STILLPOINT .

THERAPY - ASSESSMENT - CONSULTATION

PAUL W. FREHNER PSY.D.

General Information – Adults

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Cell _____ DOB _____

Social Security #: _____

Insurance _____

_____

Employer _____

_____ _____ _____

Emergency Information

Notify/Relationship: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Work _____ Other _____

Medical

Physician: _____ Phone: _____

Address: _____

City/State/Zip: _____

For scheduling and financial information only, NOT for clinical information:

Are you allowing Dr. Paul Frehner to leave messages or text msgs. on your phone? □ yes □ no

Are you allowing Dr. Paul Frehner to use e-mail correspondence with you? □ yes □ no

If YES on which number? _____which email?_____

Payment:

Please bring your insurance card to your first session.

Pay or copay is expected at the beginning of each session. Checks, cash and credit cards are accepted.

Checks should be made out to STILLPOINT PSYCHOLOGICAL SERVICES.

There is a $ 25.00 charge for returned checks. We also reserve the right to collect outstanding balances by using your credit card information. Please kindly provide that information below:

VISA □ MC □ Other_____□ Card#_____Exp.Date:_____CVV#_____BillingZipCode_____

STILLPOINT .

THERAPY - ASSESSMENT - CONSULTATION

PAUL W. FREHNER PSY. D.

TREATMENT POLICIES REGARDING THE PSYCHOTHERAPY PROCESS

INSURANCE REIMBURSEMENT

If you have current insurance coverage, I will work directly with your insurance company for payment. If your insurance coverage lapses for any reason and treatment continues, you are responsible for incurred payments. If coverage is denied, I will communicate that to you and work with you to find a direct pay solution. It's important for you to be informed about your copays and eventual deductible amounts, which need to come out of your own pocket. In order to obtain insurance payment, your mental health information and diagnosis will have to be shared with the insurance company. The most privacy for treatment is ensured when paid out of pocket. If insurance refuses to pay for any reason, you are responsible for payment of services.

LATE CANCELLATIONS AND NO SHOWS

Once you receive confirmation through s.weekcal.com icon via text or email, your appointment is confirmed, and you are responsible for the allotted time. In case of a no-show or late cancellation, a fee of $75 will be billed for each missed session. You have the right to cancel your session for any reason 24 hours in advance. You are responsible for making arrangements for weather emergencies, transportation problems, childcare, and health issues that may interfere with your ability to attend our meeting.

COMMUNICATION

If you agree to communicate via email and/or text message, be aware that such communication is not confidential and can possibly be accessed by third parties. Such communication is restricted to scheduling and payment issues. Telehealth sessions are the exception in my practice. They are useful when a car breaks down or a Covid infection is ongoing. Any recording of telehealth session requires the explicit agreement of all parties involved.

EMERGENCIES

If you experience a mental health emergency, it is your responsibility to communicate this clearly to me. Emergency information and contact information are available at all times on my website stillpoint.us.com under Client Resources. If I determine that your safety is at risk, I will provide that information to you and help you find the necessary level of care. If I am unavailable, please go to the nearest emergency room or call the suicide hotline at 988.

LENGTH OF SESSION

A counseling or therapy session usually lasts 60 minutes. Sometimes special arrangements need to be made for longer sessions.

PSYCHOTHERAPY PROCESS

Psychotherapy is a collaborative process. I will use all my skills and dedication to do my part in our work, and I expect the same from you. While I have good results in most cases, I cannot guarantee a particular outcome. If you have concerns about our work, please voice them to me directly. I encourage you to obtain knowledge of the procedures, goals, and possible side effects of psychotherapy. I intend to make our professional contact one in which you receive the maximum benefit, and I will also inform you about alternatives to psychotherapy should that be appropriate. One of the risks of individual therapy is the increased possibility of a separation from your partner if your partner is not keeping up with the changes that you are undertaking. If you have concerns in this regard, please bring these up with me in session. Psychotherapy can be tremendously beneficial for some individuals, though there may also be some risks and discomfort.

SUPERVISION, TRAINING, AND ETHICS

As a licensed psychologist, I am required to accumulate 20 hours of training per year, including 6 hours of ethics continuing education. Psychologists must also engage in supervision, usually by way of peer supervision and consultation, on a regular basis during the year. If you should ever question any of our work in terms of competence or ethical standards, please bring that up for our immediate discussion. The Board of Psychology in Concord, NH oversees the licensing and competence of psychologists and counselors in New Hampshire.

CLIENT'S RIGHTS AND CONFIDENTIALITY

At any time, it is your right as a client to question and/or refuse therapeutic or diagnostic procedures or methods or gain whatever information you wish to know about the process and course of therapy. Clients are also assured of confidentiality, which is protected by both ethical practice and by law. There are important exceptions to confidentiality that are legally mandated. These exceptions include that: (1) I notify relevant others if I judge that a client has an intention to harm another individual or self; (2) I report any incidence of suspected child abuse, neglect, or molestation to protect the children involved; (3) I report any incidence of suspected abuse of elderly or dependent adults; (4) In legal cases, I, or my records, may be subpoenaed by the court. In these cases you are responsible for the costs incurred.

MINORS AND PARENTS

I work with teenagers starting at age 14. I ask parents to grant their teenager confidentiality for our work so that they can freely discuss what is on their mind. I will, however, convey to parents if their child is engaged in behaviors that can lead to 'irreversible consequences' and put their health and safety at risk. Whenever possible, informing parents will happen with the inclusion of the teenager. Parental involvement can be a necessary and crucial part of treatment. Each situation will need to be decided on a case-by-case basis. Please contact me immediately if you have any concerns regarding your teenager or my work with him/her. A family therapy session, with your teenager, the parents, and me present, can resolve many issues and concerns.

STILLPOINT .

THERAPY - ASSESSMENT - CONSULTATION

PAUL W. FREHNER PSY.D.

FEES

The charges for my services are based on the usual, customary, and reasonable fee profiles for this area. My fee is $175.00 per 60-minute clinical hour. The fee also includes my time on your behalf, including record-keeping and preparations. Other additional charges are outlined in the Extended Services Contract. You are responsible for payment for uncovered services. Sessions, both in person and by video, beyond what insurance authorizes will be billed to the client directly. Uncovered services are billed at the $175.00 per hour rate. I am required to give you an estimate of possible costs that can occur to you should your insurance end abruptly or if your deductible has not yet been met. Expected costs are $700.00 for weekly psychotherapy attendance per month. Usual copays range from $10.00 to $40.00 per session.

MEDICAL EXAM

Current ethical standards for psychologists require that you have had a physical exam within the 6-month period in which we first work together. I suggest you do this right away.

TERMINATION

Ending psychotherapy may occur at any time and may be initiated by either the client or the therapist. I suggest that if a client decides to end therapy, there be a final termination session(s) to explore the reasons for termination. Most of the time it becomes obvious when it is time to end treatment. Sometimes a break is warranted, and you may decide to come back at a later point when you are ready for more work. It is best for these decisions to be made jointly.

VACATIONS AND HOLIDAYS

Each year I am away several times for conferences and vacation. In the summer, I usually take a lengthy vacation. In my extended absences, I always arrange for coverage for emergencies and unforeseen events. If you need services during my absence, we will make prior arrangements for you. I usually give ample notice to my clients when I will be away.

I hereby acknowledge and accept the above stated rules and agreements regarding my psychotherapeutic treatment:

_____ _____

Name (please print) Date

_____

Signature

This information is available on my website as well: STILLPOINT.US.COM

STILLPOINT PSYCHOLOGICAL SERVICES 174 CONCORD STR. SUITE # 310 PETERBOROUGH NH 03458

stillpoint.us.com Fax (877) 904-8613

STILLPOINT .

THERAPY - ASSESSMENT - CONSULTATION

PAUL W. FREHNER PSY.D.

Notice of Privacy and Confidentiality Practices

This notice describes how Paul W. Frehner, Psy.D. and STiLLPOINT PSYCHOLOGICAL SERVICES PLLC may use and disclose your healthcare information and how you can obtain access to this information. Please review it carefully.

Paul W. Frehner, Psy. D. is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health including demographic information, either created by Paul W. Frehner, Psy. D., or received by Paul W. Frehner, Psy. D. from other health care providers. Paul W. Frehner, Psy.D. is required to provide you with notice of his legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Paul W. Frehner, Psy.D. will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information. Paul W. Frehner, Psy. D. reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that he maintains. Patients will be provided with a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice at any time.

Uses and Disclosures of Your Protected Health Information Not Requiring Your Consent

Paul W. Frehner, Psy. D. may use and disclose your protected health information without your written consent or authorization for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependency. There are also restrictions on disclosing HIV test results.

Treatment related communication may include:

1. Providing, coordinating, or managing any related services by one or more healthcare providers;
2. Consultation between healthcare providers concerning a patient;
3. Referrals to other providers for treatment;
4. Referrals to nursing homes, foster care homes, or home health agencies;
5. Communication with your insurance company in regards to billing for services you receive. This information will include a mental health diagnosis and some information re: progression of treatment;
6. In emergency situations this may include communication with your primary care physician and with relatives that you have designated as emergency contacts.
7. Communication to DCYF and police if safety concerns are present (information re; abuse of any kind, threats to the safety of self and others).

This information can be viewed at any time on my website, *stillpoint.us.com*

I hereby acknowledge and accept the above stated rules regarding my protected health care information:

_____ _____

Name (please print) Date

_____

Signature

STILLPOINT .

THERAPY - ASSESSMENT - CONSULTATION

PAUL W. FREHNER PSY.D.

Release of Information:

Pertaining to:

Name: _____

DOB: _____

Address:_____

_____

I hereby give Paul W. Frehner,Psy.D. and STILLPOINT PSYCHOLOGICAL SERVICES permission to exchange information regarding myself (or if the patient is a minor regarding my child) with the following parties:

LEVEL OF PRIVILEGE: (please initial) □ exchange_____ □ give only_____ □ receive only _____

Agency:_____

Name: _____

Address: _____

_____Phone Number: _____

Date: _____ Signature: _____

Print Name: _____

Unless revoked, this release will be in force for the length of the treatment with Dr. Paul W. Frehner, Psy.D.