



**anna graybeal, ph.d.**

clinical psychologist

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## Client Information and Agreement Form

Welcome to my practice. I am pleased to have you as a client. This Agreement contains important information about my professional services and provides the ethical and legal basis for our work together. The final page is a form for you to complete and sign, acknowledging your agreement to accept these policies.

*Psychological Services:* I provide individual, couples and group psychotherapy services. In our first sessions together we will work to establish your goals for treatment and begin to understand the factors that contribute to your issues of concern. Together we will decide whether I am the right therapist for you.

*Appointments:* I generally schedule appointments on a weekly or more frequent basis. If you must cancel or change a scheduled appointment, please contact me at least 24 hours in advance. Since the time has been reserved for you, I will charge you the regular fee for appointments not cancelled at least 24 hours ahead.

*Professional Fees:* My fee is currently \$180 for a 45-minute session. Payment is due at time of service, by check or cash.

*Contacting Me:* My phone number is 512-680-8259. I welcome your calls and voicemails, but I do not text or email.

*The Confidentiality of Your Healthcare Information:* The law protects the privacy of all communications between a client and a psychologist. In most situations I may release information about you *only* if you provide me with written authorization. However, there are certain situations that deny me complete control over the confidentiality of your information. For example, I am required to report to the proper authorities in situations of suspected abuse to a minor, elder, or disabled person. I may also be obliged to warn a potential victim if I believe that a client may be intending to do them harm. If a client is at serious risk for inflicting self-harm, I am required to make efforts to assure their safety. There are also rare cases where records are ordered and I may be forced to yield them to a court and/or governmental agency. Since I do not support the unwarranted violation of your privacy, I will do everything I can to protect your healthcare information. However, I must obey the law. If such a situation were to occur, I would make every effort to discuss it with you thoroughly before releasing any information.

If you ask me to release information to someone else, such as another healthcare provider, I will ask for your written consent. Note that my fees for the preparation of client-requested documents, e.g., for use in court, are substantially higher than my therapy fees. Finally, please note that I cannot ensure the confidentiality of electronic communications.



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Please complete this form and sign at the bottom. Your signature will indicate that you understand and agree to the information and policies described in the "Client Information and Agreement Form" and that you have received and understood the HIPAA privacy information.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Telephone numbers (place a check by the best number to reach you):

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Type of work you do \_\_\_\_\_

Name of your employer \_\_\_\_\_

Emergency contact person and phone number \_\_\_\_\_

Partner's name & age \_\_\_\_\_ Your marital status \_\_\_\_\_

Names and ages of others who live with you  
\_\_\_\_\_

How did you find me? \_\_\_\_\_

If you were referred by a specific person, may I thank them? \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Parent or Guardian Date  
(if client is a minor)