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 $225. The initial session is $250.

_____ I authorize Dr. Hickman to email my invoice to me each month at the email provided. I understand this will come from a third party company.

_____ Once sessions have been established, I will pay at the end of my last session of the month. If paying by check or cash, I will pay the last session of the month. If paying by credit card, Dr. Hickman will bill for the month on the last session of the month (a convenience fee not to exceed the credit card fee will be assessed).

_____ 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:

Name: _____

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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. This credit card number will be used for my monthly statements. Once my credit card is entered in Dr. Hickman's billing program, I understand my card numbers (except the last 4 numbers) will be redacted in order to maintain the security of my 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

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COVID-19 Addendum

Due to the ongoing pandemic, I wanted to let you know of current policies:

- If you
  - have symptoms consistent with COVID-19, especially fever, please do not come to your appointment. We can meet by phone in lieu of an in-person meeting if you are feeling well enough to meet.
  - test positive for COVID-19, we will meet via phone for the number of days recommended by the CDC if and when you feel well enough to meet for your session(s).
  - have first hand exposure to someone who has tested positive, we will meet via phone for the number of days recommended by the CDC.
  - are in close proximity to someone who had first hand exposure to someone who tested positive, please call the office so we can discuss a plan about in-person versus phone sessions
- If I
  - have symptoms consistent with COVID-19, I will contact you and plan to meet via phone if I am feeling well enough to be present for your session(s).
  - test positive for COVID-19, we will meet via phone for the number of days recommended by the CDC if and when I feel well enough to meet for your session(s).
  - have first hand exposure to someone who has tested positive, we will meet via phone for the number of days recommended by the CDC. I will get tested as soon as I am able and will return to in-person meetings upon a negative test.

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