



Gregory M. Crow, Ph.D.

Psychologist

NEW PATIENT INFORMATION

DATE _____

LAST NAME OF PATIENT _____ FIRST NAME _____

I do not have any form of Medicare coverage, whether it be disability or otherwise. _____ (Please Initial)

PATIENT STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

MARITAL STATUS: _____ S=single M=married Se=separated D=divorce W=widowed

BIRTHDATE _____ AGE _____ SEX: []M []F Email _____

HOME TELEPHONE (_____) _____ CELL TELEPHONE (_____) _____

EMPLOYER _____ WORK TELEPHONE _____ x _____

WHO REFERRED YOU? _____

I AUTHORIZE A **THANK YOU FOR REFERRING LETTER** TO BE MAILED (PLEASE INITIAL) _____

**PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICES ARE RENDERED
SEE PAGE 3 FOR ITEMIZED CHARGES**

INFORMATION PERTAINING TO SPOUSE, PARTNER OR GUARDIAN

LAST NAME _____ FIRST NAME _____

I do not have any form of Medicare coverage, whether it be disability or otherwise. _____ (Please Initial)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ AGE _____ SEX: []M []F Email _____

HOME TELEPHONE (_____) _____ CELL TELEPHONE (_____) _____

EMPLOYER _____ WORK TELEPHONE _____ x _____

INFORMATION PERTAINING TO PATIENT'S CHILDREN

NAME	BIRTHDAY	AGE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

7510 East Angus Drive
Scottsdale, Arizona 85251
480-947-1989
Appts 623 -572-4128
Fax 480 -621-4105

TREATMENT AGREEMENT

PLEASE REVIEW AND ASK ABOUT ANYTHING YOU DO NOT FULLY UNDERSTAND.

PLEASE INITIAL AND SIGN WHERE INDICATED AFTER THOROUGHLY READING.

BENEFITS AND EMOTIONAL RISKS: Most people who come in for treatment are seeking help to improve significant relationships and/or receive relief and education related to mental and emotional problems they are experiencing. When you first come into therapy we will mutually establish a treatment plan for you and review it together as we proceed. You may refuse any treatment that I recommend and/or withdraw informed consent in writing at anytime. Revocation of informed consent will be binding on me unless I have taken action in reliance on it. Refusal of counseling treatment or withdrawal from counseling may have potential consequences such as not reaching your counseling goals, and/or uncomfortable emotions such as sadness, guilt, and helplessness. There are no guarantees of what you will or will not experience. Once obtaining psychological services, the majority of individuals and family benefit from the process. Self-exploration, learning new skills and ventilating difficult feelings are generally quite helpful. Some risks do exist. As counseling starts, please understand that examining issues may produce strong feelings of unhappiness, anger or frustration, or shame. These and other feelings are a difficult, but natural part of the psychotherapeutic process and often provide the basis for needed change. Also, important personal decisions are often an outcome of counseling. Changes in behavior in the work place, at home and in one's family of origin produce new opportunities as well as challenges. Decisions made by one family member may be viewed negatively by another. Do not be hesitant to discuss treatment goals, procedures, or your impressions of the services that are being provided.

CONFIDENTIALITY: A client's confidentiality is important and is legally protected. There are circumstances where that privileged communication is limited: 1) We are required to report suspected child or elder abuse or neglect and are obligated to take steps to inform others if a client is a danger to self or others. 2) Confidentiality may be waived if a client sues the psychologist or in the event of a court order or other legal proceeding. 3) When a clinician is out of town another professional will cover crisis calls and that person may be advised of issues that might arise on your case. 4) If a health plan is expected to pay for some portion of the cost of services, it must be understood that some communication of same information regarding diagnosis, course of treatment and prognosis may be shared. 5) In the event that group counseling services are provided, it is acknowledged that the doctor or practice cannot be held responsible for a breach of confidentiality on the part of a peer group member (see group rules sheet).

In accordance with Arizona Revised Statute (A.R.S.) § 12-2293, with your written request of access to or copies of your client records, I shall promptly provide your client records to you or the person that you designate in writing (for example, another health professional or your legal representative) unless I determine and notify you that access to your client records is contraindicated. Also, I am exempt from making available raw test data and psychometric testing materials. There may also be additional limitations on access to your records not mentioned here but found in the Arizona Revised Statutes that apply. If I determine that you should not have access to your client records, I shall note this determination in your client record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence. In the event of my extended unavailability, a protocol has been developed providing for your access to your records.

COUPLES' COUNSELING: At times one or both individuals may have history of or be presently involved in activities that their partner does not know about. In many cases, keeping significant information secret is not in the best interest of the relationship. Please raise these issues privately with me as soon as possible and if, in my opinion, these issues need to be brought into counseling I will support ways to accomplish that. If we do not have agreement going forward, I will terminate our couples' work and suggest other alternatives for you.

REPPRESSED MEMORY: I understand from the beginning of treatment with Dr. Crow that he cannot confirm or deny my memories – whether they be “repressed” memories or not. Dr. Crow will help me process the resulting feelings and issues that may surface as a result of any memories. I understand that the reliability of repressed memory is controversial and that the decision whether or not to confront the “perpetrator” is controversial due to it's potential ill effects on me and my family. I understand the risks and challenges and potential ramifications (both ways) of this very difficult issue and that Dr. Crow will support my decision either way.

INITIAL _____

INITIAL _____ (SPOUSE, SIGNIFICANT OTHER)

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Fax 480 -621-4105

RELEASE OF INFORMATION: In order to provide the most efficient and appropriate care, it is important that we obtain records from previous care givers. Please complete one *Release of Information* form for each professional you wish us to communicate with.

HOURS/AVAILABILITY: Appointments are scheduled weekdays between the hours of 8:15am and 4:15pm and are for a counseling hour, 40-50 minutes in length. To set an appointment, call Sandy at 623-572-4128 during the hours of 8am-12pm Monday through Friday. You may leave a message for Dr. Crow any time by calling 480-947-1989. For emergencies during non-office hours, please call your family physician, 911, or go to an emergency room.

CANCELLATIONS: It is my policy to charge for appointments not canceled as follows:

“ONE hour” session a minimum of 24 hours cancellation notice
“TWO hour” session a minimum of 72 hours cancellation notice

To assist in your compliance with this policy, you may leave a message at 623-572-4128 24 hours a day. I understand that it is my responsibility to call a minimum of **24 hours** prior to a scheduled appointment to cancel a “one hour” appointment regardless of the reason. By not complying, I am responsible for the full amount of \$175, which cannot and will not be billed to insurance. I understand that a minimum of **72 hours (3 days)** is required to cancel a “two hour” appointment regardless of the reason. By not complying, I am responsible for the full amount of \$350, which cannot and will not be billed to insurance.

EMERGENCIES: In the event of an emergency or crisis and Dr. Crow is unavailable, call your primary care physician, a crisis intervention service or go to an emergency room.

CASE PREPARATION: There will be times that I will be required to gather information from prior therapists, family, acquaintances, complete paperwork, etc. The majority of the time this is expected and simply part of the process and there is no additional charge. Should an occasion arise that requires a greater amount of time than usual gathering information or a crisis intervention resulting in the cancellation of a scheduled appointment(s), there will be an additional charge.

PAYMENT: It is expected that clients **PAY FOR EACH VISIT AT THE TIME OF THE SESSION.** I do not accept credit card payments associated with any type of healthcare account.

INSURANCE: I DO NOT ACCEPT INSURANCE. You will receive a receipt at the time of the session that you may file either to your insurance company or submit to a flex plan or medical savings account. I do not accept any credit card payment associated with any type of healthcare account. **It is your responsibility to know what your health plan will and will not cover.** Benefit information obtained from your insurance company does not guarantee payment. Actual amounts may differ as the benefit determination of claim payment is made at the point the claim is processed. **I understand that at times my insurance company may contact the provider for information regarding a claim I have submitted. In such case(s), I authorize the release of any medical or other information necessary to process the claim.** Some insurance carriers are now requiring case management for out-of-network benefits even though I am not a contracted provider. If this is your situation, you may not have coverage. If you have any questions please call Sandy for assistance.

CHARGES: The following standard charges apply:

INITIAL CONSULTATION	\$200.00 /40-50 minute session
INDIVIDUAL THERAPY	\$175.00 /40-50 minute session
INDIVIDUAL THERAPY	\$115.00 /20-30 minute session
FAMILY THERAPY	\$175.00 /40-50 minute session (NOTE: Family Therapy may not be covered by your insurance)
GROUP PSYCHOTHERAPY	\$ 60.00 /90 min
PSYCHOLOGICAL TESTING	\$150.00 /hour
CASE PREPARATION and CRISIS INTERVENTION	\$175.00 /hour
FORENSIC FEES – charges are from portal to portal when not at Dr. Crow’s office	\$200 /20-30 minutes \$250 /30-60 minutes
Deposition	\$250 /per half hour by phone \$1,000/per half day in person
Court Appearance	\$2,000/per day \$1,000/per half day
Cancellation – Dr. Crow may charge a cancellation fee when a scheduled deposition or court appearance is cancelled less than 72-hours in advance. The cancellation fee will be based on the number of hours cancelled.	
RETURNED CHECKS	\$ 25.00
MONTHLY PROCESSING FEE	10% of balance

No payment or contact to our office in 120 days constitutes the account as delinquent and may be referred for collections.

=====

INITIAL _____

INITIAL _____ (SPOUSE, SIGNIFICANT OTHER)

I have initialed each page of this Treatment Agreement indicating that I have read and reviewed the information contained herein. I have had the opportunity to ask any questions and they have been answered to my satisfaction. I accept these understandings and agree to have my self/son/daughter/family participate in treatment.

SIGNATURE of client or parent if client is a minor

DATE

SIGNATURE (Spouse/Significant Other)

DATE

I have received the Notice of Privacy Policy.

SIGNATURE of client or parent if client is a minor

DATE

SIGNATURE (Spouse/Significant Other)

DATE



Gregory M. Crow, Ph.D.

Psychologist

AUTHORIZATION FOR INFORMATION RELEASE

RE: _____ DOB: _____

I authorize Dr. Crow's office and the individual(s) stated below to discuss and/or exchange information as initialed below. It is understood that this release is granted to assist the staff with appointment scheduling and financial arrangements.

It is understood this authorization covers the scheduling of couple's appointments where both parties are expected to be present and it is further understood that information regarding individual appointments will remain confidential.

INITIAL BELOW

_____ Couple's Appointment(s) _____ Make Appointment(s) for the other
_____ Billing/Payment Information _____ Insurance Information (if applicable)

NAME

RELATIONSHIP

_____	_____
_____	_____
_____	_____
_____	_____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be released or disclosed without my written permission unless otherwise provided for in the law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. **This consent (unless revoked earlier) expires one year subsequent to the signing of this release.**

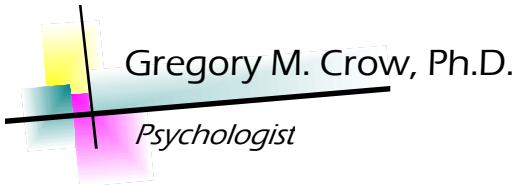
NAME _____

ADDRESS _____

SIGNATURE _____ DATE _____

(CLIENT/PARENT/GUARDIAN IF MINOR)

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INITIAL BELOW

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_____ Billing/Payment Information _____ Insurance Information (if applicable)

NAME

RELATIONSHIP

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be released or disclosed without my written permission unless otherwise provided for in the law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. **This consent (unless revoked earlier) expires one year subsequent to the signing of this release.**

NAME _____

ADDRESS _____

SIGNATURE _____ DATE _____

(CLIENT/PARENT/GUARDIAN IF MINOR)

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AUTHORIZATION FOR INFORMATION RELEASE

TO: _____
COUNSELOR, AGENCY, DOCTOR OR HOSPITAL

ADDRESS PHONE

RE: _____ DOB: _____

I authorize Dr. Crow and the agency or individual stated above to discuss and/or exchange information and/or reports as initialed below. It is understood that this release is granted to assist the staff at each agency/office. It is further understood that this information once obtained, it will not be released to any other agency or individual.

INITIAL ON THE LINE(S) BELOW	
_____ Social history/intake	_____ Treatment notes
_____ Psychological exam	_____ Hospitalization records
_____ Thank-you for referral letter	_____ Testing results
_____ Other (Specify) _____	

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be released or disclosed without my written permission unless otherwise provided for in the law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. **This consent (unless revoked earlier) expires one year subsequent to the signing of this release.**

NAME _____

ADDRESS _____

SIGNATURE _____ DATE _____
(PARENT/GUARDIAN IF MINOR)

WITNESS _____ DATE _____
(IF RELATIVE, STATE RELATIONSHIP)

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