

Michelle M. Forrester, Ph.D.  
Licensed Psychologist #2-5359

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Welcome to the practice of Dr. Michelle M. Forrester! This packet contains the first set of forms you will need to complete prior to your initial appointment with Dr. Forrester.

Enclosed in this packet you will find:

-Office Policies

-Notice of Privacy Practices – Consent

(review the Notice of Privacy Practices on the website under Patient Privacy or request a copy from our office)

-Authorization for Evaluation and Treatment

-Authorization for Release of and/or Exchange of Information

(if there is another provider we should speak with regarding your child)

-Authorization for Email Communication

Please also complete the appropriate ***Child History Form*** for your child (found under New Patient Forms) and return all items to Dr. Forrester prior to your initial appointment.

Please do not hesitate to contact us at 713-598-3559 or [drmmf@comcast.net](mailto:drmmf@comcast.net) if you have any questions or concerns.

We look forward to meeting you,

Dr. Michelle M. Forrester and Staff

## Office Policies

*Please initial indicating that you have read and understand each item:*

\_\_\_ Confidentiality: I understand that Dr. Forrester's staff will maintain confidentiality and will not provide any information about me or my child to others except under mandate of the law. (See consent form for details)

\_\_\_ Cancellation: I understand that my failure to provide 24-hour advance notice of my cancellation will result in me being charged for the appointment. I understand all missed appointment fees must be paid prior to (or on the date of) the next scheduled appointment.

\_\_\_ Missed Group Sessions: I understand that I am allowed one missed session per semester in group therapy. Even with 24-hour notice, all missed group sessions (aside from one missed session per semester) are charged the full amount of the appointment fee and must be paid prior to (or on the date of) the next scheduled appointment. I understand that I will not be provided a receipt for missed sessions, as this fee is not reimbursable by insurance.

\_\_\_ Late Arrival: I understand that as a courtesy to other clients, I will not receive an extension of the scheduled appointment time as a result of my late arrival and thus my appointment will be shortened.

\_\_\_ Identifying Information: I understand that any published research or other materials will not contain any identifying information and that my records will not be released without my written consent. Due to HIPPA, this also means that information will not be disclosed to anyone, even family members, without written consent.

\_\_\_ Etiquette: I agree not to come into the office under the influence of alcohol or non-prescribed drugs. I agree to silence my cell phone and will not talk on my cell phone while in session unless there is an emergency. I agree to maintain privacy of others I may see in the office and will not disclose any information about other group members or their families (if participating in a group).

\_\_\_ Payment: I understand that payment is expected in advance or at the time of service. Acceptable forms of payment are cash or check (credit cards are not accepted). Dr. Forrester does not accept insurance payment; however my receipt will contain the necessary documentation I need in order to file with my insurance company. I understand that I should have my payment ready prior to arrival to avoid any delay in services. A fee of \$25 will be applied for returned checks (and future cash payments required) and late payments.

\_\_\_ Preparing for Initial Appointment: I understand that I need to prepare my child for their visit. There is no need to tell my child he/she is going to see the doctor. The word "Doctor" often triggers fears, especially in young children. Parents should tell their child they are going to see someone named "Ms. Michelle" who has a room full of toys that they can play with. Children are often excited to see the playroom and this helps allay any fears. I agree to assure my child that I will stay with them and they will not be left alone.

\_\_\_ Preparing for Assessment/Evaluation: I understand that to prepare my child for an assessment/evaluation appointment I need to inform them that they will do "work" and will be provided with play and snack breaks. I understand that it is my responsibility to bring a snack to this appointment and that I will remain in the waiting room for the duration of the appointment.

\_\_\_ Supervised Interns: I understand that services from Dr. Forrester's supervised interns are considered an out-of-pocket expense and cannot be submitted to my insurance carrier for reimbursement.

\_\_\_\_\_  
**Child's Name**

\_\_\_\_\_  
**Child's Date of Birth**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Notice of Privacy Practices - Consent**

**Consent for the use or disclosure of health information for treatment, payment, or health care operations.**

Our Notice of Privacy Practices was provided to you and included information about how Dr. Michelle M. Forrester may use or disclose your personal and health information. We request your consent for the use and disclosure of mental health and medical information for treatment, payment, or health care operations. You have a right to review our Notice of Privacy Practices before signing this consent form.

By signing this consent form you:

- 1) acknowledge that a copy of our Notice of Privacy Practices has been provided to you; and
- 2) consent to our use and disclosure of your personal and health information for treatment, payment, or health care operations.

You have the right to revoke this consent in writing at any time, except where health information has already been used or disclosed in reliance upon this consent.

\_\_\_\_\_  
**Child's Name**

\_\_\_\_\_  
**Child's Date of Birth**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Authorization for Evaluation and Treatment**

*Please print:*

**Child's Name:** \_\_\_\_\_ **Child's Date of Birth:** \_\_\_\_\_

Parent(s)/Guardian: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

I/We, \_\_\_\_\_, hereby give full consent for my/our child and/or myself/ourselves to receive psychological evaluation and treatment services of Dr. Michelle M. Forrester until I/we notify her or until she determines that services are no longer appropriate or will no longer be provided.

I/We further certify that I/we have the legal authority to authorize and consent to this evaluation and/or treatment as parent(s), managing conservator, or guardian(s) of this child.

I/We understand that any information that I/we provide to Dr. Forrester is confidential and generally will not be released to others without my/our written consent. However, I/we understand that state and/or federal law might require Dr. Forrester to disclose confidential information without my/our consent in certain circumstances. I understand that Dr. Forrester may be required to disclose confidential information, without the consent of a client or a client's legally authorized representative, in one or more of the following situations: (1) if a client is evaluated to be a danger to self or others; (2) if Dr. Forrester believes a child is the victim of abuse or neglect; (3) if information is disclosed about the physical or sexual abuse or neglect of a child, elder, or disabled person; (4) if a suit is filed by me/us or my/our child against Dr. Forrester for breach of duty; and (5) if a court order, legal proceeding, statute, or regulation requires disclosure.

I/We understand that I/we will not receive a copy of my/our child's records without the approval of Dr. Forrester or another authorized professional.

My/Our signature on this consent form verifies that I/we have had the opportunity to ask questions regarding Dr. Forrester's policies, procedures and therapy techniques, that my/our questions were answered to my/our satisfaction by Dr. Forrester, and that I/we voluntarily give my/our consent for treatment. I/we understand that I/we have the right to withdraw my/our consent for treatment at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Child

**Authorization for Release of and/or Exchange of Information**

*Please print:*

\_\_\_\_\_  
**Child's Name**

\_\_\_\_\_  
**Child's Date of Birth**

NAME OF PERSON OR AGENCY PERMISSION IS GRANTED TO SHARE INFORMATION WITH:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

I, \_\_\_\_\_, hereby give Dr. Michelle M. Forrester permission for the mutual exchange of pertinent information regarding my child/family with the above named person/agency, including academic, social, medical, psychological, and/or psychiatric information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

THIS CONSENT EXPIRES ONE YEAR FROM DATE SIGNED, UNLESS AN EARLIER EXPIRATION DATE IS ENTERED HERE \_\_\_\_\_.

**Authorization for Email Communication**

*Please print:*

Names(s): \_\_\_\_\_

By signing this consent I am authorizing Dr. Michelle Forrester and her staff members to communicate with me via email for NON-Clinical information such as appointment reminders/confirmations, referral information, and billing questions.

Due to the difficulty of ensuring the confidentiality of electronic communication, this method of communication is not appropriate in an emergency and is not intended to provide care or treatment. All communication that involves confidential information should be directed to Dr. Forrester or her staff via phone or in person.

\_\_\_\_\_  
Email address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Child