Barbara J. Mosbacher, Ph.D.

Clinical Psychologist
Psychoanalyst

281-546-4115

BJM@BarbaraMosbacher.com
BarbaraMosbacher.com

4203 Montrose Blvd, #370
Houston, Texas 77006

Patient Data

Please Print Clearly

Patient Name: _____ Social Security Number: _____

Home Address: _____ City & State: _____ Zip Code: _____

Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Email Address: _____

Children's Names and Ages: _____

Preferred Pronouns: _____

Spouse/Partner: _____ Responsible Party: _____

Home Address: _____ City & State: _____ Zip Code: _____

Email Address: _____

Person to call in case of an emergency: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referred by:_____

Do I have permission to thank the person who referred you? Yes No

Missed Appointment Policy

Missed appointment charges are your responsibility. You will be charged for the appointment at your usual/allowable rate if you do not call to cancel an appointment at least forty-eight (48) hours in advance. For clients in psychoanalysis, missed appointments are you responsibility.

Signature of Patient/Responsible Party: _____ Date: _____

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Consent for Treatment

Consent for Treatment, Consent for Use and Disclosure of Protected Health Information, Policies to Protect Your Privacy and Limitations on Confidentiality

Name of Patient: _____
Carefully review this agreement, your rights, and how medical information about you may be used and disclosed, before signing.

By signing this agreement, I (the undersigned) do hereby voluntarily consent to a full range of psychological services, which may include evaluation, recommendation and/or treatment by Barbara Mosbacher, PH.D.

With my consent, Barbara Mosbacher, PH.D., may create and maintain a record of protected health information (PHI) and may use and disclose my protected health information for the purposes of treatment, payment and health care operations. For a more complete description of such uses and disclosures, please refer to Dr. Mosbacher's Notice of Privacy Practices.

I have had the opportunity to review the Notice of Privacy Practices prior to signing this consent. I understand that Dr. Mosbacher reserves the right to revise her Notice of Privacy Practices at any time and that a copy of such may be obtained by forwarding a written request to her office. If Dr. Mosbacher revises her policies and procedures, I will be informed only if I am impacted.

Dr. Mosbacher may not use or disclose PHI or psychotherapy notes for purposes outside of treatment, payment and health care operations without my specific signed authorization. I may revoke such authorizations at any time, provided each revocation is in writing and Dr. Mosbacher has not relied on that authorization.

Dr. Mosbacher may be required by law to use or disclose my PHI without my consent or authorization under certain circumstances that include but are not limited to the following:

- If I am evaluated to be a danger to myself or others;
- If I am a minor, elderly or disabled person and Dr. Mosbacher believes that I am the victim of abuse or neglect or if I divulge information about such abuse;
- If Dr. Mosbacher has reason to believe I have abused or neglected a minor, an elderly or disabled person;
- If I file suit against Dr. Mosbacher for malpractice;
- If a court order, other legal proceedings, or statute requires disclosure;
- If the patient is a minor, a custodial parent has access to the medical record unless limited by court order.

I further acknowledge that a third party payer may have access to otherwise confidential information.

With my consent, Dr. Mosbacher and/or her staff may call my home, or other designated location, and leave a message on voicemail or in person, in reference to any items that assist in carrying out treatment, payment and health care operations, such as appointment reminders, insurance matters, and issues pertaining to my clinical care. Dr. Mosbacher and/or her staff may mail to my home or other designated location any items that assist in carrying out treatment, payment and health care operations, such as appointment reminders and patient statements.

I agree that this authorization will remain in effect for the duration of all psychological services rendered, or until such authorization is revoked by me, in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I agree that a photocopy of this form may be used in lieu of the original. If I do not sign this consent, Dr. Mosbacher may choose to decline to provide me treatment.

Signature of Patient: _____ Date: _____

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Record of Disclosure

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The patient is also provided the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the patient's office instead of to the patient's home.

Please indicate how you prefer to be contacted on each item:

Home Phone: _____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave discreet message with call-back number only.

Work Phone: _____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave discreet message with call-back number only.

Cell Phone: _____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave discreet message with call-back number only.
- ☐ Is texting O.K. (primarily for scheduling purposes.)

Written Communication: _____

- ☐ O.K. to mail to my home address.
- ☐ O.K. to mail to my work/office address.

Other Instructions: _____

Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

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Child Patient Data

Please Print Clearly

Child's Name: _____ Date:_____

Home Address: _____ City & State: _____ Zip Code: _____

Date of Birth: _____ Gender: _____ Relationship: _____

Home Phone: _____ Evening Phone: _____ Cell Phone: _____

Is there a second address on weekends? _____

Father's Name: _____

Home Address: _____ City & State: _____ Zip Code: _____

Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Responsible Billing Party? Yes No

Mother's Name: _____

Home Address: _____ City & State: _____ Zip Code: _____

Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Responsible Billing Party? Yes No

Person to call in case of an emergency: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referred by:_____

Will you be filing with your insurance? Yes No

Missed Appointment Policy

Missed appointment charges are your responsibility. You will be charged for the appointment at your usual/allowable rate if you do not call to cancel an appointment at least forty-eight (48) hours in advance.

Signature of Patient/Responsible Party: _____ Date: _____

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Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. A noteable exception is if Barbara J. Mosbacher, Ph.D. is subpoenaed by a judge or court.

Exception Name(s): _____

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor patients have the right to access the client's records.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Signature of Patient: _____ Date: _____

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Credit Card Authorization

Account Information:

Name on Credit Card: _____

3 Digit Security Code (Amex – 4 Digits): _____

Credit Card Billing Address: _____ City & State: _____ Zip Code: ____

Payment Information:

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____ Expiration Date:_____

Authorization:

As evidenced by my signature below, I authorize Barbara Mosbacher to charge my credit card for:

☐ All recurring or non recurring weekly or monthly charges ☐ Current invoice totaling $ _____

Signature of Card/Account Holder: _____ Date: _____

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Authorization to Release

I, _____ , (Patient) hereby authorize Barbara J. Mosbacher, Ph.D. (Provider) to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to: _____

_____

This disclosure of information and records authorized by Patient is required for the following purpose: _____

_____

Such disclosure shall be limited to the following specific types of information:_____

_____

Signature of Patient: _____ Date: _____