William G. Danton, Ph.D.

DIPLOMATE IN CLINICAL PSYCHOLOGY, A.B.P.P.

**GENERAL INFORMATION: ADULT**

**NAME OF PATIENT:** M or F **EMAIL:**

Social Security #: Date of Birth: / / Referred by:

Mailing Address: City: State: Zip:

Street Address: City: State: Zip:

Phone: (Home) (Cell) (Business)

Employer: Carrier: Messages OK? Yes or No

**Emergency Contact Name:** Relationship: Phone:

**Name of Person Responsible for Payment:**

Address: City: State: Zip:

Social Security #: Date of Birth: / / Phone:

**PRIMARY INSURANCE:** Policy:

Insurance Address: Phone:

Insured's Name: Social Security #:

Insured's Address: Date of Birth: / /

**SECONDARY INSURANCE:** Policy:

Insurance Address: Phone:

Insured's Name: Social Security #:

Insured's Address: Date of Birth: / /

**HEALTH INSURANCE PAYMENT AUTHORIZATION**

I authorize my provider to release any medical or other information required by my insurance company and billing service that is necessary to process this claim. I understand that I am responsible for the full amount of billed service, including amount not paid by insurance.

initial

I authorize payment of behavioral health benefits to my provider for services in the attached bill.

initial

Signature Print Name Date

Revised 8/19/13

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**PROFESSIONAL FEES**

Fees are as follows, unless your provider has a contracted rate with your insurance company:

Initial Evaluation $250
Individual, Family, or Couples Psychotherapy $220

Psychological Testing and Report Writing $198

A pro-rated fee may be charged for professional services, such as telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, or time spent performing other services.

Unless otherwise stated, it is our policy to avoid being a party to litigation. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of your provider's professional time, including preparation and transportation costs, even if he or she is called to testify by another party.

**INSURANCE**

As a courtesy service, we bill many major insurance companies. It is important to understand:

1. It may be necessary to release information about your treatment to the insurance company, including a clinical diagnosis, a treatment plan, or a treatment summary. Please be aware that this information will become part of your insurance company's files.
2. Your insurance coverage is a contract between you and the insurance company. Our relationship is with you, not your insurance company. Not all services are a covered benefit in all contracts. Any balance that accumulates because of a discrepancy between your payment and the insurance company's is your responsibility. **All charges are your responsibility whether your insurance company pays or not**.
3. It is your responsibility to understand the requirements and coverage of your insurance plan, including, determining whether or not your doctor is in-network, if there are referral or pre-certification requirements, and your copayment or deductible responsibilities. If authorization has not been granted, you will be responsible for all charges incurred. If you choose to use your out of network benefits, you will be responsible for the full fee. **Copayments and deductibles are due before each appointment**.
4. Appointments are typically scheduled for 50 minutes, one time per week. You will be expected to attend each scheduled visit or provide 24 hours advanced notice if you need to cancel. **If you fail to attend without calling or give us less than 24 hours notice you will be charged the full session fee**.
5. **If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, you provide authorization to charge your credit card on file for any outstanding balance**. If you do not provide authorization, we have the option of using legal means to secure payment, including using a collection agency. This will require disclosure of confidential information. You may be held liable for legal and collection charges. We ask for a credit card number to be kept on file in the eventuality that we should need to follow through on the above stated policies.

I have read, understood, and agree to these terms.

Signature of Client or Legal Representative Print Name Date

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**THERAPIST-CLIENT SERVICES AGREEMENT**

**Welcome to** my practice and thank you for choosing me for your behavioral health needs. This agreement contains important information about our professional services and business policies. Please read it carefully. If you have any questions, please feel free to ask.

**PHILOSOPHY**

We expect to do everything within our professional competencies to be helpful to you. The best gains in therapy are achieved by cooperation between you and your provider. We welcome your active participation in planning therapy and encourage you to ask questions whenever they arise.

**PSYCHOLOGICAL SERVICES**

In psychotherapy there are many different methods we may use to deal with the particular problems you or your child are experiencing. Psychotherapy is not like a medical doctor visit. Instead, it calls for your active participation. In order for therapy to be most successful, your provider will expect you to work on therapy goals during sessions and at home.

Psychotherapy can have benefits and risks. There are no guarantees of what you will experience. Since therapy often involves discussing unpleasant aspects of you and your child's life, you or your child may experience uncomfortable feelings. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

During our first few sessions your provider will evaluate your and your child's needs. By the end of the evaluation, he or she will offer you some first impressions of what treatment will include. Please consider this information carefully and decide whether or not you feel comfortable working with this provider. Then, you and your provider can decide if he or she is the best person to help you meet your treatment goals. If you decide to continue with therapy, you and your provider will agree on a treatment plan and discuss this during a feedback visit.

Therapy involves a large commitment of time, money, and energy, so you should choose your or your child's therapist carefully. If you have questions about your provider’s procedures, please discuss them with him or her whenever they arise. If at any time you wish to stop treatment, your therapist will be happy to help you set up a meeting with another qualified professional. Please note that although each provider operates within Clinic AD, all clinicians are independent practitioners and are not affiliated. Please note that for adults over age 23, all health care records will be kept for 5 years, in compliance with Nevada State Law and then will be destroyed. For children, records will be kept until age 23, and then destroyed.

**CONFIDENTIALITY**

You have the legal right to have your communication with your provider kept confidential. In general, your provider will not reveal what you discuss with him or her unless you sign an "Authorization for Release of Information" form. In our work with children and adolescents, although you hold legal privilege to your child's healthcare information, therapy is most beneficial if your child is allowed to have a confidential relationship with his or her provider. Your therapist will inform you if your child is an imminent, severe, physical danger to him or herself or others. By signing this consent, you agree to your minor child holding privilege over his/her healthcare information and agree to allow your provider to determine when it is appropriate to inform you about the content of your child's sessions. In order to provide our clients with excellent service, we consult with other professionals. We will not disclose any identifiable information.

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**There are certain exceptions to this general rule of confidentiality.**

* *Child Abuse*: If your provider has reasonable cause to believe that a child has been abused or neglected,

he or she must report this and relevant information within 24 hours to the Nevada Division of Child and Family Services or a law enforcement agency.

* *Adult and Domestic Abuse*: If your provider has reasonable cause to believe that an older or vulnerable

person has been abused, neglected, exploited, or isolated, he or she must make a report within 24 hours

to the local office of the Nevada Department of Human Resources Division of Aging Services or a law enforcement agency.

* *Health Oversight*: If your provider receives a request from the Nevada Board of Psychological Examiners with respect to an inquiry or complaint about my professional conduct, he or she must make available any records relevant to such inquiry.
* *Judicial or Administrative Proceedings*: If you are involved in a court proceeding and a request is made for information about the professional services that you have received and/or the records thereof, such information is privileged under state law, your provider will not release this information without written authorization from you or your legally-appointed representative, or a court order. This privilege does not

Apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

* *Serious Threat to Health or Safety*: Your provider may disclose confidential information from your records if he or she believes such disclosure is necessary to protect you or another person from a clear and substantial risk of imminent, serious harm. Your provider may only disclose such information and to such persons as are consistent with the standards of his or her profession in addressing such problems.
* *Worker's Compensation*: If you file a worker's compensation claim, and if you receive provide treatment to you relevant to that claim, then your provider must submit to your employer's insurer or a third party administrator, a report on services rendered.

**CONTACT INFORMATION**

You may call me at 775.846.3363 at any time. My work schedule varies and I may not immediately available by telephone. When unavailable, please feel free to leave a confidential voicemail. I will make every effort to return your call within 24 hours or during the next scheduled day, with the exception of holidays, weekends, and vacation days. If you cannot reach me in an emergency, call 911 or the Crisis Call Center at 775.784.8090. You may also seek help from the nearest emergency room. If I am unavailable for an extended period of time, I will provide you with the name of a trusted colleague to contact, if necessary.

**CONSENT**

I have received and read a copy of the Therapist-Client Services Agreement and the Notice of Privacy Policies and Practices. I understand that this office adheres to the regulations mandated by the Health Insurance Portability and Accountability Act (HIPPA, Title II). I understand these policies and have had an opportunity to discuss and questions I have with my provider. I agree to the fees and services as described and understand confidentiality and limits of confidentiality. I hereby authorize my clinician to provide me, or my legal dependent with behavioral health services. I also understand that at anytime during service, I may withdraw my consent to participate.

Signature of Client (or client's legal representative) Date

Name of Client (or legal representative)

Provider Date