Gary R. Elkins, PhD, ABPP, ABPH

Informed Consent

This document is to provide you with information regarding your diagnostic evaluation and treatment and to verify your informed consent to my services. The circumstances that lead an individual to seek psychological services and psychotherapy are quite varied. Some enter the relationship with a clearly defined intent while others are driven by a vague sense of personal dissatisfaction. My role as your Psychologist will be to complete a diagnostic psychological interview, conduct any psychological testing that I deem helpful, obtain information to assist me in your care, and provide psychological treatment and recommendations. This will include interviews to facilitate an exploratory process that will enable me to evaluate your current situation. This process involves a thorough examination of you and your current state of affairs, including your thoughts, feelings, and behaviors.

The psychotherapeutic process involves distinctive working stages from the initial session to the conclusion and termination of services, each of which contains therapeutic value. You should know that I view the psychotherapy relationship as a collaborative effort between the patient and psychologist. Therapeutic gains do not typically arise spontaneously, nor will your circumstances improve without a genuine effort on your part. Your evaluation and treatment may involve clinical interview, psychological testing, cognitive-behavioral therapy, hypnotherapy, biofeedback, supportive psychotherapy, or other psychological interventions. As my client or patient, it is within your right to participate in the process of setting goals and planning your therapeutic treatment. If for any reason I am unable to meet your needs as a psychologist, I will provide referrals to other qualified practitioners in the local area.

There are potential risks associated with the diagnostic interview and psychological treatment of which you should be aware; first and foremost, know that the process of change may be uncomfortable. You may acquire insight to information that is unpleasant and difficult to process. Family members and significant others may be reactive to changes you initiate as a result of counseling, and you could experience loss in relationships as you gain awareness and implement changes in your own behavior. In many cases, individuals and families experience escalations in problems before improvements transpire.

My psychotherapy style is comprised of techniques from various theoretical perspectives and includes an educational component intended to impart knowledge and skills that will ultimately enable you to proceed independently with confidence. The length of time required to accomplish such a goal will depend on the specific nature and complexity of the issues surrounding your unique situation.

Although the therapeutic relationship involves an intimate connection between the client and psychologist, it is imperative that our relationship remains purely professional in nature. All of our sessions will become a part of your clinical record. As such, the information you share with me is considered confidential and may not be disclosed without your expressed written consent. Certain exceptions do exist. As your psychologist, I am legally bound to take action and/or make disclosures any time it is deemed necessary for the protection of life. Additionally, disclosure of counseling information will be required in situations which: (1) you authorize me to inform someone else (as in the case of insurance reimbursement or consultation with another professional), (2) I am ordered by a court of law to disclose your information, (3) I determine that you are a danger to yourself or others, (4) I become aware that there is neglect or abuse (whether physical or sexual) involving a child or an aged adult.

I may engage in periodic staffing or consultation with other professionals about client-related issues as a means of providing better services to clients. Nonetheless, specific information revealing client identity will remain in confidence according to the limits of confidentiality outlined above. I will consult and communicate with your physicians and other health care professionals as I deem helpful in providing evaluation and treatment services to you.

I will provide you with information regarding my diagnostic impression, treatment recommendations, procedures for emergent care if needed, and provide you with an opportunity to ask questions and answer questions. It is your responsibility to ask any questions that you may have, provide any relevant information, and engage in the process of diagnostic evaluation, psychological testing, and psychotherapy or counseling in an involved and cooperative manner.

Parents/Guardians: If you are seeking services for a child or adolescent, you may be required to participate in an initial family session (parent and child) as well as a concluding family session. Know that it is within your rights as parents or legal guardians of minor children (under the age of 18) to request information concerning your child's progress and treatment. However, it is often harmful to the therapeutic process if I am not able to assure your child that our work will remain confidential. Therefore, I ask that you, as parents/guardians, agree not to ask specific questions concerning the detail/content of information disclosed during individual sessions with your child. In turn, I agree to work collaboratively with him/her in an effort to provide you with general updates when requested and disclose information to you in preservation of the therapeutic relationship. If you are a divorced parent or if there is any legal history in regard to services to a child or adolescent you are seeking services for, I require that you provide legal documents that clarify your legal rights and right to consent to or make decisions about the child or adolescent you are seeking services from me.

For clients who choose to file insurance claims, please be aware that in order for you to be reimbursed by your health care provider, I will be required to diagnose a mental health condition and provide supportive documentation of such to your insurance provider. If a qualifying diagnosis is appropriate in your particular case, I will inform you of the diagnosis prior to submitting it to your health insurance provider. Be aware that all services may not be covered in all contracts and that any diagnosis made will become a part of your medical/insurance record. It is your responsibility to contact your insurance carrier and request a pre-authorization number, to know your co-pay, and whether you are required to meet a deductible. As a courtesy I will file your claim. However, verification of eligibility or filing of a claim does not guarantee payment. If your personal information should change, it is your responsibility to keep me informed. As any changes in address, employment, marital status or even your phone number can result in denial of payment.

Fees are considered part of your evaluation of therapy. Payment of your fee or co-pay by cash or personal check is your responsibility and is due at the end of each session. Current fees are as follows but are subject to change and you will be informed and responsible for payment of any change or increase in these fees as they may apply to you:

CPT CODE	Description of Service	Reimbursement
908010	Psychiatric Diagnostic Examination Interview	$175
908060	Psychotherapy, Individual Office (45-60) Min.	$110
9085337	Group Psychotherapy, 75-120 Min.	$45
908800	Hypnotherapy	$135
961510	Health Behavior Assessment	$35 per unit
961520	Health Behavior Intervention, Individual Office	$35 per unit
961530	Health Behavior Intervention, Group (60-75) Min.	$35 per unit
909010	Biofeedback	$40 per unit
961010	Psychological Testing w/ Interp. & Report; per hour	$110
961190	Neuropsychological Testing by Tech w/ Interp. per hour	$135
961160	Neurobehavioral Status Examination; per hour	$145

If your insurance is the Scott and White Health Plan you will be required to pay the co-pay at the time of service. If you have other insurance you will be required to pay at the time of service and I will assist you in providing information for you to file with your insurance provider. If you pay out of pocket, you will be required to pay at the time of service. If you arrive late your session will be shortened by the amount of time that you are late. In the event that you are unable to keep a scheduled appointment, you will be required to provide a minimum 24-hour advanced notification. Failure to do so will result in a $50 cancellation fee. Returned checks are subject to an additional fee of $25. If your check is returned, you will be required to make any future payments by cash or money order.

After-hours calls, emergencies, or out of the office therapy will be billed at the rate of your regular fee, billed by the quarter hour. This includes travel time and phone calls in excess of three minutes. In the event of an emergency you may contact me at (254) 913-3026. If I am unavailable and your situation required immediate attention, please contact the local police department or go directly to the Scott and White Clinic and Hospital emergency room or call Scott and White Hospital at 724-2111 or in the case of an immediate emergency 911.

I currently hold a Ph.D. degree from Texas A&M University. I completed my internship in clinical psychology at Wilford Hall USAF Medical Center. I am qualified to practice psychology by the State of Texas through a license in psychology issued by the Texas State Board of Examiners of Psychologists. I received specialty certification from the American Board of Professional Psychology in Clinical Health Psychology. I also received Diploma status (Specialty Certification) from the American Board of Psychological Hypnosis and have served as President of the American Board of Psychological Hypnosis and the American Society of Clinical Hypnosis. If at any time you are dissatisfied with my services, I encourage you to discuss your concerns with me directly. If for any reason we are unable to resolve the situation to your satisfaction, you may file a complaint with the Texas State Board of Examiners of Psychologists at (512) 305-7700. Complaint Hot Line 1-800-821-3205.

This document is constructed for the purpose of informing you about your rights as a client. If, at any time, questions or concerns arise about any aspect of psychological services, I welcome and encourage you to discuss them with me directly.

MY SIGNATURE BELOW (on page 3) AS A PATIENT OF CLIENT OF DR. GARY ELKINS ACKNOWLEDGES THAT I HAVE READ AND FULLY UNDERSTAND THE INFORMATION CONTAINED IN THIS CONTRACT AND PROVIDE MY INFORMED CONSENT FOR PSYCHOLOGICAL DIAGNOSTIC INTERVIEW, PSYCHOLOGICAL TESTING, AND PSYCHOTHERAPY OR OTHER PSYCHOLOGICAL SERVICES THAT MAY BE PROVIDED TO ME BY DR. GARY ELKINS. ANY QUESTIONS I MAY HAVE HAD ABOUT THIS STATEMENT HAVE EEN ANSWERED TO MY SATISFACTION. I FURTHERMORE AGREE TO RELEASE GARY ELKINS, PH.D. FROM ANY AND ALL LIABILITIES.

_____	_____
CLIENT SIGNATURE	DATE
_____	_____
PARENT OR LEGAL GUARDIAN SIGNATURE (IF CLIENT IS A MINOR)	DATE
_____	_____
GARY ELKINS, PH.D.	DATE