# Contact Information

Julia C. Babcock, Ph.D
4010 Blue Bonnet #202
Houston, TX 77025
281-844-8364
info@juliababcock.com

Name: _____

Address: _____

City, State, ZIP:_____

Preferred Phone #: _____

This is my (circle one): home / work/ cell phone

Is leaving a message on this phone OK? Yes No

Alternate Phone #: _____

This is my (circle one): home / work/ cell phone

Is leaving a message on this phone OK? Yes No

Email: _____

I acknowledge that information contained in communications via devices with limited security control (email, telephone, texting) is not confidential. Communications by email or texting should be limited to scheduling appointments.

_____ _____

Client's Signature Date Staff/Therapist's Signature Date

Julia C. Babcock, Ph.D.
Licensed Clinical Psychologist
4010 Blue Bonnet, Suite #202
Houston, TX 77025

# Informed Consent

I,_____ agree to allow the Dr. Julia C. Babcock
client, parent / guardian)
to provide me/us with psychological treatment. I understand that this may include individual, marital/family, or group psychotherapy as well as psychological testing or other services which may be considered appropriate or necessary to my treatment. I have the right to an explanation as to the nature and purpose of the services I receive and have my questions about these services answered. I have the right to withdraw this consent at any time by submitting such withdrawal in writing to Dr. Babcock.

I understand that therapy and assessment sessions cost $200 per 50 minute session for weekdays, $250 on weekends, evenings after 5pm and holidays, to be paid at the beginning at the session. Sessions lasting longer than 50 min. will be billed at the same hourly rate. I also understand that I will be charged a $100 fee if I fail to attend a scheduled appointment without cancelling or rescheduling at least 24 hours before the appointment. I understand that this no-show fee will be charged to my credit card on file. Fees for legal services are $300/hour with an upfront retainer of $1,000 minimum.

The information concerning my case is confidential and it is not available to individuals or agencies without my written consent. Information about my case may be discussed by psychologists and other professionals for the purpose of diagnosis, treatment planning, or psychotherapy supervision with written consent. Information about my case may also be used for research purposes; however, no information which will identify me in any way will appear in any research report or publication. For couples therapy, if one partner request records, records will be sent to both partners automatically.

There are a few instances in which information concerning my case may be required to be released without my agreement. Such a release of information could occur if:

1. I pose a serious danger to my self or others.
2. There is evidence to suggest child or elder abuse.
3. The court issues a subpoena concerning my records.
4. A valid medical emergency occurs.

I acknowledge that information contained in communications via devices with limited security control (email, telephone, texting) is not confidential. Communications by email or texting should be limited to scheduling appointments. Dr. Babcock does not accept insurance but will issue you an invoice that you may submit to your insurance company for possible reimbursement. The University of Houston is in no way liable for the independently operated, private practice work of Dr. Babcock.

I have read and understand what is written above.

| | | | |
|---|---|---|---|
| _____ | | _____ | |
| Client's Signature<br>(Parent / Guardian Signature) | Date | Staff/Therapist's Signature<br>(Date) | Date |

**Consent to participate in a telemedicine appointment**

1. I understand that my health care provider wishes me to engage in a telemedicine consultation using Doxy.me.

2. My health care provider has explained to me how the Doxy.me video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the Doxy.me videoconferencing connections are not adequate for the situation.

4. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a Doxy.me telemedicine consultation.

6. In an emergency, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist’s responsibility will conclude upon the termination of the Doxy.me video conference connection.

7. I have had a direct conversation with my healthcare 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.

**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.

Participant

_____ _____

Name Date

Provider

_____ _____

Name

Date

# Payment Information

Julia C. Babcock, Ph.D
4010 Blue Bonnet #202
Houston, TX 77025
281-844-8364
jbabcock@uh.edu

Billing Name: _____

Billing Street Address: _____

Billing ZIP Code:_____

I will be paying by: **CASH** **CHECK** **MASTERCARD or VISA**

**VENMO** **SQUARE CASH**

I consent for Dr. Babcock to bill sessions, missed sessions, or late cancellations (less than 24 hours in advance) to my credit card, below. I acknowledge that there are no refunds for services provided.

Signature: _____

Credit Card Number: _____

Expiration date: _____

CCV: _____