France Frederick, Ph.D.
Clinical Psychologist
131 Fairhope Avenue
Fairhope, AL 36532
Telephone: 251-928-0765
Fax: 251-990-9059
License #946

Psychologist
The undersigned psychologist is a licensed Clinical Psychologist engaged in private practice psychological services to clients directly and is an "out of network" provider for insurance companies that have mental health benefits.

Although it is not always easy to seek help from a psychologist, it is my hope that you will be better able to understand your situation and feelings and move toward resolving your difficulties. As a psychologist, using my knowledge of human development and behavior, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and try new approaches in order for change to occur. You may bring other family members to a therapist session if you feel it would be helpful or if it is recommended.

Appointments
Appointments are made with France Frederick by calling 251-928-0765 or within session time. Standing appointments are to be agreed upon between patient and therapist and for a specified time. It is important to note that if a session needs to be cancelled or rescheduled, you are responsible for notifying the psychologist at least 36 hours in advance or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments.

Number of Visits
The number of sessions needed depends on many factors and will be discussed in the sessions.

Length of Sessions
Therapy sessions are 60-90 minutes in length unless a different time limit is discussed. Children's sessions may be shorter and evaluation sessions may be considerably longer. Agreed upon lengths of sessions may vary circumstantially.

Relationship
The therapeutic relationship is a professional one that involves the client and psychologist and often other family members or individuals with the inner circle of relationships within the limits of the therapeutic milieu.

Cancellations
Cancellations must be received at least 36 hours before scheduled appointments; otherwise, YOU will be charged the customary fee for that missed appointment. You are responsible for calling to cancel or reschedule your appointment.

Payment for Services
The charge for your initial session is $180 per hour and this session will be at least 1.5 hours long. The charge for any subsequent sessions will also be billed at $180 per hour. (See rate section in the Financial Policy for additional details)

You will be responsible for the full payment of all charges incurred on your account.
Different co-payments are required by various insurance coverage plans. Your co-payment is based on the provisions of your insurance policy's coverage- not by the psychologists. In addition, the co-pay may be different for your first visit than subsequent visits. Your co-pay may also vary depending on the length of your sessions. You are responsible for and shall pay your copay portion of the charges for psychotherapy at the time the services are provided. It is recommended that you determine your co-payment before your first visit by calling your benefits office or insurance company.

Although it is my goal as a psychologist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and expectations to confidentiality are discussed in the section below. In the event that disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the normally hourly rate for time involved in preparing for and giving testimony as well as any legal fees that I might incur to file motions to protect confidentiality or legal fees incurred as consultations related to your case. Such payments are to be made at the time prior to the time this psychologist renders these services.

Confidentiality
Discussions between a psychologist and a client are confidential. No information will be released without the client's written consent unless mandated by the law. Possible exceptions to confidentiality include, but are not limited to the following situations: child abuse, abuse of elderly or disabled, abuse, of patients in mental health facilities, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is an issue, situations where the psychologist has a duty to disclose, fee disputes between the psychologist and the client, a negligence suit brought by the client against the psychologist, or the filing of a complaint with the licensing board.

If you have any questions regarding confidentiality, you should bring them to the psychologist's attention and discuss this matter further.
By signing this information and consent form, you are giving your consent to the undersigned psychologist to share confidential information with all persons mandated by law and with your insurance carrier responsible for providing your mental health care services and payment for those services. You Are also releasing and holding harmless the undersigned psychologist from any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the undersigned psychologist reasonably believes that I am a danger either physically or emotionally to myself or another person, I specifically consent for the psychologist to want the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name(s) **Telephone Number(s)**

_____ _____

_____ _____

Communication

I consent for the undersigned psychologist to communicate with me by email, mail, and telephone at the following addresses and phone numbers and I WILL IMMEDIATELY NOTIFY the psychologist in the event of any changes.

Mailing Address _____

Email Address _____

Telephone Numbers _____ _____

_____ _____

Risks of Psychotherapy

Therapy is the Greek word for change. You may learn things about yourself that are uncomfortable or discomforting. Often, growth does not occur until we experience and confront issues that include sadness, sorrow, anxiety or pain. The success of our work depends on the quality of efforts on both our parts, and the realization that you are responsible for lifestyle choices and/or changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of the couple choosing to end their marriage.

AFTER HOURS EMERGENCIES

If there is any emergency, you may call 251-928-0765.

If you get the voicemail, it may be more prudent to go directly to the nearest Emergency Room. Do not wait for a return phone call if the situation requires immediate attention. Phone calls and emergencies are billed in 15-minutes increments.

Psychologist Incapacity or Death

I acknowledge that in the event the undersigned psychologist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my files and records. By signing this information and consent form, I give my consent allowing another licensed professional selected by the undersigned psychologist to take possessions of my file records.

Consent to Treatment

I voluntarily agree to receive Psychological Services, assessment, care and treatment and authorize the undersigned psychologist to provide such care, treatment or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment or services and that I may stop such care, treatment or services that I receive as long as I allow 36 hours cancellation for any appointments.

By signing the Client Information and Consent form, I, the client acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything that is unclear to me.

_____ _____

Client Date

As witnessed by:

_____

France M. Frederick, Ph.D.
Clinical Psychologist

France Frederick, Ph.D.
Clinical Psychologist
131 Fairhope Avenue
Fairhope, AL 36532

Financial Policy

- **All accounts are secured with a Visa or MasterCard- No expectations.**
  A credit card authorization is included in your paperwork.

- **Payment is expected at the time of service unless you wish to be billed monthly, in which case you will have 15 days from the date of the statement to pay the account in full.** If payment is not made by this date, your credit card will be charged for the full amount due. If your credit card is denied, you will not be allowed any additional services by France Frederick, Ph.D. until the balance is paid in full. This office will not make phone call reminders to you regarding past due accounts.

- **Rates for services are as follows:**

Individual Session	$150 per 50 minutes
Individual Session	$180 per 60 minutes
Couples/ Family Session	$180 per 50 minutes
Phone Sessions	$45 per 15-minute increments
Court/ Depositions	$2000 per hour
Testing	$150 per hour
Special Reports	$200 per hour

  Phone Sessions, Depositions, Court Appearances and Special Reports are not billable to insurance companies and payment for these services will be your full responsibility.

- **Cancellation Policy**
  36- hour cancellation requirement: If you are unable to keep your appointment, you must give 36 hours prior notice or you will be billed for the session.

- **Insurance Information**
  Dr. Frederick is an "out of network" provider for ALL insurance companies. That makes you responsible for the entire fee billed for services minus the actual payment made by your insurance company. This office does not make adjustments for the difference in the amount paid and the amount allowed by your insurance company.
  Deductibles usually start at the beginning of the calendar year, so you will be billed accordingly.

- **If you wish to pay at each session, please have your check made out prior to your visit so that you may use the entire time allotted for your session.**

PATIENT REGISTRATION FORM

PATIENT NAME:
_____

PHYSICAL ADDRESS:
_____

MAILING ADDRESS: _____

Email Address: _____

Telephone Home: _____ **Cellphone:** _____

SEX: M F

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

DATE OF BIRTH: _____ **SS#:** _____
_____

EMPLOYER: _____
PHONE: _____

SPOUSE'S NAME: _____ **SS#:** _____ **DOB:**_____

SPOUSE'S EMPLOYER:_____ **PHONE:**_____

If patient is a child fill out the following:
FATHER'S EMPLOYER:_____
PHONE:_____

FATHER'S EMPLOYER:_____
PHONE:_____

FATHER'S SS#:_____
DOB:_____

MOTHER'S NAME: _____ **PHONE:**_____

MOTHER'S EMPLOYER:_____ **PHONE:** _____

MOTHER'S SS#:_____ **PHONE:**_____
_____

In case of an emergency, Notify

NAME:_____ RELATIONSHIP:_____

TELEPHONE HOME:_____ WORK:_____

CELL:_____

Household Members:

Name	DOB	Relation	Education

Referred By: _____ Previous Therapist: _____

_____

FINANCIAL POLICY

I have received a copy of Financial Policy and Charges as they apply. _____
Patient Initials

INSURANCE INFORMATION

Insurance Company:_____

Primary Insured:_____

Primary Insured DOB:_____ Employer:_____

Patient's Relationship to Primary Insured: SELF SPOUSE CHILD GRANDCHILD

ID/Contract #:_____ Group#:_____

Ins Address: _____

Ins Phone:_____Please provide a copy of your insurance card.

AUTHORIZATION TO PAY BENEFITS TO PRACTITIONER AND TO RELEASE INFORMATION:

I hereby authorize France Frederick, PHD to release any information acquired in the course of my treatment necessary to process insurance claims and to submit claims for and receive any benefits for which I (or patient) may be eligible for services rendered by Dr. Frederick, realizing I am responsible for paying non-covered services.

_____ _____

Patient or Guarantor Signature **Date**

INSURANCE BENEFITS

Due to many changes in insurance policies, it is no longer an easy task each policy. It is your responsibility to know your individual coverage. We urge to check with your insurance company regarding "out of network" benefits. Failing to comply with this suggestion could mean you are responsible for all costs.
Your insurance policy is between you and your insurance company.

_____ _____

Patient or Guarantor Signature **Date**

CREDIT CARD AUTHORIZATION

All accounts must be secured with a Visa or MasterCard. I understand that I will be sent a monthly statement and that I will have 15 days from the date of the statement to pay the account balance in full or my credit card will be charged for the outstanding balance. I also understand that if my credit card is denied, I will not be allowed any additional services by France Frederick, PHD until the balance is paid.

VISA MASTERCARD

Credit Card Number: _____ **Exp Date:**_____

Name on Card:_____

Signature of Card Holder:_____ **Date:**_____

Credit Card Authorization

All accounts must be secured with a Visa or MasterCard. I understand that I will be sent a monthly statement and that I will have 15 days from the date of the statement to pay the account balance in full or my credit card will be charged for the outstanding balance. I also understand that if my credit card is denied, I will not be allowed any additional services by France Frederick, PHD until the balance is paid.

Check below if you do not wish to receive a statement:

_____ I authorize France Frederick, PHD to charge my credit card monthly for the balance in full without sending a statement _____(initial)

VISA MASTERCARD

Credit Card Number: _____ Exp Date:_____

Name on Card:_____

Signature of Card Holder:_____ Date:_____

Email Authorization

I authorize France Frederick, PHD to email with any correspondence to many account. This will include eligibility and benefits from my insurance and any questions that I may have in reference to my monthly statement. I will not hold France Frederick liable for anyone other than myself receiving the email. I do understand that it is my responsibility to give France Frederick my current email address at all times.

Email Address:_____

Signature of Authorization: _____