Judy A. Tyson, Ph.D., CGP, LLC
Potomac Grove Psychiatry
8915 Shady Grove Court
Gaithersburg, Maryland 20877
301-963-0060

Hello,

Welcome to Potomac Grove Psychiatry.

In our consultation sessions together we will discuss your concerns. If you are coming for a consultation with someone else, you both will have the opportunity to express your concerns. You will have an opportunity to learn how I work. And we will conclude these sessions with a discussion of my observations regarding your needs and my commendations for a treatment plan

I would like you to know your rights to confidentiality as well as about my office policies. Please read the following papers. They are for your information. If you have any concerns or need clarification about any of my policies please ask me when we meet.

You have a questionnaire to fill out which we will review when we meet. If you are here with another person to address concerns, it is necessary for EACH of you to fill out the questionnaire. My intention is to learn about what brings you to psychotherapy. Over time, we will focus on a variety of factors that may have influenced your present day circumstances. The questionnaire does not take the place of talking together. In our consultation sessions I encourage you to share anything with me that you consider relevant to your concerns; what you see as your strengths as well as what issues you need help with.

I look forward to meeting you,

Judy Tyson

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EVALUATION AND CONSULTATION PROCESS

If you are here with someone else:
EACH of you must fill out this entire questionnaire.

Initial each point indicating you have read it.

_____In order for me to assess your concerns and develop a treatment plan, we need to meet for a number of evaluation sessions. This is a time to ask me questions about how I work and for me to assess and suggest what sort of therapeutic help is appropriate to meet your needs.

_____My evaluation includes getting to know you from a number of perspectives: emotional and physical health; religious and spiritual life; significant relationships; occupation; and any particular stressors you have experienced in the past or are currently experiencing.

_____Once the evaluation is completed we will discuss my treatment recommendations.

_____My recommendations for your treatment could include, include: *one or a combination of* therapies, such as:

- _____Individual, couples, group psychotherapy with me or one of the colleagues with whom I collaborate.

- _____Consultation with another professional for a second opinion.

_____We will discuss the options I recommend, and you will have the opportunity to ask questions about my choice of treatment options.

_____Treatment is a commitment to time spent in sessions as well as follow through of treatment recommendations for out of your sessions. Also, there are *financial considerations, appointment scheduling,* and *length of the time your particular treatment needs require*. We will discuss all of this as part of your consultation and evaluation.

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OUR RELATIONSHIP

I would like you to understand how I do things. Read each point below. Initial *only* if you understand and agree.

If you do not understand or do not agree with a point, please discuss it with me.

PRIVACY

- _____Our meetings and everything we discuss is confidential.
- _____I am bound by law and a Code of Ethics to not reveal that I am your psychotherapist unless I have your written permission. You my withdraw your written permission at any time.
- _____*There is one exception to keeping confidentiality*: If I think you are a danger to yourself or are dangerous to someone else, I am required *by law* to tell someone who could be able to help keep you and anyone else safe.
- _____If I believe it is in your best interest for me to discuss your mental health and treatment anyone, I will discuss this with you and request your written permission..
- _____PGP clinicians use a "treatment team" approach in order to give our patients our professional best. You give me permission to consult with other clinicians, when, in my clinical judgment, it appears to be in your best interest.

TO CANCEL OR RESCHEDULE AN EXSISTING APPOINTMENT

- _____Please speak with the PGP receptionist (Ext. 10) in order to:
  Make appointments
  Reschedule appointments
  Cancel an appointment
- _____If you cancel an appointment, the receptionist will give you a cancellation number. This number will confirm the day that you called to cancel your appointment.

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HOW TO GET IN TOUCH WITH ME

- _____Leave a message on my private, confidential voice mail (EXT 15) at any time.
- _____I check my voicemail during my office hours, Monday through Thursday. I will return your call during my office hours. They vary Monday through Thursday. *If you need attention immediately* you will need to call 911 or go to your nearest emergency room.

FEES AND BILLING

- _____The fee for your session is due when you check in, before your session.
- _____If you and I agree to extend your session, there will be an additional fee.
- _____There might be a time when we agree that it is in your best interest for me to discuss your treatment with one of your treating doctors. If it is necessary for me to consult with one of your treating doctors, there will be a charge for my consultation time with that doctor if the time exceeds 10 minutes.
- _____There is a charge for therapy consultations by telephone longer than 10 minutes.
- _____There is a charge for reports written outside of your session time.
- _____There is a charge for checks returned from the bank.
- _____You will get a receipt for your payment that includes information needed to submit for insurance reimbursement. Please be advised that if you submit a claim your diagnosis must be disclosed in order for you to receive reimbursement.
  Some policies also require minimal information about the reason you are in therapy. If this is the case, I will need your authorization to give this information. I will have you read the information before I submit it.

CANCELLATION POLICY

- _____If you need to cancel your appointment: There will be no charge a*s long as you cancel your appointment at least 2 business/ weekdays days* before your cancelled appointment.
- _____If your cancellation for your appointment is untimely (less than 2 weekdays notice) and choose to reschedule within the week *you will still be charged for the cancelled appointment*..
- _____If I must cancel an appointment I will do my best to notify you well in advance and I will make every effort to reschedule that session.

Name_____ Birthdate_____ Date_____

What name would you like me to call you?_____

Phone number I may call to reach you:_____

May I leave my name? Yes ____ No ____

Address_____
Street City State Zip

Referred by: Person_____ Internet_____
WEBSITE

Relationship to person who referred you_____
Physician, Friend, Website, Family Member, Other

IT IS IMPORTANT TO ME THAT YOU UNDERSTAND:

- Your rights to privacy
- My office procedures
- My Cancellation Policy
- How to make your appointments with me

<u>Your Privacy Rights and My Office Policies,</u>

I HAVE READ, UNDERSTAND, AND ACCEPT THE POLICIES ABOUT:

- **_____ My rights to confidentiality and privacy**
- **_____ Dr. Tyson's cancellation policy**
- **_____ How to make my appointments with Dr. Tyson**
- **_____ Dr. Tyson's office procedures**

_____(SEAL) _____
SIGNATURE DATE

FOR OFFICE USE:
DSM V _____ CPT, intake: _____ CPT, intake: _____

Name: _____ Date of Birth: _____ Age_____

Marital/Commitment Status (*CIRCLE*): SINGLE MARRIED LIFE PARTNER

SEPARATED DIVORCED WIDOWED OTHER_____

Date of *present* marriage/committed relationship/significant other:_____ to present.
DATE

Partnership history: Date met: _____ Date began living together: _____

Previous marriages or significant relationships and dates: _____

Circle: I am a: BIRTH PARENT FOSTER PARENT ADOPTIVE PARENT STEP PARENT
I AM NOT A PARENT OTHER_____

List each of your children (step children/foster/ adopted), age, & where he/she is living: _____

_____

_____

All people who live in your home now and their relationship to you:_____

_____

Religious upbringing:_____

Religious orientation now:_____

Rx'd Medication; over the counter drugs, & supplements you use. (Take daily; Other)

_____

Describe *your* use now or in the past of alcohol and cigarettes:_____

_____

Describe the use of alcohol & cigarettes of anyone *living with you*: _____

_____

Have problems with drugs, alcohol, food, sexual, gambling, other? Please explain; use the back of the page for more writing space._____

Have you, any family member, or friend ever been molested or inappropriately touched, or physically hurt by anyone? Please briefly explain, use the back of the page for more writing space.

_____