

# Beryl Rushefsky, PhD

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## NEW CLIENT INFORMATION

Client Name: \_\_\_\_\_ Marital Status \_\_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Current Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Mobile) \_\_\_\_\_

May we contact you at your e-mail address?  Yes  No e-mail: \_\_\_\_\_

Employer/School \_\_\_\_\_ Occupation/Grade \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_ **CLIENT'S PHYSICIAN** \_\_\_\_\_

May we thank them for the referral?  Yes  No May we contact your doctor?  Yes  No

PARTNERS NAME (if applies): \_\_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Current Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Mobile) \_\_\_\_\_

May we contact you at your e-mail address?  Yes  No e-mail: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**PERSON(S) ASSUMING FINANCIAL RESPONSIBILITY:**

NAME: \_\_\_\_\_ Marital Status \_\_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Current Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Mobile) \_\_\_\_\_

May we contact you at your e-mail address?  Yes  No e-mail: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

OTHER PARENT/RESPONSIBLE PARTY NAME \_\_\_\_\_

Marital Status \_\_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Current Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Mobile) \_\_\_\_\_

May we contact you at your e-mail address?  Yes  No e-mail: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Siblings Name(s) (If applies)

\_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

I hereby give consent for treatment and have full legal authority to do so.

Yes  No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# INSURANCE INFORMATION

Do you wish us to submit claims to your insurance company?  Yes  No

Client relationship to the insured:  Self  Spouse  Child  Other

If the insured is someone other than one of the individuals previously listed, please complete this section. Otherwise, please name the insured.

Insured's name: \_\_\_\_\_ Marital Status \_\_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Current Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Mobile) \_\_\_\_\_

May we contact you at your e-mail address?  Yes  No e-mail: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## Policy Information

Name of insurance company \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Plan name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

## Medical Release Statement

**I authorize the release of any clinical or other information necessary to process my insurance claim. I also authorize payment of insurance benefits to the provider filing the insurance claim.**

Yes  No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Clinical Information**  
(parents may fill this out for minors, if necessary)

What led you to seek treatment and/or assessment at this time?

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How long have you/your child had the current problem(s)? \_\_\_\_\_

What do you hope to gain from therapy/assessment?

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**Are you (or the client) feeling like hurting your (or his/her) self or others at this time?**      Yes p      No p

**Have you (or the client) felt like hurting your (or his/her) self or others in the past year?**      Yes p      No p

**Have you (him/her) ever been hospitalized for any mental or emotional problems?**      Yes p      No p

**If so, please described briefly below:**

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Are there any legal issues concerning your pursuit of therapy (child custody, divorce, employment, school, or court requirements)?      Yes p      No p  
If yes, please explain below:

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Is any attorney, court, school, or employer requiring documentation of any kind regarding your therapy? If yes, please explain below      Yes p      No p

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Please initial and date

\_\_\_\_\_

Initials

\_\_\_\_\_

Date

## FEES

(Note: session fees are based on 45-50 minute sessions; Fees for longer sessions are prorated from the basic fees in 15 minute increments)

Initial Diagnostic Interview:	\$200.00
Follow-Up Sessions for Individuals, Families & Couples:	\$150.00
***Telephone Consultations:	
Initial 10 Minutes:	No Charge
Calls Longer Than 10 Minutes:	\$150/hour (15 minute increments)
****Psychological Testing:	Varies with the Evaluation
***Presentations:	\$150/Program Hour
***Attendance at ARD/Other School Meetings:	\$150/hour, minimum one hour
Travel Time:	\$50/hour, minimum one half hour
***Court Related Services:	\$300/hour
Minimum Fee:	\$600 (Payable in Advance)
Travel Time:	\$50/hour, minimum one half hour
***Returned Checks:	\$25.00

### \*\*\*Cannot Be Billed to Insurance

\*\*\*\*Psychological testing is done on a fee for service basis and I do not accept insurance for this service. Upon request, I can provide a statement with which the client can seek insurance reimbursement.

**PAYMENTS DUE:** Your payment or co-payment/co-insurance is expected at the beginning of each session. Also, please realize that any amounts left unpaid by your insurance (such as annual deductibles) will be your responsibility to pay

**CANCELED APPOINTMENTS:** Please remember that without a full 24 hours notice, your credit card will be billed for full payment of your missed session. A missed session cannot be billed to insurance. If you do have to cancel an appointment, you may leave a message 24 hours a day, seven days a week at 512-345-6781 x5.

**STATEMENTS:** You'll be sent a statement for any balances owed on a periodic basis. Payment is due upon receipt of the bill.

**EMERGENCIES:** In the event of a life-threatening emergency, please call 911. If the emergency is not life-threatening, you can call the 24-hour health hotline at 512-472-4357. Please contact Dr. Rushefsky as soon as possible after you have done so

Yes  No

**I have read and understood the information on this sheet**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Credit Card Information

Please provide the required information about the credit card you will use to pay any fees for missed appointments or to make payments on your account.

Type of Credit Card:       Visa     MasterCard

Credit Card Number: \_\_\_\_\_

3 Digit Security Code on Back of Card: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_

Billing Address of Credit Card: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By checking the "Yes" box below, I grant Beryl Rushefsky, PhD my permission to charge the account described above for missed session fees.

Yes       No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**(Optional – Line through if you do not wish to grant this permission)** By checking the "yes" box below, I grant Beryl Rushefsky, PhD my permission to charge the account described above for any outstanding balance (subject to the provisions of my and Dr. Rushefsky's contractual agreement with my insurance company, if any).

Yes       No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Summary Notice of Privacy Practices

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY**

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## ***My Commitment to Your Privacy***

My practice is committed to maintaining the privacy of your personal health information. Confidentiality is essential to my profession. I will only use the information that I get from you to provide you with treatment, to arrange payment for my services or for some other health-care operations. If either you or I wish to share your information for any other purposes, I will discuss this with you and ask you to sign a release.

**Please note:** State and federal laws may require disclosure in legal situations such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.
2. When a judge requires disclosure, such as in lawsuits and legal proceedings.
3. When a law enforcement official requires me to do so.
4. When necessary for Workers Compensation and similar benefit programs.

Yes  No

**I have read and understood the information on this sheet**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date