

BLAKE P. MITCHELL, PhD  
Licensed Clinical Psychologist  
17103 Preston Road, Suite 288  
Dallas, TX 75248  
214/629-1389

I would like to first welcome you to my practice and thank you for your decision to trust me with the health and well being of you and your family. Below you will find several pieces of information that will be helpful to both parties as we begin and continue through this process. If you have any questions and/or concerns about any of the information presented below, please ask at any time.

### **Policies and Procedures**

**Records of Your Care:** Visits, and in some cases telephone contacts, are documented in your personal file and maintained with specific attention given to patient privacy and confidentiality. Record entries try to balance reasonable expectations of privacy against the possible need for information during future care.

**Limitations to Privacy:** What is discussed during the course of treatment is held in the strictest of confidence. However, Federal and State law governs the limits of your privacy, and it is important for you to understand the limitations prior to initiating a professional assessment or treatment relationship with a clinic provider. Release of your record *generally requires your written consent*. However, your *therapist is required to release* the following information:

1. If the therapist or staff believes that you intend to harm yourself or someone else, it is our duty to initiate appropriate action to protect you or others. This may include informing appropriate authorities.
2. In situations of suspected abuse, it is our duty to inform appropriate agencies.
3. Your records may be subject to subpoena when ordered by a judge.
4. Disclosure will be made to insurance carriers to process claims for services rendered. You are required to provide other insurance information.
5. If you are seen in group therapy, you and every member of the group will be told that anything discussed is private. This includes the names of the group members or any problems that they present. This is not to be talked about with anyone outside of the group. Confidentiality will only exist to the extent that each patient trusts and respects every other member of the group.

**Payment of Services:** Payments for services rendered are due at the time the services are provided and are the responsibility of the client/guarantor. Due to a wide variety of insurance policies and coverage, we cannot guarantee that your policy or insurance company covers the services provided. The client and/or guarantor are ultimately

responsible for payment since the services are provided to the client and not to his/her insurance company. Returned checks are assessed a charge of \$20.00. Fees for other services that may arise as treatment progresses, including telephone consultations, psychological testing and report writing and legal services, will be discussed as they arise.

**Cancellation Policy:** 24-Hour notice must be given prior to the scheduled appointment time. If a 24-Hour notice is not given, the full fee will be charged.

**Your Rights:** You have the right to obtain and expect considerate and respectful care, with recognition of your personal dignity. You have the right to know at all times, the professional status and professional credentials of your health care provider. You have the right to an explanation concerning your diagnosis, treatment and prognosis of illness in understandable terms. You have the right to be advised of information needed to make knowledgeable decisions regarding consent or refusal of treatment. Such information should include significant complications, risks, benefits and appropriate alternative treatments.

I look forward to working with you and your family.

Blake P. Mitchell, PhD

Please sign the following page acknowledging receipt and understanding of the above information and return it to our office with the subsequent questionnaire.

BLAKE P. MITCHELL, PhD  
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Your signature affirms that:

You have read the Policies and Procedures and have been informed of some of the structures and/or responsibilities of this psychological treatment process. This disclosure was understood and enabled you to make an informed, voluntary consent to this treatment. It is understood that you may revoke this consent at any time.

You are financially responsible for payment in full of all services by Blake P. Mitchell, PhD. Should you get behind in your financial responsibilities, Dr. Mitchell has the right to withhold further treatment until payment for prior services has been received.

You represent that you have the legal authority to obtain counseling for any minor children treated.

\_\_\_\_\_  
**Signature / Patient or Legal Guardian**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Day      Month      Year**