Carol Pierce-Davis,
Ph.D.
Psychologist

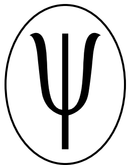
National Register of
Health Service Providers

Texas Health Service
Provider

Board Certified
Diplomate Fellow
Psychopharmacology

Board Certified
Diplomate Fellow
Serious Mental Illness

Board Certified
Medical Psychologist



4131 Spicewood Springs Road
Suite K6
Austin, TX 78759

Phone: 512-413-3025
Fax: 800-420-4784

drcpiercedavis@gmail.com

www.carolpiercedavisphd.com

CLIENT INFORMATION

Date ______________________

Referred by ________________

PATIENT:
Name__________________________________Marital Status _______________

SS#____________________Gender______DOB______________Age________

Current Address ____

City, State, Zip____

Telephone (mob)_______________Email Address_________________________

SPOUSE:
Name________________________________DOB__________________________

SS#________________________________Employer________________________

PHYSCIAN________________________Telephone_______________________

IN CASE OF EMERGENCY, NOTIFY__________________________________

Telephone ____________________________Relationship___________________

INSURANCE INFORMATION

Name of Insurance Company____
(Be sure to provide doctor with Insurance card and drivers license, as well as pre-authorization number if needed)

Policy-holder's Name ____________________________DOB________________

Policy-holder's SS Number or Insurance ID Number__________________________

I authorize the release of information necessary to process my insurance claim.

Signature______________________________Date__________________________

I authorize insurance payments to the provider.
Signature____Date__________________

FOR OFFICE USE ONLY: INITIAL/PROVISIONAL DIAGNOSIS________________

OFFICE GUIDELINES

For the Office of
Carol Pierce-Davis, Ph.D.

Your doctor will go over each guideline carefully with you during your first meeting.
If you have any questions, please feel free to ask.

Fees. The basic fee for therapy is $125.00 per 45 minute session. The initial session is $150.00. Fees for other services such as psychological testing, reports, talking with other professionals, extended telephone conversations are billed at an hourly rate.

Payments Due. Your payment or co-payment is expected at each session. You may pay with cash or check. Visa, MasterCard, Discover, and American Express cards can also be used for payment.

Any amounts left unpaid by your insurance such as deductibles or end-of-benefits will be your responsibility. It is also your responsibility to be familiar with your insurance benefits and procedures; and any changes that may occur in them. If you have questions about insurance billing, your balance or payments, please address them with your doctor.

Cancelled appointments. Please remember that without a *full 24 hours notice,* you will be responsible for full payment of your missed session. *A missed session cannot be billed to insurance.* To cancel an appointment, you may email or leave a message at minimum, 24 hours a day at 512-413-3025, voice or text. *Please do not leave any confidential or clinically related material in text or email. Your confidentiality cannot be protected in formats such as text or email. These forms of communication are used for scheduling messages only.*

Emergencies. In the event of an emergency, the most appropriate number to call is 911. Messages can be left for your doctor 24 hours a day at 512-413-3025. You may also access trained listeners who are available 24 hours a day:

24-Hour Help Hotline (only at nights) 512-472-4357

I have read and understand the information on this sheet.

____________________________________ ____________________
Signature Date

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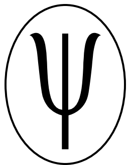

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CONFIDENTIALITY

Unless stated otherwise (see below), your identity and all information disclosed during therapy sessions will be kept strictly confidential.

Please understand that if you are using insurance to assist in payment for services, your insurance company will have access to your identity and require a diagnosis for consideration of coverage.

Exceptions are limited to the following:

1. Confidentiality will be waived if the adult client or custodial parent or guardian of a minor receiving services signs a Release of Information form. Information released will be specifically defined on the form and will be released only to the party identified on the form.

2. Confidentiality will be waived if a client appears to be at risk of harming self, or others, or where a reasonable suspicion of child physical or sexual abuse or elder abuse exists.

3. If a client is ever involved in litigation, the client's file can be subpoenaed by a judge of the court.

4. Where the identified client is a minor, although parents are privy to information disclosed in a session, each case will be treated on an individual basis, and your therapist will discuss and clarify issues of confidentiality regarding your child's treatment prior to initiating treatment.

I have read and my doctor has reviewed with me, and I understand the information on this sheet.

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Signature and Date