PATRICIA KOCH, Ph.D., LICENSED PSYCHOLOGIST
3103 Bee Cave Road, Suite 101, Austin, TX 78746
(512) 371-7221 (office/fax) (512) 773-3923 (cell)

Couples Information Form

How long have you been in the current relationship?_____

How and under what circumstances did you meet each other?_____
_____
_____

What are the strengths in your current relationship?_____
_____
_____

What are the present concerns or problems in the relationship?_____
_____
_____

What help have you sought for the relationship? When, where, how?_____
_____
_____

Are you currently working with any other therapists?____ If yes, give names, phone numbers and length of time. _____
_____

How do you nurture the relationship?_____
_____
_____
_____

How do you express and receive affection in your relationship?_____
_____
_____
_____

How often do you make love with each other?_____
_____

Has there ever been any violence in your relationship?_____
If so, please describe_____
_____
_____
_____

Have there been any separations in your relationship?_____
If so, please describe_____
_____
_____

What is your goal for the relationship in making this appointment?_____
_____
_____
_____

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Confidential Health History Questionnaire
Please fill out and return with accompanying paperwork

Name_____Date of Birth_____Today's Date_____

1. Please describe your goal in making this appointment.

_____
_____

2. What motivated you to seek this appointment at this time?

_____

3. What help have you sought for this problem or related problems? Include dates of past therapy.

_____
_____

4. What results did you have? _____
_____

5. List all current medications or treatments for health problems, including natural remedies and vitamins. (use back if necessary)

_____
_____

6. If you are taking medications, list the prescribing physician_____

7. Do you use:

Alcohol	___Yes ___No	Frequency of Use_____ Amount_____
Drugs	___Yes ___No	Frequency of Use_____ Amount_____
Tobacco	___Yes ___No	Frequency of Use_____ Amount_____
Caffeine	___Yes ___No	Frequency of Use_____ Amount_____

8. Describe any physical problems you are experiencing_____

_____

Name_____

9. List the age(s) that any of the following occurred in your life:

MEDICAL	OTHER
_____liver disease	_____juvenile delinquency
	_____childhood fears
_____kidney disease	_____school phobia
	_____hyperactivity
_____pancreatitis	_____drug/alcohol abuse
	_____running away
_____epilepsy	_____teenage pregnancy
	_____truancy
_____thyroid disease	_____bedwetting
	_____physical abuse
_____cancer	_____sexual abuse
	_____incest
_____heart trouble	_____anorexia
	_____rape
_____diabetes	_____binge eating
	_____suicide attempts
_____venereal disease	_____sexual problem
	_____self-mutilation
_____AIDS or HIV	_____recent divorce
	_____behavior problems

10. What do you do for relaxation, fun, or pleasure_____
_____

11. What beliefs do you hold about yourself?_____
_____

12. How do other people describe you?_____
_____

13. Describe your current intimate relationship(s)._____
_____

14. What are your spiritual practices?_____
_____

15. Please list any past/current medical or psychological problems suffered by your children, siblings, parents, or grandparents (depression, anxiety, drug/alcohol abuse, suicide, or psychiatric hospitalization).

_____
_____

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OFFICE INFORMATION

· **I appreciate the opportunity to work together with you. My goal is to provide effective and efficient help for the problems you are experiencing. Below is information about my office policies.**

· **My intention is for my office to feel comfort and safe. Please let me know if there is anything I can do to help you feel more comfortable.**

· The first appointment is generally an **Initial Evaluation** and lasts approximately one to one and a quarter hours. Prior to the first visit, please complete the appropriate forms as they provide information for the first meeting. You can send those forms back or bring them with you on your first visit.

· The information you share with me is confidential and this information will not be discussed with anyone without written consent, except in the following situations: 1.) If you share information that indicates that you are a danger to yourself or others; 2.) If abuse of a minor, elderly, or disabled person is suspected, or if you provide information about such abuse; 3.) To insurers for claims payment; 4.) To mental health professionals who are in association with the psychologist for purposes of "covering" for me when I am unavailable or for purposes of hospitalization or for emergency psychiatric services; 5.) As required by state law; 6.) If I was appointed by the court to evaluate/provide service to you; 7.) If you file a suit against me for breach of a duty.

· Please notify me as soon as possible and within 24 hours when canceling or rescheduling an appointment. The reason for doing this is that we have agreed to meet at a specific time and this time slot is reserved for you. Missed appointments or those canceled with less than 24-hour notice carry a charge of 75% of full fee. This fee is payable before or at the time of the next appointment. The client, not the insurance carrier, is responsible for this charge. Payment is expected at the time of service. I accept cash, checks, or Visa or Mastercard credit cards.

· You are responsible for knowing your insurance benefits, including knowing whether a mental health provider is on your plan, and the type of services covered by your plan. The services you receive may exceed the benefits provided in your insurance or managed care benefits package. Managed care/insurance plans are often complicated, and I share what I know to help guide you in understanding what services and costs your plan accepts. Ultimately, it is your responsibility to know and manage your benefits. Accounts due for over 30 days are considered overdue. Delinquent accounts may be turned over to a collection agency and a surcharge will be added.

· I check my voice mail throughout the day and return calls as soon as possible, usually within a couple of hours or at the end of my work day. For urgent matters feel free to contact me on my business cell phone (512) 773-3923. In a life threatening situation contact your doctor, psychiatrist, the mental health hotline 472-4357, or go to the nearest emergency room.

· Please let me know if you have any questions or problem with my services. It is most productive to work out concerns at the time they occur. The ethical guidelines and practice standards published by the American Psychological Association and the American Association of Marriage and Family Therapists are adhered to in my practice. Questions about consumers' rights may be addressed to the Texas State Board of Examiners of Psychology (512/305-7700) and The Texas State Board of Examiners for Marriage and Family Therapists (512/834-6657)..

Keep a copy of this for your records

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Fee Information

The following is a list of my fees for psychological services:

Diagnostic Assessment/Intake Assessment	(90791)	$170
Individual Therapy 45 minutes	(90834)	$130
Family/Couples Therapy 50 minutes	(90847)	$150
Individual Therapy 30 minutes	(90832)	$ 75
Individual Therapy 60 minutes	(90808)	$150
Individual/Family Therapy 90 minutes		$200
Group Therapy 90 minutes	(90853)	$ 50
Neurofeedback in 10 session packets		$1200
Coaching 60 minutes		$130
Reports, letters up to 20 minutes		$ 50
Reports, letters up to 45 minutes		$100
Telephone Contact < 15 minutes		$ 35
Telephone Contact < 30 minutes		$ 60
Telephone Contact < 45 minutes		$ 85
Court or Deposition Services (per hour)		$250
No Call/No Show w/out 24 hour notice (Insurance does not cover this cost)		75 % of full fee

These fees do not reflect any contracted discounts with managed care plans or individuals. The total fee, or the agreed upon co-payments are due at the time of service unless alternative arrangements have been made.
****

My signature attests to the following: 1) I have read the Office Information and Fee Information forms, and I consent to engage in psychological services; 2) I authorize Patricia Koch, Ph.D. to release any pertinent information acquired in the course of my evaluation and treatment to my insurance company; 3) If pertinent, I authorize my insurance benefits to be paid directly to Patricia Koch, Ph.D., and I understand I am financially responsible for noncovered services; 4) I understand that Patricia Koch, Ph.D. is not "on-call" after office hours or on weekends; 5) I understand that Dr. Koch is a sole practitioner in independent practice and is not part of a group practice.

Signed_____Date_____
(Client)

Signed_____Date_____
(Client)

Keep one copy of this contract for your records.
Return one copy to me.

REGISTRATION INFORMATION

Please Print Date_____

Last Name First Name MI

Street Address Apt. No City State Zip

Social Security No. Sex Date of Birth Home Phone Cell Phone

Employer Occupation Work Phone E-mail

PRIMARY INSURANCE INFORMATION

Insurance Company/Plan Group No. Member Identification No.

Insurance Claim Address Insurance Phone No. Effective Dates

Self Spouse Dependent Other

Policyholder Last Name First Name MI Relationship to Policyholder

Policy holder Street. Address Apt. No. City State Zip

Policyholder Employer Occupation Date of Birth Sex

Policyholder Home Phone **Policyholder Work Phone** **Other Phone**

SECONDARY INSURANCE INFORMATION

Insurance Company/Plan Group No. Social Security No./Member No.

Insurance Claim Address Insurance Phone No. Effective Dates

Self Spouse Dependent Other

Policyholder Last Name First Name MI Relationship to Policyholder

Policy holder Street. Address Apt. No. City State Zip

Policyholder Employer Occupation Date of Birth Sex

Policyholder Home Phone Policyholder Work Phone Other Phone

EMERGENCY CONTACT

Last Name First Name Home Phone No. Work Phone No. Other Phone

Street Address Apt. No. City State Zip

Patricia Koch, Ph.D. Licensed Psychologist
HIPAA Notice of Privacy

Patient Name_____ Date of Birth_____

THIS NOTICE DESCRIBES HOW YOUR PRIVATE HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Private Health Information may be used and disclosed in the following circumstances:

1. **When required for public health issues such as workman's compensation.**
2. **Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.**
3. **When required by any state or federal law, including abuse and neglect.**
4. **When required for any specialized government or military functions including active personnel, reservist, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.**
5. **When used for any clerical purposes and necessary chart audits.**

You as the patient have rights to your private Health Information, including,

1. **The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored within 30-60 days.**
2. **The right to request information of any party that has requested information pertaining to your private health information.**
3. **The right to receive confidential information regarding your private health information.**
4. **The right to revoke this consent in writing, however, this will not affect any information already disclosed.**

I, as a private practitioner have the responsibility to:

1. **Make each patient aware of the Privacy Notice.**
2. **At any time make the necessary changes to Privacy Notice that are required by law.**

If you as the patient feel your privacy has been violated you have the right to complain by filing a written complaint with the Secretary of Health and Human Services in Washington, D.C.

I_____, hereby authorize Patricia Koch, Ph.D. to release private health information on my behalf to the following person(s): _____

_____ _____

Patient/Legal Guardian/Signature **Date**

_____ _____

Witness **Date**

Patricia Koch, Ph.D. Licensed Psychologist

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, & OPERATION

I understand that as part of my healthcare, Patricia Koch, Ph.D. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- **A basis for planning my care and treatment.**
- **A means for communication among health professionals who contribute to my care.**
- **A source of information for applying my diagnosis information to my bill.**
- **A means by which a third-party payer can verify that services billed were provided.**
- **A tool for routine operations such as assessing quality of care.**

I understand and have been provided with a HIPAA Notice of Privacy that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Patricia Koch, Ph.D. reserves the right to change her notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that my health information will not be used for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment or payment. I understand that I may revoke this consent in writing, except to the extent that Patricia Koch, Ph.D. has already taken action in reliance thereon.

___ I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Witness Date

Patricia K. Koch, Ph.D.
Licensed Psychologist

Consent to E-Mail

In order to comply with HIPAA law, I am required to inform you that while my computer is passworded, my E-mail is not considered to be secure.
If you would like to communicate with me my E-mail, you are required to provide informed consent.

I understand that my E-mail communications with Patricia Koch, Ph.D. are not considered secure. However I would like to communicate with her via E-mail.

_____ _____
Patient/Legal Guardian Date

_____ _____
Witness Date

SCL - 90 (revised)

NAME_____DATE_____

INSTRUCTIONS: During the **last 2 weeks**, how much has each of the problems listed below bothered or distressed you?

Key: 0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely

1.	Soreness of your muscles	0	1	2	3	4
2.	Numbness or tingling in parts of your body	0	1	2	3	4
3.	Heavy feelings in your arms or legs	0	1	2	3	4
4.	Weakness in parts of your body	0	1	2	3	4
5.	Pains in heart or chest	0	1	2	3	4
6.	Hot or cold spells	0	1	2	3	4
7.	Pains in lower back	0	1	2	3	4
8.	Trouble getting your breath	0	1	2	3	4
9.	Faintness or dizziness	0	1	2	3	4
10.	A lump in your throat	0	1	2	3	4
11.	Headaches	0	1	2	3	4
12.	Nausea or upset stomach	0	1	2	3	4

1.	Having to check and double-check	0	1	2	3	4
2.	Having to do things very slowly to insure correctness	0	1	2	3	4
3.	Your mind going blank	0	1	2	3	4
4.	Trouble remembering things	0	1	2	3	4
5.	Difficulty making decisions	0	1	2	3	4
6.	Trouble concentrating	0	1	2	3	4
7.	Worried about sloppiness or carelessness	0	1	2	3	4
8.	Feeling blocked in getting things done	0	1	2	3	4
9.	Having to repeat the same actions, i.e., counting, washing	0	1	2	3	4
10.	Unwanted thoughts, etc., that won't leave your mind	0	1	2	3	4

1.	Feeling afraid in open spaces or on the streets	0	1	2	3	4
2.	Feeling afraid to go out of your house alone	0	1	2	3	4
3.	Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
4.	Feeling uneasy in crowds, such as shopping or at the movies	0	1	2	3	4
5.	Feeling nervous when you are left alone	0	1	2	3	4
6.	Feeling afraid you will faint in public	0	1	2	3	4
7.	Having to avoid certain things, etc., because they frighten you	0	1	2	3	4

1.	Feeling others are to blame for most of your troubles	0	1	2	3	4
2.	Feeling that most people can not be trusted	0	1	2	3	4
3.	Feeling that you are watched or talked about by others	0	1	2	3	4
4.	Having ideas or beliefs that others do not share	0	1	2	3	4
5.	Others not giving you proper credit for your achievements	0	1	2	3	4
6.	Feeling that people will take advantage of you if you let them	0	1	2	3	4

1.	The idea that someone else can control thoughts	0	1	2	3	4
2.	Hearing voices that other people do not hear	0	1	2	3	4
3.	Other people being aware of your private thoughts	0	1	2	3	4

4. Having thoughts that are not your own	0	1	2	3	4
5. Feeling lonely even when you are with people	0	1	2	3	4
6. Having thoughts about sex that bother you a lot	0	1	2	3	4
7. The idea that you should be punished for your sins	0	1	2	3	4
8. The idea that something serious is wrong with your body	0	1	2	3	4
9. Never feeling close to another person	0	1	2	3	4
10. The idea that something is wrong with your mind	0	1	2	3	4

0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely

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1. Poor appetite	0	1	2	3	4
2. Overeating	0	1	2	3	4
3. Trouble falling asleep	0	1	2	3	4
4. Awakening in the early morning	0	1	2	3	4
5. Sleep that is restless and disturbed	0	1	2	3	4
6. Thoughts of dying and death	0	1	2	3	4
7. Feelings of guilt	0	1	2	3	4

1. Feeling critical of others	0	1	2	3	4
2. Feeling shy or uneasy with the opposite sex	0	1	2	3	4
3. Your feelings are easily hurt	0	1	2	3	4
4. Feeling others do not understand you or are unsympathetic	0	1	2	3	4
5. Feeling that people are unfriendly or dislike you	0	1	2	3	4
6. Feeling inferior to others	0	1	2	3	4
7. Feeling uneasy when people are watching or talking about you	0	1	2	3	4
8. Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
9. Feeling very self-conscious with others	0	1	2	3	4

1. Loss of sexual interest or pleasure	0	1	2	3	4
2. Feeling low in energy or slowed down	0	1	2	3	4
3. Thoughts of ending your life	0	1	2	3	4
4. Crying easily	0	1	2	3	4
5. Feeling of being trapped or caught	0	1	2	3	4
6. Feeling inferior to others	0	1	2	3	4
7. Feeling lonely	0	1	2	3	4
8. Feeling blue	0	1	2	3	4
9. Worrying too much about things	0	1	2	3	4
10. Feeling no interest in things	0	1	2	3	4
11. Feeling hopeless about the future	0	1	2	3	4
12. Feeling everything is an effort	0	1	2	3	4
13. Feelings of worthlessness	0	1	2	3	4

1. Nervousness or shakiness inside	0	1	2	3	4
2. Trembling	0	1	2	3	4
3. Suddenly scared for no reason	0	1	2	3	4
4. Feeling fearful	0	1	2	3	4
5. Heart pounding or racing	0	1	2	3	4
6. Feeling tense or keyed up	0	1	2	3	4
7. Spells of terror and panic	0	1	2	3	4
8. Feeling so restless you can't sit still	0	1	2	3	4

9.	Feeling that familiar things are strange or unreal	0	1	2	3	4

1.	Feeling pushed to get things done	0	1	2	3	4
2.	Feeling easily annoyed or irritated	0	1	2	3	4
3.	Tempter outbursts you can not control	0	1	2	3	4
4.	Having urges to beat, injure, or harm someone	0	1	2	3	4
5.	Having urges to break or smash things	0	1	2	3	4
6.	Getting into frequent arguments	0	1	2	3	4
7.	Shouting or throwing things	0	1	2	3	4

Patricia Koch, Ph.D. Licensed Psychologist

Release of Information Authorization

Patient Name _____ Date of Birth _____

Social Security Number _____

To/From_____ To/From_____

_____ _____

_____ _____

Type of Individual Identifiable Health Information

____Psychological Assessment
____Initial Evaluation
____Termination Summary
____Progress in Treatment
____Treatment Plan
____Medical Information
____Vocational Information/Assessment
____School Records
____School Academic and Behavioral Data
____Special Education Evaluation & Records
____Legal Information
____Other_____

The Purpose for this Release:

____Legal Circumstances
____Continuity of Care
____Coordination of Treatment
____Other
____Insurance Purposes
____Disability Determination
____Vocational Rehabilitation

I understand that I can revoke my authorization at any time except that disclosure has already taken place, and if not previously revoked, this authorization will expire one year from the date signed.

I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL ABUSE or MENTAL HEALTH TREATMENT.

PROHIBITION ON DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Patient/Legal Guardian Signature **Date**

ID Verified_____

_____ _____

Witness **Date**