Michelle M. Forrester, Ph.D.
Licensed Psychologist #2-5359
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www.michellemforrester.com

Welcome to the practice of Dr. Michelle M. Forrester! This packet contains the first set of forms you will need to complete prior to your initial appointment with Dr. Forrester.

Enclosed in this packet you will find:

- Authorization for Evaluation and Treatment
- Office Policies
- Notice of Privacy Practices – Consent
  (Notice of Privacy Practices on the website under Patient Privacy or request a copy from our office)
- Authorization for Release of and/or Exchange of Information
  (if there is another provider we should speak with regarding your child)
- Custody Dispute Contract
- Informed Consent for Telepsychology

Please also complete the appropriate ***Child History Form*** for your child (found under New Patient Forms on our website). Appointments are not confirmed until all items are received.

Please do not hesitate to contact us at 713-598-3559 or admin@michellemforrester.net if you have any questions or concerns.

We look forward to meeting you,

Dr. Michelle M. Forrester and Staff

Michelle M. Forrester, Ph.D.
Licensed Psychologist #2-5359

Authorization for Evaluation and Treatment

Please print:

Child's Name: _____ **Child's Date of Birth: _____**

Parent(s)/Guardian(s): _____

Relationship to Child: _____

I/We, _____, I/we hereby give full consent for my/our child and/or myself/ourselves to receive psychological evaluation and treatment services of Dr. Michelle M. Forrester (and services from her assistants, contractors, interns, and staff as may be necessary per her judgment) until I/we notify her or until she determines that services are no longer appropriate or will no longer be provided.

I/We further certify that I/we have the legal authority to authorize and consent to this evaluation and/or treatment as parent(s), managing conservator, or guardian(s) of this child.

I/We understand that any information that I/we provide to Dr. Forrester is confidential and generally will not be released to others without my/our written consent. However, I/we understand that state and/or federal law might require Dr. Forrester to disclose confidential information without my/our consent in certain circumstances. I understand that Dr. Forrester may be required to disclose confidential information, without the consent of a client or a client's legally authorized representative, in one or more of the following situations: (1) if a client is evaluated to be a danger to self or others; (2) if Dr. Forrester believes a child is the victim of abuse or neglect; (3) if information is disclosed about the physical or sexual abuse or neglect of a child, elder, or disabled person; (4) if a suit is filed by me/us or my/our child against Dr. Forrester for breach of duty; and (5) if a court order, legal proceeding, statue, or regulation requires disclosure.

I/We understand that I/we will not receive a copy of my/our child's records without the approval of Dr. Forrester or another authorized professional.

My/Our signature on this consent form verifies that I/we have had the opportunity to ask questions regarding Dr. Forrester's policies, procedures and therapy techniques, that my/our questions were answered to my/our satisfaction by Dr. Forrester, and that I/we voluntarily give my/our consent for treatment. I/we understand that I/we have the right to withdraw my/our consent for treatment at any time.

_____ _____
Printed Name Relationship to Child

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Child

_____ _____
Signature Date

Michelle M. Forrester, Ph.D.
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Office Policies

Confidentiality: Dr. Forrester's staff will maintain confidentiality and will not provide disclose any client information to others except under mandate of the law. (See Authorization for Evaluation and Treatment form for details)

Cancellation: All appointments cancelled without 24-hour advance notice will be charged the full appointment fee. All fees not paid prior to (or on the date of) the next scheduled appointment are subject to a late fee of $25. Missed appointment fees and late fees are not reimbursed by insurance.

Missed Group Sessions: Even with 24-hour advance notice, all missed group sessions are charged the full amount of the appointment fee and missed session fees are not reimbursable by insurance.

Late Arrival: As a courtesy to other clients, appointments will not be extended as a result of a late arrival and thus the appointment will be shortened.

Identifying Information: Any published materials will not contain any identifying information and records will not be released without written consent. Due to HIPPA, information will not be disclosed to anyone, even family members, without written consent.

Etiquette: Clients may not come into the office under the influence of alcohol or non-prescribed drugs. Clients are asked to silence and refrain from using cell phones while in session unless there is an emergency. All clients must agree to maintain privacy of people they may see in the office and not disclose any information about others.

Accompaniment: A parent or another appointed adult must remain on site (and may not leave the building) for the duration of appointments and must accompany children in and out of office for each appointment.

Payment: Payment is expected in advance or at the time of service. Acceptable forms of payment are cash, check, and Zelle (credit cards are not accepted). A fee of $25 will be applied for returned checks and late payments (and future cash payments may be required). The office does not provide annual statements.

Insurance: Insurance payment is not accepted. Receipts will be provided, and clients may contact their insurance company regarding possible reimbursement of fees. We do not submit claims to insurance providers on behalf of clients.

Therapist Availability: Dr. Forrester does not provide 24-hour crisis service. If immediate assistance is required, or someone feels unsafe, they must agree to call 911 or go to the nearest emergency room.

Termination of Therapy: If the decision is made to discontinue therapy, time needs to be allowed to discuss this. In rare circumstances Dr. Forrester may determine that therapy would be best provided by someone else. In this event, she will do her best to provide an appropriate referral.

Litigation and Custody Disputes: Dr. Forrester and her staff will not voluntarily participate in any litigation or custody dispute and will generally not communicate with a client's attorney. In the event we are subpoenaed or ordered by a court of law, reimbursement will be required for time spent in preparation, travel, and appearance.

Supervised Interns: Services from Dr. Forrester's supervised interns (students, post-doctoral fellows) are considered an out-of-pocket expense and cannot be submitted to any insurance carrier for reimbursement.

Email Communication: Dr. Forrester and staff may communicate with clients via email regarding appointments, referrals, and billing. All communication that involves confidential information should be directed to Dr. Forrester or her staff via phone or in person. Email communication is not appropriate in an emergency and is not intended to provide care or treatment.

Your signature on this consent form indicates you *understand and agree* to all office policies outlined above.

_____ _____

Child's Name **Child's Date of Birth**

_____ _____

Parent/Guardian Signature Date

Michelle M. Forrester, Ph.D.
Licensed Psychologist #2-5359

Notice of Privacy Practices - Consent

Consent for the use or disclosure of health information for treatment, payment, or health care operations.

Our Notice of Privacy Practices was provided to you and included information about how the office of Dr. Michelle M. Forrester may use or disclose your personal and health information. We request your consent for the use and disclosure of mental health and medical information for treatment, payment, or health care operations. You have a right to review our Notice of Privacy Practices before signing this consent form.

By signing this consent form, you:

1) acknowledge that a copy of our Notice of Privacy Practices has been provided to you; and
2) consent to our use and disclosure of your personal and health information for treatment, payment, or health care operations.

You have the right to revoke this consent in writing at any time, except where health information has already been used or disclosed in reliance upon this consent.

_____ _____

Child's Name **Child's Date of Birth**

_____ _____

Parent/Guardian Signature Date

Michelle M. Forrester, Ph.D.
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Authorization for Release of and/or Exchange of Information

Please print:

Name of Individual, Professional, or Agency Permission is Granted to Share Information with:

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Check One:

_____ I authorize the release of any records that have been obtained by the office of Dr. Michelle M. Forrester from other providers.

_____ I DO NOT authorize the release of records, in the possession of the office of Dr. Michelle M. Forrester, that have been obtained from other providers.

I hereby give the office of Dr. Michelle M. Forrester permission for the mutual exchange of pertinent information regarding my child/family with the above-named Individual/Professional/Agency, including academic, social, medical, psychological, and/or psychiatric information.

_____ _____

Child's Name **Child's Date of Birth**

_____ _____

Parent/Guardian Signature Date

Michelle M. Forrester, Ph.D.
Licensed Psychologist #2-5359

Custody Dispute Contract

Please print:

Child's Name: _____ **Child's Date of Birth: _____**

The purpose of this contract is to obtain a written agreement that psychologist, Michelle M. Forrester, Ph.D. and any of the staff/therapists who work at her office with my child, will not be asked to participate in any litigation regarding any custody, visitation or access disputes. I understand that if Dr. Forrester, or any of the staff/therapists who work at her office with my child, is asked to participate in any litigation, their neutral role with the family is likely to be compromised. This may seriously jeopardize any progress that has been made in therapy, as well as interfere with future progress. This may also limit my child's willingness to seek help from a psychologist or other therapist later in life as it could violate my child's trust/confidentiality between my child and the therapist. It is crucial that Dr. Forrester, any therapist working with my child, the parents, and my child have every reassurance that there will be absolutely no involvement on Dr. Forrester's part in any current or future litigation between parents.

Both parents are asked to sign this statement stating that they are in agreement:

We wish to enlist the services of Michelle M. Forrester, Ph.D., P.C. in the treatment of our child. We understand that such treatment will be compromised if information revealed therein is brought to the attention of the court in the course of a custody dispute. Accordingly, we mutually pledge that we will neither individually, nor jointly, involve Dr. Forrester or any therapist working with her on behalf of our child in any litigation whatsoever. We will neither request nor require Dr. Forrester or any staff/therapist working with her on behalf of our child to provide testimony in court. We will neither request nor require Dr. Forrester or any therapist working with her on behalf of our child to turn over their notes to the court or any attorneys or other personnel involved in any custody dispute process. If the services of a mental health professional are desired for court purposes, the services of a person other than Dr. Forrester or anyone working in her office must be enlisted. Referrals can be provided upon request.

_____	_____
Printed Name	Relationship to Child
_____	_____
Signature	Date
_____	_____
Printed Name	Relationship to Child
_____	_____
Signature	Date

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Informed Consent for Telepsychology

Information for the use of phone or internet for appointments

Risks to confidentiality: There is potential for other people to overhear sessions if you are not in a private place during the session. We will take reasonable steps to ensure your privacy. It is important that you find a private place for the session and protect the privacy of sessions on your device (computer, cell phone, tablet).

Issues related to technology: There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Crisis management and intervention: Usually, we will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, you must agree to address any potential crisis situation that may arise during the course of our telepsychology work by calling 911 or going to your nearest emergency room.

Efficacy: Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications: Sessions will take place via telephone or video conference (via Zoom). Certain systems may be required in order to use telepsychology services. You are solely responsible for any cost required to obtain necessary equipment, accessories, or software to take part in telepsychology. For communication between sessions, we will use email communication via HIPPA compliant email or phone calls.

Confidentiality: We have a legal and ethical responsibility to make our best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology). The extent of confidentiality and the exceptions to confidentiality that are outlined in our Authorization for Evaluation and Treatment Informed Consent still apply in telepsychology. Please let us know if you have any questions about exceptions to confidentiality.

Session Interruptions: 1) If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call us back; instead, call 911 or go to your nearest emergency room. Contact us after you have called 911 or obtained emergency services. 2) If the session is interrupted and you are not having an emergency, disconnect from the session and we will attempt to contact you again via telephone or video conference. In the event that a technological failure occurs, and we are unable to finish the session, you will be charged a prorated amount.

Fees: The fees for telepsychology are the same as for in-person appointments. Insurance may not cover sessions conducted via telepsychology. It is your responsibility to contact your insurance to determine whether sessions will be eligible for reimbursement.

Records: Telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. We will maintain a record of sessions in the same way we maintain records of in-person sessions in accordance with our policies.

Informed Consent: This agreement is intended as a supplement to the Authorization for Evaluation and Treatment Informed Consent and does not amend any of the terms of that agreement.

Your signature on this consent form indicates you *understand and agree* to all terms and conditions outlined above.

_____ _____

Child's Name **Child's Date of Birth**

_____ _____

Parent/Guardian Signature Date