Intake and Medical History (Adult)

1. **Please enter your information.**

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Occupation _____ Employer _____

Referred to our clinic by
☐ Doctor ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Online ☐ Other

Other family members seen here: _____

2. **Billing Information**

Person responsible for bill _____

Birth date _____

Address (if different) _____

Home phone no.: _____

Is this person a patient here?
○ Yes ○ No

Occupation: _____ Employer: _____

Employer address: _____

Employer phone no.: _____

3. In Case of Emergency

Name of a local friend or relative (not living at same address)

Relationship to patient

Phone Number

4. General Information

Are you Right or Left handed?
○ Right ○ Left ○ Ambidextrous

Current Height:

Current Weight:

Primary Care Physician:

Who referred you to our office?

What brings you to our office?

5. Education Information

Did you graduate from high school?
○ Yes ○ No

If so, where?

If not, what was your highest level of high school?

Did you attend college?
○ Yes ○ No

If so, where?

Did you earn a degree?
○ Yes ○ No

Type of degree:

Major:

If no degree, how many credits did you earn?

Did you attend any special classes for difficulties with:
☐ Reading ☐ Writing ☐ Spelling ☐ Math

Do you have any vocational training/special job skills? If so, please list.

Any behavioral difficulties in school (e.g., suspension, detentions, fighting, drugs, etc.)?
○ Yes ○ No

Do you live:
☐ Alone ☐ With Children ☐ Significant Other ☐ Spouse ☐ Family

Do you require assistance with:
☐ Preparing your meals ☐ Self-care ☐ Travel the community ☐ Shopping ☐ Keeping appointments
☐ Laundry ☐ Bathing ☐ Cleaning ☐ Paying bills

6. Occupational Information

Are you currently employed?
○ Yes ○ No

If yes, who is your employer?

_____

What do you do (did you do if retired) for work?

_____

7. Military Service

Have you ever served in the military?
○ Yes ○ No

If so, which branch?

_____

8. Legal History

Have you been arrested?
○ Yes ○ No

If so, when?

_____

If you have been arrested, please explain:

_____

Are you currently on legal probation or have pending charges?
○ Yes ○ No

If yes, explain (duration of probation, when your
probation started and when does it end):

_____

_____

9. Substance Abuse History

How much alcohol do you drink weekly?

_____

When did you last drink alcohol?

_____

How often do you use street drugs?
○ Daily ○ Weekly ○ Monthly ○ Rarely ○ Never

List type of drug(s) using/used:

_____

Do you use nicotine or any nicotine products?
○ Yes ○ No

Describe your frequency of nicotine use (e.g., daily, weekly, etc.)

_____

10. Health and Social Information

Marital Status:
○ Never Married ○ Partnered ○ Married ○ Separated ○ Divorced ○ Widowed

How long have you been married/divorced/widowed/separated?

_____

City/State where you were born?

_____

Who raised you?

_____

Any childhood developmental delay/problems?
☐ Sitting ☐ Standing ☐ Walking ☐ Talking ☐ None

Any history of:
☐ Physical abuse ☐ Verbal Abuse ☐ Sexual Abuse

Have you witnessed domestic violence?
○ Yes ○ No

Number of Children and their ages: _____

Number of Boys: _____

Number of Girls:

_____

Do your children live with you?
○ Yes ○ No

Are you having any problems with your sleep habits? If yes, please indicate below:
☐ No problems with sleeping habits ☐ Sleeping too little/much ☐ Trouble falling asleep
☐ Trouble staying awake ☐ Disturbing dreams

Do you snore?
○ Yes ○ No

Are you having any problems with appetite or eating habits? If yes, please indicate:
☐ No problems with eating habits ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

Have you experienced significant weight change in the last 2 months?
○ Yes ○ No

If yes, how much have you gained/lost?

_____

11. **Medical Conditions: Please check any current applicable conditions and provide date diagnosed with condition(s):**

Medical Condition	Self	Family member	Whom
AIDS			
Asthma			
Autoimmune disorders			
Blood Disease			
High blood pressure			
Low blood pressure			
Cancer			
Diabetes			
Eating disorders			
Thyroid problems			
Female problems			
HIV positive status			
Hepatitis			
High cholesterol			
Heart disease			
Hearing disorder			
Kidney disease			
Ringing of the ears			
History of head trauma			
Seizures			

12. **Medical History**

Please list any difficulties not noted above:

_____

Please list any surgeries you have had:

_____

Have you ever lost consciousness?

○ Yes ○ No

How long were you unconscious:

_____

Please list ANY ALLERGIES you have:

_____

13. Medications: Please list CURRENT medications

	Start Date:	Name of Medication:	Dosage:	How do you take it? (e.g., by mouth, injection, inhale, etc.)	Dr. who prescribed:
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

14. Mental Health

Are you currently receiving psychiatric/psychological services?
○ Yes ○ No

If yes, where do you receive services and how long:

_____

Have you had previous talk therapy?
○ Yes ○ No

If yes, previous therapist's name:

_____

Has psychotherapy been effective for you?
○ Yes ○ No

Have you had recent thoughts of suicide?
○ Frequently ○ Sometimes ○ Rarely ○ Never

Have you ever been admitted to a psychiatric facility?
○ Yes ○ No

If yes, how many times, where and why?

_____

Have you ever experienced depressed mood?
○ Yes ○ No

If yes, when did you first become depressed (age)? _____

When were you last depressed? _____

What happens when you are depressed? (Check all that apply)
☐ Isolate ☐ Cry ☐ Suicidal thoughts ☐ Feelings of guilt ☐ Loss of interest in activities or hobbies
☐ Persistent sad, anxious, or "empty" feelings ☐ Persistent aches or pains ☐ Hopeless ☐ Worthless
☐ Fatigue

Do you experience any of the following? (Check all that apply)
☐ Inflated self-esteem or grandiosity ☐ Reduced need for sleep ☐ More talkative than usual
☐ Racing thoughts ☐ Distractibility (i.e., attention too easily drawn to unimportant things)
☐ Increase in goal-directed activity (either socially, at work or school, or sexually)
☐ Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

Do you suffer from Anxiety?
○ Yes ○ No

Do you suffer from Panic Attacks?
○ Yes ○ No

If yes, when did you first start experiencing panic attacks (what age)?

When did you last experience panic attacks?

How many panic attacks do you experience on average in a month?

What causes your panic attacks? (e.g., going outside, talking to others, etc.)

During a panic attack, do you experience any of the following? (Check all that apply)
☐ Heart palpitations ☐ Chest pains ☐ Stomach upset ☐ Dizziness ☐ Difficulty breathing ☐ Tingling
☐ Hot flashes ☐ Trembling ☐ Dreamlike sensations or perceptual distortions ☐ Terror
☐ A need to escape
☐ Nervousness about the possibility of losing control and doing something embarrassing
☐ Fear of dying

Have you ever experienced hallucinations?
○ Yes ○ No

What type of hallucinations? Visions or sounds?

When did you first start experiencing hallucinations (what age)?

Were you under the influence of drugs when you experienced hallucinations?
○ Yes ○ No

Have you ever had unexplained losses of time or memory lapses?
○ Yes ○ No

Have you experienced repetitive thoughts? (e.g., Obsessions)
○ Yes ○ No

Have you experienced repetitive behaviors? (e.g., Frequent checking, hand-washing)
○ Yes ○ No

Have you ever had homicidal thoughts?
○ Yes ○ No

If yes, when did you last experience homicidal thoughts?

_____

If yes, did you ever act on such thoughts?
○ Yes ○ No

Have you ever had any suicide attempts?
○ Yes ○ No

15. Traumatic Event History

Have you experienced or witnessed a traumatic event which involved death or serious injury, or a threat to the physical integrity of oneself or others?
○ Yes ○ No

Your response to the event involved intense fear, helplessness or horror:
○ Yes ○ No

You persistently re-experience the event in one of the following ways (Check all that apply):
☐ Recurrent distressing thoughts, perceptions, or images of the event
☐ Recurrent distressing dreams of the event
☐ Feeling as if the event was happening again through flashbacks
☐ Psychological/physical distress upon exposure to things that remind you of the event

Do you attempt to avoid situations, people, or things that remind you of the traumatic event?
○ Yes ○ No

Have your symptoms lasted longer than one month?
○ Yes ○ No

Have above symptoms resulted in significant distress in social situations or work?
○ Yes ○ No

16. Family/Health History: Has anyone in your family (immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list family member, e.g., sister, parent, uncle, etc.):

	Yes/No	Who
Depression		
Anxiety Disorders		
Schizophrenia		
Alcohol/Substance Abuse		
Learning Disabilities		
Bipolar Disorder		
Panic Attacks		
Suicide Attempts		
Eating Disorders		
Trauma History		

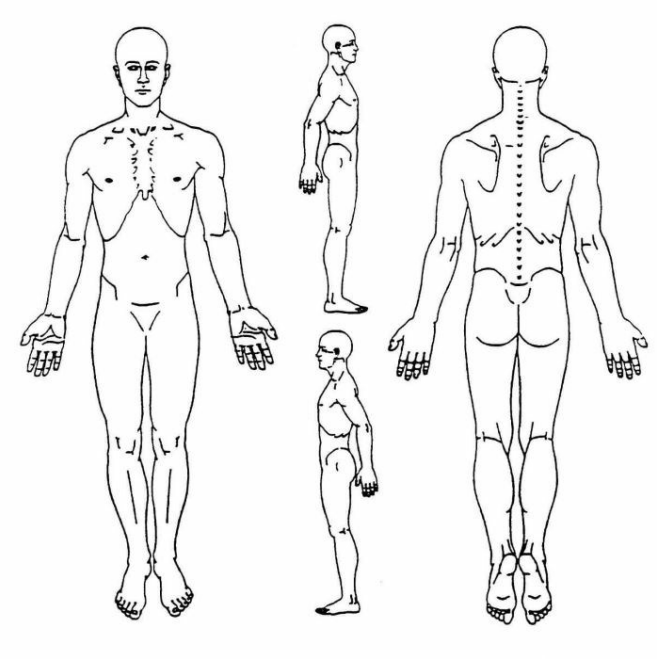
17. During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?

	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
Little interest or pleasure doing things?	0	1	2	3	4
Feeling down, depressed, or hopeless?	0	1	2	3	4
Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
Sleeping less than usual, but still having a lot of energy?	0	1	2	3	4
Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
Feeling panic or being frightened?	0	1	2	3	4
Avoiding situations that make you anxious?	0	1	2	3	4
Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4
Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
Thoughts of actually hurting yourself?	0	1	2	3	4
Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
Problems with sleep that affected your sleep quality over all?	0	1	2	3	4
Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
Not knowing who you really are or what you want out of life?	0	1	2	3	4

Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4
Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4

18. **If applicable: On the diagram, shade the areas where you feel pain.**

0 - Sharp 1 - Throbbing 2 - Aching 3 - Burning



Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH

Doxy.me or SImpleHealth is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice and/or Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice or Doxy.me nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice or Doxy.me facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice or Doxy.me – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice or Doxy.me.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a health care provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the health care provider in diagnosis and treatment of your condition.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Session Notes: I do keep "Session notes" and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

   a. For my use in treating you.

   b. For my use in training or supervising associates to help them improve their clinical skills.

   c. For my use in defending myself in legal proceedings instituted by you.

   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

   e. Required by law and the use or disclosure is limited to the requirements of such law.

   f. Required by law for certain health oversight activities pertaining to the originator of the session notes.

   g. Required by a coroner who is performing duties authorized by law.

   h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a health care provider, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a health care provider, I will not sell your PHI in the regular course of my business.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the patients who received one form of care versus those who received another form of care for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "session notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on the date electronically transmitted

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Informed Consent for Psychotherapy

General Information: The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process: You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality: The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

Treatment Agreement

Welcome to my practice! This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

NEUROPSYCHOLOGICAL/PSYCHOLOGICAL SERVICES

Assessment: Neuropsychological/psychological assessment can last anywhere from 2 to 6 hours depending on the nature of the referral question. Following administration of tests, I spend additional time scoring, interpreting, and writing a narrative report summarizing the findings. The results are then discussed in a feedback session which is conducted in the office.

Therapy: Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. If you have questions about my procedures, we should discuss them whenever they arise.

MEETINGS

Therapy: Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 business hours advance notice of cancellation. Failure to provide 24-business hours advance notice will result in a cancellation fee of **$50.00** for therapy sessions.

Assessment: Due to the several hours reserved for neuropsychological evaluations, we require at least a 48-business hour advance notice for cancellations. Failure to provide a 48-business hour advance notice will result in a cancellation fee of **$500.00** for neuropsychological/psychological evaluations.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

PROFESSIONAL FEES

Fees are due at the time of service. My fee for an initial appointment is $ 195.00. Thereafter, my session fee is $165.00 for psychotherapy.

My hourly fee for neuropsychological assessment purposes is $230.00. Assessment refers to the administration, scoring, interpretation, and report writing. Other services may include telephone conversations, consulting with other professionals with your permission, and preparation of records or treatment summaries. If you are or become involved in legal proceedings that require my participation, you will be expected to pay for my professional time. If you are here for evaluation at the request of a third party, signing this notice acknowledges that the limits of confidentiality have been explained to you and you understand these limits with respect to the evaluation and test results. This form serves as written, informed consent to all aspects of evaluation and treatment by Dr. Legler.

You agree that the fee for services is payable by:

Myself. Though my health insurance may reimburse me for some of these fees, I understand that I am fully responsible for payment for these services.

Additionally, I recognize that I am ultimately responsible for fees incurred on behalf of my care, which are the reasonable and customary fees of Dr. Legler.

CONTACTING ME

Due to my office schedule, I am often not immediately available by telephone. I will be unable to answer the phone when I am with another patient. I will make every effort to return your call on the same day you make it (with the exception of weekends/ holidays). If you experience an emergency, you should contact the nearest emergency room, or dial 911.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of Florida. Under the Florida Telemedicine Act, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

2. All existing confidentiality protections are equally applicable.

3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to treatment, better continuity of care, and reduction of lost work time and travel costs. Effective treatment is often facilitated when the healthcare provider gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. The provider may make assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in services, potential risks include, but are not limited to the provider's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed,

Dr. Whitney Legler, Psy.D.
Licensed Clinical Psychologist
3003 Cardinal Drive, Suite A
Vero Beach, FL 32963
Phone: 772-231-5554 Fax: 772-231-1088
www.WhitneyLegler.com

any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the provider not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the provider.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the treatment is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If treatment is terminated for any reason or you request another provider, I will provide you with a list of qualified Psychologist to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. IN ADDITION, THIS SERVES AS AN ACKNOWLEDGEMENT THAT YOU BEEN PROVIDED WITH THE HIPAA NOTICE FORM DESCRIBED ABOVE FOR YOUR REVIEW.