Michelle M. Forrester, Ph.D.
Licensed Psychologist #2-5359
9601 Katy Freeway, Suite 175 ● Houston, TX 77024
Phone 713-598-3559 ● admin@michellemforrester.net
www.michellemforrester.com

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 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)
-Custody Dispute Contract
(to be completed by parents in the process of separation/divorce)

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

Please do not hesitate to contact us at 713-598-3559 or admin@michellemforrester.net if you have any questions or concerns.

We look forward to meeting you,

Dr. Michelle M. Forrester and Staff

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

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. I understand missed appointment fees are not reimbursed by insurance.

___Missed Group Sessions: I understand that even with 24-hour advance notice, all missed group sessions are charged the full amount of the appointment fee. 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 and not talk on my cell phone while in session unless there is an emergency. I agree to maintain privacy of people I may see in the office and will not disclose any information about others.

___I understand that I, or another appointed adult, must remain on site (and may not leave the building) for the duration of my child's appointment. I agree to accompany my child into/out of the office for each appointment.

___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). A fee of $25 will be applied for returned checks and late payments (and future cash payments will be required). I understand that annual statements are not provided; thus I will retain my receipts and statements for my own records.

__ Insurance: Dr. Forrester does not accept insurance payment and she does not deal directly with the insurance company; however, my receipt will contain the necessary documentation I need in order to file a claim with my insurance company if I choose to do so. I understand that if I choose to seek reimbursement from my insurance company, the decision for reimbursement lies with them.

__Therapist Availability: I understand that Dr. Forrester does not provide 24-hour crisis service. If I require immediate assistance, or feel unsafe, I will call 911 or go to the nearest emergency room.

__ Termination of Therapy: I understand that it is my decision to discontinue and that I need to allow time to discuss this. I understand that there may be rare circumstances where Dr. Forrester determines that my therapy would be best provided by someone else. In this event, she will discuss this with me and do her best to provide an appropriate referral.

__ Litigation and Custody Disputes: I understand that Dr. Forrester will not voluntarily participate in any litigation or custody dispute and will generally not communicate with a client's attorney. In the event she is subpoenaed or ordered by a court of law, I agree to reimburse her for time spent in preparation, travel, and time for appearance.

___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 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.

__ Email Communication: I authorize Dr. Forrester and her staff members to communicate with me via email for information such as appointment reminders/confirmations, referral information, and billing questions. I understand that 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.

_____ _____

Child's Name **Child's Date of Birth**

_____ _____

Parent/Guardian Signature Date

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

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

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

Authorization for Evaluation and Treatment

Please print:

Child's Name: _____ **Child's Date of Birth: _____**

Parent(s)/Guardian: _____

Relationship to Child: _____

I/We, _____, 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 (and care from her assistants, contractors, interns, and staff as may be necessary per her judgment) 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, statue, 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

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

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: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Check One:

_____ I authorize the release of any records that have been obtained by the office of Dr. Michelle M. Forrester from other providers.

_____ I DO NOT authorize the release of records, in the possession of the office of Dr. Michelle M. Forrester, that have been obtained from other providers.

I, _____, hereby give the office of 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.

_____ _____
Parent/Guardian Signature Date

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

Custody Dispute Contract

****to be completed by parents that are divorced or in the process of separation/divorce****

Please print:

Child's Name: _____ Child's Date of Birth: _____

The purpose of this contract is to obtain a written agreement that psychologist, Michelle M. Forrester, Ph.D. and any of the therapists who work at her office with my child, will not be asked to participate in any litigation regarding any custody, visitation or access disputes. I understand that if Dr. Forrester, or any of the therapists who work at her office with my child, is asked to participate in any litigation, their neutral role with the family is likely to be compromised. This may seriously jeopardize any progress that has been made in therapy, as well as interfere with future progress. This may also limit my child's willingness to seek help from a psychologist or other therapist later in life as it could violate my child's trust/confidentiality between my child and the therapist. It is crucial that Dr. Forrester, any therapist working with my child, the parents, and my child have every reassurance that there will be absolutely no involvement on Dr. Forrester's part in any current or future litigation between parents.

Both parents are asked to sign this statement stating that they are in agreement:
We wish to enlist the services of Michelle M. Forrester, Ph.D., P.C. in the treatment of our child, _____.
We understand that such treatment will be compromised if information revealed therein is brought to the attention of the court in the course of a custody dispute. Accordingly, we mutually pledge that we will neither individually, nor jointly, involve Dr. Forrester or any therapist working with her on behalf of our child in any litigation whatsoever. We will neither request nor require Dr. Forrester or any therapist working with her on behalf of our child to provide testimony in court. We will neither request nor require Dr. Forrester or any therapist working with her on behalf of our child to turn over their notes to the court or any attorneys or other personnel involved in any custody dispute process. If the services of a mental health professional are desired for court purposes, the services of a person other than Dr. Forrester or anyone working in her office must be enlisted. Referrals can be provided upon request.

_____	_____
Signature	Date
_____	_____
Printed Name	Relationship to Child
_____	_____
Signature	Date
_____	_____
Printed Name	Relationship to Child