Scott O. Hickman, PsyD, PLLC
1340 N White Chapel Blvd, Ste 130
Southlake, TX 76092
817-381-6865

Informed Consent and Agreement

Please acknowledge your understanding by initialing each item below:

_____ I understand the fee for each individual session is $180. The initial session is $210.

_____ Once sessions have been established, I will pay at the end of my last session of the month, in person, with check, cash, or credit card.

_____ I understand that I will be charged the full session fee for all cancelled or missed appointments unless able to reschedule according to the office policy.

_____ I understand the guidelines of confidentiality.

_____ I understand I should contact 911 or go to my nearest emergency room in case of emergency.

_____ I understand Dr. Hickman's policy regarding legal/forensics involvement. I acknowledge I will be responsible for any forensic fees ($500/hour) if Dr. Hickman is subpoenaed to court (unless another party has agreed to payment).

_____ If I choose to terminate treatment, I agree to attend one final session in order to discuss the issues surrounding my desire to end. Also, this allows Dr. Hickman to provide any referrals, if warranted.

By signing this document, I am acknowledging I have read the documents "Psychotherapist-Patient Agreement" and the "Texas Notice of Privacy" and am in agreement and understanding with the policies outlined in both documents. I understand I can ask questions of clarification at any point during treatment.

I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with Dr. Hickman before ending therapy.

I hereby agree to enter into therapy with Scott O. Hickman, PsyD.

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

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Confidential Questionnaire

Name: _____ Date: _____

Street Address: _____ City/State/Zip: _____

May I send mail to your home address? Yes ___ No ___

Phone Number: _____ Email: _____

May I leave a message: On your phone? Yes ___ No ___ Via email? Yes ___ No ___

Birthdate/Age: _____ Marital Status: _____ Occupation: _____

Education (Highest level): _____

Names, relationships, and ages of the individuals currently living with you:

Have you ever been in psychotherapy or any type of counseling before? Yes ___ No ___

If yes, what was your experience like (duration, type of therapy, feelings about treatment)?

Contact Person (In Case of Emergency):

Name: _____ Relationship: _____ Phone: _____

Referral Source:

How did you hear about me (person's name, website)? _____

What brings you to therapy (reasons, expectations, duration, etc)? Fill space below; attach further pages if needed:

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Credit Card Authorization Form

I authorize Scott O. Hickman, PsyD, to keep my signature on file. I understand that I will still be responsible for any and all charges per this agreement. By agreeing to this, I am still responsible for paying my bill in a timely manner. This credit card number will only be used when I am not present (as in a no-show/late cancellation) or if I forget to bring payment for my sessions. I will plan to pay for all my sessions in person with check, cash, or credit card.

Patient's Name: _____

Cardholder's Name: _____

Cardholder's Zip Code: _____

Account #: _____

Expiration Date: _____ / _____ Code on Back of Card: _____

Signature: _____ Date Signed: ____ / ____ / _____
mm dd yyyy