Beth Creager Berger, Ph.D.
Licensed Psychologist PSY18818
Phone: (858) 442-2421

4510 Executive Drive, Suite #115
San Diego, CA 92121
Fax: (858) 558-8538

During your first session, your therapist will discuss several important issues with you. This form will help acquaint you with the nature of our services. Please ask for clarification for any issue that may concern you.

Status of Therapist: Your therapist, Beth Creager Berger, Ph.D., is a licensed clinical psychologist.

_____ **Confidentiality**: In accordance with California law, the information disclosed by you in therapy is confidential and is not released or accessible to anyone else without your written permission. By law, the following exceptions apply and may require that relevant information is given to others: (1) danger to self, (2) danger to others, (3) when a child, disabled person, or elderly person is physically abused, sexually abused, or neglected, (4) when a court of law issues a legitimate subpoena, and (5) when a collection service is required for unpaid client bills.

In Case of Emergencies: You may call Dr. Berger at (858) 442-2421 and leave a message stating that it is urgent. Dr. Berger typically returns urgent calls within an hour. If you need to speak with someone more immediately please call 911 or the San Diego Crisis 24 hour hotline at 1-800-479-3339.

Payment of Services:

_____I agree to pay in full for services rendered by my therapist.
_____I understand that my fee is $165 for a 45-60 minute session, or $40 for each 60- 90 minute group session, and that extended sessions or non-emergency phone therapy will incur an additional prorated fee.
_____I understand that I must make cancellations of therapy appointments 24 hours in advance and that I will be charged a full fee for missed appointments or cancellations less than 24 hours in advance.
_____I understand that basic information necessary for record keeping of appointments, payments, diagnosis, address, and telephone, and any other information required for insurance billing will be released to the insurance company.
_____I understand that any uncollected bills for services or missed appointments may result in disclosure of my name, telephone number, SS#, and address to a collection agency or small claims court. I also understand that I am responsible for any bills that my insurance does not reimburse.

Treatment Outcome: There are no guarantees that treatment will be successful, although most clients do make significant progress. The length and outcome of treatment is based upon your motivation for treatment, how long you have had the symptoms, the skill of the therapist, and other factors.

I HAVE READ AND UNDERSTOOD THE INFORMATION ABOVE AND HAVE RECEIVED A COPY OF THIS INFORMATION .

_____ _____ _____ _____
Client Date Beth Creager Berger, Ph.D. Date

Beth Creager Berger, Ph.D.,
Psychological Assistant #PSB 28463 James L. Shenk, Ph.D., Supervisor, Lie. Psychologist PSY 11550
3262 Holiday Court, Suite 220 - La Jolla, CA 92037

Date:

Client:

Progress Notes

Agenda:

Homework Follow-Up:

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Progress:

Current symptoms *I* problems:

Medication *I* medical issues *I* M.D.s *I* substance use:

Content *I* focus of session (including relevant cognitions):

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Psychological Assistant #PSB28463

:1. (858) 689-4607 :X (858) *450-1161*

3262 Holiday Ct, Ste. 220 La Jolla, CA *92037*

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AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize
(print client name) (doctor, therapist, or hospital)
tB _le__ re_Wlnt j)_Y_OOl{}gi{;,_l, m_di_, Ol _<luca.ti<mal infQQn11otiQU concerning my evaluation

or treatment to

(l1hone #)

(name)

(agency/clinic/hospital)

(address)

The infonnation being released includes:

(specify nature/extent of released information) ,

The purpose of this release is:

(specify the reason for releasing the information)

I understand that I may ,revoke (end) this authorization at any time by oral or written c'OID.ID.\\\\\C,<.\t\OI\. to the \?eISOn being authorized <;tbove. ' Unless I revoke this authorization prior to

such time, it shall remain valid and in ellect IO! \ _() cl'3."j'2., encliw6 on
(date authorization expires)

(client signature) ,

(date - of birth)

(today's date)

(parent / guardian / legal representative)

(to day's date)

(signature of witness)

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Beth Creager Berger, Ph.D.
Psychological Assistant #PSB28463 .
James L. Shenk, Ph.D., Supervisor, Lie. Psychologist PSY 11550 3262 Holiday Court, Suite 220 La Jolla, CA 92037

Patient".

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Client Information Sheet

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Pro\'1der's name: .JlpJlles L. Ghe].k, _h.B-;, . License # PSYl155'O

Patient

Last Name

First Name

MI

Parent/Guardian (if above is minor)

Last Name

First Name

MI

Address

Telephone numbers to reach patient by:

Home:

()Okay to 'caU? - Leave a message? DO NOT CALL

Business: (

)Okay to taU? - Leave a message? DO NOT CALL

DIAGNOSIS:

FEE PER SESSION: $

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Pri\'ate Pal Mail to:

Insurance

Insurance Name/Address HM 0 *I* PPO *I* Indemnity

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