Leanne Carlson, Ph.D., HSPP
8395 Keystone Crossing, Suite 104
Indianapolis, Indiana 46240
(317)431-0897
Fax (317)598-0355

Welcome to my practice. I am pleased to have the opportunity to work with you. I hope that this handout will provide information helpful in making an informed decision to seek services. Please feel free to ask questions about this policy at any time.

Appointments:

Services are available by appointment only, but I will make every effort to address emergencies as soon as possible. Please call the office at (317)431-0897 and leave a message. I will try to return your call within 24 hours. After hours, please call the Community Hospitals crisis service at 621-5700.

50 minutes are scheduled for psychotherapy sessions. Please be aware that testing fees include time for actual testing, interpretation of results and generating reports. Appointment times are reserved for you, and I ask that appointments be cancelled within 24 hours. Failure to show for an appointment may result in a $75 charge.

Leanne Carlson, Ph.D., HSPP
8395 Keystone Crossing, Suite 104
Indianapolis, Indiana 46240
(317)431-0897
Fax (317)598-0355

NEW CLIENT REGISTRATION

DATE: _____

CLIENT INFORMATION:

Name:_____
(Last) (First) (Middle initial)

Maiden Name:_____ Marital Status:_____ Gender: M F

Age: _____ Date of Birth: _____ SS#_____

Address:_____

City: _____ State:_____ Zip:_____ County:_____

Telephone: _____ _____ _____
(home) (work) (mobile)

E-mail address:_____

PLEASE ONLY PROVIDE TELEPHONE NUMBERS WHERE YOU MAY BE CONTACTED

Is the client a minor? Y N If so, who is the guardian? _____

Are parents divorced? Y N Is so, who has legal custody? _____

EMPLOYMENT INFORMATION:

Employer:_____ Length of Employment: _____

Employer Address:_____

NEXT OF KIN INFORMATION: Who to contact in the event of an emergency

Name:_____ Relationship:_____

Address:_____ Phone:_____

Who referred you to the office?_____

INSURANCE INFORMATION:

Name of insurance company:_____ Phone:_____

Name of policyholder:_____ Date of Birth:_____ Relationship_____

Insurance ID #:_____ Group #:_____

Is referral/prior authorization needed? Y N Have you obtained referral if necessary? Y N Referral #_____

Is your deductible satisfied? Y N Copay? Y N amount: _____

FAMILY INFORMATION: Please list persons currently living in your household

Name	Age	Gender	Relationship	Occupation

MEDICAL HISTORY:

Have you ever received psychological help? Y N If so, please provide names of providers and outcome

Please list major diseases, surgeries, and hospitalizations:

Name and telephone number of family physician:

Other physicians who are currently treating:

Medications:

Name	Dosage/Frequency	Purpose

Medication Allergies:

Please provide information on family history of severe medical or psychiatric problems:

Please provide a brief reason for seeking treatment at this time:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Permission for Treatment:

Permission is hereby granted to Leanne Carlson, PhD., HSPP to administer psychological evaluation and treatment as deemed necessary to myself and/or the minor child named on this registration. I certify that I have the legal right to seek treatment for this person.

_____	_____	_____	_____
Date	Signature	Relationship	Witness

Guarantor's Statement:

I agree to pay all accumulated charges not covered by verified and assigned insurance for myself or the minor child named on this registration.

_____	_____	_____	_____
Date	Signature	Relationship	Witness

Leanne Carlson, Ph.D., HSPP
8395 Keystone Crossing, Suite 104
Indianapolis, Indiana 46240
(317)431-0897
Fax (317)598-0355

CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned, agree and consent to participate in the mental health services provided by Leanne Carlson, Ph.D., HSPP as defined by Indiana State Law. This consent applies to my child or ward if they are the person named on the registration.

I understand that I am consenting only to those mental health services that my provider is qualified to provide within the scope of her training.

I understand that this agreement does not guarantee that we will attain my goals. However, I agree that I will pay for access to Dr. Carlson's resources as a mental health provider and her willingness to apply her skills and resources in good faith.

I stipulate that this agreement will be part of my medical record which is accessible to me and Dr. Carlson, but to no other person without my written consent, except as required by law. My provider may discuss my medical record with my physician or physician's group _____
Name of Physician

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the release of any information regarding services rendered and allow a photocopy of my signature to be used to file insurance if necessary. I direct my insurance to issue payment for all mental health services due me directly to Dr. Carlson. This assignment and authorization will remain in effect until revoked by me in writing. I understand that I am responsible for the fees for all services rendered.

My signature indicates that I have read the above disclosure statement and understand the information. I agree with the conditions of treatment stated or implied here. I have received a copy of this office policies and notices of privacy practices.

_____ _____
Client signature date

_____ _____
Parent/Guardian signature date

_____ _____
Witness date

Leanne Carlson, Ph.D., HSPP
8395 Keystone Crossing, Suite 104
Indianapolis, Indiana 46240
317-431-0897

Electronic Media/Social Media Policy

E-mail – Electronic mail should be used only for administrative communication, such as checking/arranging appointments or the communication of basic information. It should not be used to communicate therapeutic/highly personal information. E-mail is stored on servers even after it is opened, and e-mail sent through an employer's e-mail account is the property of the employer, so privacy is not guaranteed.

Social Media – I cannot be "friends" with any client on Facebook or like social media. Because information on my Facebook page can be seen by all of my "friends," privacy of clients is compromised. Likewise, I cannot follow clients on Twitter or like media.

Texting – Text messages should be used only for administrative purposes, such as scheduling/changing appointments. My text messages are password protected.

All client data that is stored on my computer is encrypted. Text and e-mail messages are additionally protected by passwords.

Please check below if you would like to be able to communicate with me via e-mail or text message following the guidelines outlined above.

_____ I would like to communicate via the e-mail address _____

_____

_____ I would like to communicate via text to the following number:_____

I understand that I am responsible to communicate any changes in the above information.

_____ _____
Signature of Client date