

MARK PRANGE, PH.D.

CLINICAL PSYCHOLOGY
CHILD AND FAMILY PSYCHOLOGY

INTAKE INFORMATION

Client Name _____ Date _____

Name of Parent or Guardian (if under 18 years old) _____

Home Street Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Work Phone () _____

Cell Phone () _____ Email address: _____

Birth date ____/____/____ Age _____ Gender (circle) Male Female

Marital Status (circle) Single Married Separated Divorced Widowed Partner

Education _____

Are you presently enrolled as a student? (circle) Yes No If yes (circle) Full Time Part Time

Name of school if currently enrolled: _____

If Employed:

Employer _____ Occupation _____

Work Street Address _____

City _____ State _____ Zip Code _____

How did you hear about Dr. Prange?

Referred by _____

MARK PRANGE, PH.D.

DUTY TO WARN

Although confidentiality and privileged communication remain rights of all clients of psychologists according to state law, some courts have held that if an individual intends to take harmful or dangerous action against another human being, or against themselves, it is the psychologist's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior, or the family of the client who intends to harm himself of such an intention.

The psychologist will under no circumstances inform such individuals without first sharing that intention with the client. Every effort will be made to resolve the issue before such a breach of confidentiality takes place.

I have read the above and understand the psychologist's social responsibility to make such decisions where necessary.

Signed by _____ Date _____

MARK PRANGE, PH.D.

FEE POLICY

The fees are set in accordance with the type and extent of psychological services that are rendered. All fees are due at the time services are rendered.

The fee for individual, family, or joint psychotherapy is \$200.00 per 50-minute session. Should Dr. Prange be contacted after hours on an emergency basis, the client will be charged for a telephone consultation in 15-minute increments at \$200 per hour.

In the case of psychological assessments, the fee will be set at the first session. This fee is payable during the time of the assessment.

The fee for a session that is missed and is not canceled 24 hours in advance is \$100.

There will be a \$75 charge for returned checks.

Dr. Prange accepts VISA, Mastercard, and Discover credit card payments. Please be advised if you chose to elect credit card payment it will be completed via Internet transaction with Availity.

I have read the proceeding information and I understand it.

Signature

Date

MARK PRANGE, PH.D.

Consent to use and disclose your health information

This form is an agreement between you, _____ and me, Mark Prange, Ph.D. When we use the word “you” below, it can mean you, your child, a relative, or other person if you have written his or her name here _____ .

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others for business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, we will inform you and you can get a copy by calling us at (813) 961-7727.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative’s authority

Signature of authorized representative of this office or practice