Jordan Witt, Ph.D.
1531 Chapala Street #2, Santa Barbara CA 93101
Phone/Fax (805) 564-1763

In order to serve you I need the following information, held confidential except where limited by law:

Patient's Name:_____ Birth Date:_____

Residence Address:_____

City/Zip Code:_____ Employer:_____

Home Telephone:_____ Occupation:_____

Business Telephone:_____ Cell Phone/Pager:_____

Who referred you to my office?_____

IF Patient is a child:
Parents are: ____Married ____Domestic Partners ____Divorced ____Separated

	Father	Mother
Name:	_____	_____
If different from above ---		
Address	_____	_____
City/State/Zip	_____	_____
Telephone	_____	_____
SS#	_____	_____
Name of Employer	_____	_____
Business phone:	_____	_____
Occupation	_____	_____

Consent for Release of Information

I,_____, give permission for Jordan Witt, Ph.D., to contact the following individuals/organizations and to obtain and/or release psychological, medical, or educational records or services pertaining to my treatment.

Or if patient is a child, I give permission for release of their records (child's name: _____).

Name	Organization	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Such permission for release of information will be in effect for one year unless rescinded at my request.

Signed:_____

Print Name:_____

Date:_____

Jordan Witt, Ph.D.

Practice Policies and Informed Consent

I would appreciate you reading this initial policies and consent form and filling out the adjoining pages to facilitate our first meeting. Psychological treatment may take many forms, including psychological assessment, clinical interviews, or psychotherapy or behavior modification. Psychological or neuropsychological evaluations can potentially aid in diagnosis, treatment planning, and resolution of the problem that brought you to my office. However, while I should be able to answer the questions you brought to the evaluation, some areas may be inconclusive or treatments recommended may not bring resolution to all specific problems.

CONFIDENTIALITY AND RECORDS: In general, the confidentiality of all communications between a psychologist and client is protected by law, and cannot be released to anyone without your written permission. However, certain limits to confidentiality exist, which legally allow or mandate disclosure of information by mental health professionals. These include situations of suspected elder, dependent, or child abuse, to prevent bodily harm coming to a client or another person, or when compelled to do so by a judge or in certain legal proceedings. A summary of records or test findings, of course, will be provided to other professionals upon your written request. Also, if you elect to use your insurance coverage, your plan may require disclosure of certain information (date of service, diagnosis, etc.). Further information related to privacy of information is provided in a supplemental Notice of Privacy Practices form accompanying this consent. Both children and adolescents and their parents are often concerned about confidentiality of information they provide to a psychologist. For teenagers especially, some degree of confidence is often expected in discussing personal concerns. However, with agreement from all parties general information regarding treatment may be discussed and confidentiality waived in those special situations discussed above.

FEES AND BILLING: As insurance coverage for psychological and neuropsychological services has become unreliable, it is my policy that **fees are due at the time of service, and you may submit my bill for payment directly to your insurance company;** my office can facilitate submitting forms but you are responsible for full payment of the fee which we have agreed to regardless of insurance coverage. My typical hourly fee is $200; as is standard for psychological assessment, in addition to appointments, this fee will be charged for scoring tests and report writing as well as other services. Once the appointment hour is scheduled, payment is your responsibility unless cancelled with 24 hour advance notice.

CONTACTING ME: I am often not immediately available by telephone, either because I am in a session or not in the office. If you leave a message for me, I will make every effort to reach you within the same day. If it is an urgent emergency, and you feel that you cannot wait for me to return your call, you should call 211 or 911, contact your family physician, or call or go to the emergency room of your nearest hospital. If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact if necessary.

By signing this form you acknowledge that have read, understood, and agreed to the policies and consent to the procedures described above, and that you have reviewed the notice of privacy practices.

Client's Name: _____ Parent/Guardian's Name (if client is a minor): _____

_____ _____

Signature of Client (or Parent or Guardian if Client is a minor) Date