treatment). I understand and agree to these policies.

Signature of Client / Patient or Responsible Party

Date

**ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES**

_____ I have reviewed this office's Notice of Privacy Practices which explains how my (or my child's) medical information will be used and disclosed.

_____ I understand that I am entitled to receive a copy of this document.

_____ I understand that copies are available at www.drberton.com and the office.

Signature of Client/ Patient or Responsible Party

Date

