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358 Veterans Memorial Highway, Suite 10
Commack, NY 11725
(516) 336-8149

REGISTRATION FORM

PATIENT'S NAME _____ **Today's Date** _____

Social Security # _____ Birthdate _____ Marital Status □ S □ M □ D □ W

Address _____ City _____ Zip _____

Reason for appointment? _____

How were you referred? _____

May I send statements or other information to your home? □ Yes □ No

Home phone: _____ Messages: □ Okay voicemail □ Okay other person □ No messages

Work phone: _____ Messages: □ Okay voicemail □ Okay other person □ No messages

Cell phone: _____ Messages: □ Okay voicemail □ Okay other person □ No messages

Other phone: _____ Messages: □ Okay voicemail □ Okay other person □ No messages

SPOUSE / SIGNIFICANT OTHER / OTHER PARENT INFORMATION:

Name _____ Birthdate _____ Social Security # _____

Address _____ City _____ Zip _____

Home phone: _____ Messages: □ Okay voicemail □ Okay other person □ No messages

Work phone: _____ Messages: □ Okay voicemail □ Okay other person □ No messages

Cell phone: _____ Messages: □ Okay voicemail □ Okay other person □ No messages

Other phone: _____ Messages: □ Okay voicemail □ Okay other person □ No messages

OTHERS LIVING IN THE HOME, AND ALL CHILDREN:

Name _____ Birthdate _____ Name _____ Birthdate _____

Name _____ Birthdate _____ Name _____ Birthdate _____

IN CASE OF EMERGENCY, WHOM SHOULD I NOTIFY, OTHER THAN FAMILY?

Name _____ Phone _____ Relationship _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Policy # _____ Group # _____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other _____

Name of Subscriber (if other than patient): _____

Subscriber's Social Security #: _____ Gender: □ Male □ Female

Subscriber's Date of Birth: _____

Employer of Subscriber: _____ Work Phone: _____

Secondary Insurance Company: _____

Policy # _____ Group # _____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other _____

Name of Subscriber (if other than patient): _____

Subscriber's Social Security #: _____ Gender: □ Male □ Female

Subscriber's Date of Birth: _____

Employer of Subscriber: _____ Work Phone: _____

Informed Consent & Agreement For Psychotherapy Services

This document can be found on my website at www.drbethhollander.com/forms

Introduction. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to serve you better.

Information about your therapist. Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns.

Fees. The fee for service is $175 per 45-minute therapy session, unless otherwise specified. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure.

If there is a need for telephone contact, with you or a third-party, other than for scheduling purposes, you understand that you are responsible for payment of the agreed-upon fee (on a pro rata basis) for any calls lasting longer than 10 minutes.

Appointment scheduling and cancellation policies. Sessions are typically scheduled to occur one time per week at the same time and day, if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. Scheduled appointment times are reserved especially for you. If an appointment is missed, or canceled with less than 24 hours notice, you will be charged the full fee for that missed session. **Exceptions may be made if you are sick or have an unavoidable emergency.**

Delinquent accounts. You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay interest at 1.5% per month. If it becomes necessary for the account to be referred for collection action, you agree to pay the actual balance due plus any collection expenses of 30-50% of any balances owing, and any attorney's fees.

Risks and benefits of therapy. Therapy is a process in which we will discuss many issues, events, experiences, and memories for the purpose of creating positive change, so that you can experience your life more fully. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties you may be experiencing. Therapy is a joint effect between us. Progress and success may vary, depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on your part, including an active

participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences. The process may evoke strong feelings of sadness, anger, fear, anxiety, etc. There may be times in which I will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is your sole responsibility.

During the therapeutic process, many people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You should discuss with me any concerns you have regarding your progress in therapy. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Discussion of treatment plan. It is my intention to provide services that will assist you in reaching your goals. Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, and therapeutic objectives. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Termination of therapy. The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session, if at all possible.

Professional consultation. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your situation.

Collaboration with other professionals. To provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases, I may not be able to provide services without this.

Records and record keeping. I may take notes during session, and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which, by law, I am required to maintain. Such records are the sole property of the psychologist. Should you request a copy of your records, such a request must be made in writing. I reserve the right to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I typically maintain records for seven years following termination of therapy. After seven years, your records will be destroyed in a manner that preserves your confidentiality.

Confidentiality. The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required and permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else, cases involving suspected child, elder, or dependent adult abuse, cases in which I am court-ordered to testify and produce records, or as outlined in the "Notice of Privacy Practices" (copies available on my website).

Psychologist-patient privilege. The information disclosed by you, as well as any records created, is subject to the psychologist-patient privilege. The psychologist-patient privilege results from the special relationship between Psychologist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychologist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychologist-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. **You should be aware that you might be waiving the psychologist-patient privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal proceeding.** You should address any concerns you might have regarding the psychologist-patient privilege with your attorney.

Patient litigation. I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services of $150 per hour.

Email and phone communication. Some patients prefer to communicate about appointment times or other administrative issues via email. Email transmitted through regular services is not encrypted. This means that a third party may be able to access information in an email and read it, since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it. This may include your employer, if you use a work-related email address. Email should be considered more similar to a "post-card" than to a sealed letter. For that reason, I discourage sending any clinical or other sensitive information via email. **Please use the telephone for anything urgent or time-sensitive**, as I cannot guarantee that I will see an emergency email.

Please initial the options that meet your needs. You can change this at any time by communicating to me in writing. Please ask if you have questions about this.

_____ I do not wish to receive any treatment-related information via email.

_____ I understand the risks of unencrypted email, and do hereby give permission for Dr. Beth Hollander to contact me or to reply to me via unencrypted email. Please provide preferred email address:

_____

Therapy availability / emergencies. You may leave a message for me at any time on my voicemail at (516) 336-8149. If you wish for me to return your call, please be sure to leave your name and phone number(s), along with a brief message regarding the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Friday). **Please understand that as a solo outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or any emergency involving a treat to your safety or the safety of others, please call 911 to request emergency assistance or go to the nearest emergency room.** For other types of urgent situations, please follow any instructions that are provided on my voicemail at (516) 336-8149 and leave your message there. I will do my best to return your call as promptly as I can. Please do not use email for urgent situations. _____ Please initial that you have read this.

Acknowledgement

By signing below, Patient acknowledges that Patient has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with the psychologist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in therapy with the Psychologist. Moreover, Patient agrees to hold Psychologist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____	_____	_____
Patient Name (please print)	Signature of Patient (or authorized representative)	Date

I understand that I am financially responsible for payment for all services rendered.

_____	_____	_____
Name of Responsible Party	Signature of Responsible Party	Date

Consent to treatment of minors

This section must be completed by the parent or legal guardian of each child who attends session. Some custody agreements require the signatures of both parents for treatment. Because of this, it is generally my policy to require the signature of both parents in any divorce situation.

Confidentiality with minors

Minors over 12 years of age are entitled to privacy rights similar to those of adults. My role as a psychologist is to help minors learn to communicate openly and directly with their parents and I typically involve parents in the counseling process. That said, when children are making poor and dangerous decisions, parents will be brought into the conversation as soon as possible, which, in the case of many situations – such as suicidal ideation or attempts – is immediately.

I hereby consent to treatment of my child(ren) per the terms outlined in the above pages of this document:

Name _____ Birthdate _____ Name _____ Birthdate _____

_____	_____	_____
Parent / Guardian name (please print)	Parent / Guardian signature	Date
_____	_____	_____
Parent / Guardian name (please print)	Parent / Guardian signature	Date