Laurie Ferguson, Psy.D.
Licensed Clinical Psychologist, Director
Spark Psychological Services
Laurie Ferguson, Psychologist, Inc.
5975 Entrada Ave. • Atascadero, CA • 93422
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Information Regarding Office Policies and Fees
Welcome to the practice! Please let me know if you have any questions!

COVID19 Notice: To keep everyone healthy, most appointments are conducted via confidential, HIPAA-secure teletherapy (Zoom) when possible. This may limit the effectiveness of therapy or assessment, and additional in-person therapy or assessment may be needed, if desired. Please let Dr. Ferguson know what you prefer.

Cancellation Policy: Appointments are made for you only (I do not "double book" appointments). Please call or email with at least 24-hour notice to reschedule or cancel an appointment. Special circumstances sometimes occur where 24-hour notice may not be possible. To keep all our patients healthy, please reschedule your appointment if you are ill. **If illness or special circumstances do not apply, you will be billed for a missed session.** If you are more than 15 minutes late, you will need to reschedule and you will be billed for the missed session. If too many sessions are missed, or if this appointment policy is being abused, termination of services may occur.

Your Appointment, Fees and Insurance: Dr. Ferguson is an out-of-network provider for your insurance. You are responsible for covering the fee at the time of service. You will be provided a Super Bill to submit to your insurance. Contact the insurance company prior to your appointment to verify any out-of-network benefits. Personal checks, cash, credit and debit cards, and Health Care Savings Account credit/debit cards are accepted.

In shared child custody arrangements, the parent bringing the child for treatment is responsible for full payment at the time of service. In shared custody arrangements, both parents must consent for treatment.

For TCRC, Social Security, Social Services, School/College clients: An assessment by Dr. Ferguson is no guarantee of eligibility or services, which are at the sole discretion of the agency/organization. Assessment results could result in an increase or decrease of services or denial of eligibility, even if you already are eligible.

Dr. Ferguson does not accept Medicare, and her services are not reimbursable by Medicare. If you are a Medicare client or are Medicare-eligible, you must advise Dr. Ferguson. You must complete a separate contract mandated by Medicare prior to your appointment if you have Medicare or are Medicare-eligible.

Fee Schedule (with CPT codes): *fees are subject to change without notice*
Consultation, Intake Appointment and/or Diagnostic Interview (90791), $300 includes a 1-hour intake/consultation
Autism Exploration Consult (90791, 96136) $375 includes a 1-hour intake/consultation
Psychological Testing (96130, 96131, 96136, 96137), $300 per hour
Individual Therapy (90834) or Family Therapy (90846 / 90847) $180/45-50 minutes; (90837) $225/60 minutes
Expert Witness Services or any court-related services, $500/hour ($5,000 retainer required)
Brief phone call or email to change appointments, no charge
All other phone calls, emails, reports, and meetings attended are pro-rated for actual time spent by Dr. Ferguson

Late Payments: Payment is due at the time of service. There is a $35 fee for returned checks. A late fee of $25 per month is applied to past due accounts. Unpaid account balances over 30 days may be forwarded to collections and termination from the practice may occur.

What can I expect in therapy or testing? What do I tell my family member about the appointment? You know yourself the best, and you have the right to set your own goals and pace. Dr. Ferguson will inform you whether your goals are compatible with her services. How long therapy or testing takes will depend on your goals,

symptom severity, and other factors. Therapy and testing are ways to know more about your learning style, emotions, thoughts, and behaviors, so that you can succeed at school, work, and in relationships. Difficult topics are discussed and some people experience an increase in depression, anxiety, unsafe behavior, or even suicide. It is very important that you share this with Dr. Ferguson so that she can help you. For testing clients, you have a right to receive a report of Dr. Ferguson's findings in understandable language. You have a right to disagree with Dr. Ferguson's recommendations or diagnoses. Dr. Ferguson welcomes your questions and feedback, and this can improve the effectiveness of the therapy or accuracy of the assessment. You have a right to terminate therapy at any time. It is always helpful to discuss this with Dr. Ferguson so that she can give you referrals if needed.

Privacy and Confidentiality: Your privacy is very important to Dr. Ferguson. As this is a small community, we may occasionally see each other outside of our appointment. In order to protect your privacy, it is up to you if you would like to say hello or communicate in any way. I do not participate in fundraising or business endeavors of my clients. Your Personal Health Information (PHI) is protected by the Health Insurance Portability and Accountability Act (HIPAA: www.hhs.gov.). Your private information is never shared without your written authorization, or as permitted by law, including but not limited to the following:

If child or elder abuse or neglect occurs, or if a client is a danger to him- or herself or others, Dr. Ferguson is required by law to disclose this information and client contact information to the proper authorities.

In any judicial matters, confidentiality ends when a judge issues a court order for my records or if you bring a lawsuit or licensing board complaint against Dr. Ferguson.

Minor clients: Only parents/guardians with legal custody for health care decisions have access to a minor's records, regardless of who is paying for the session. Dr. Ferguson is legally prevented from releasing information to parents without the minor's consent, including information regarding pregnancy, drug or alcohol use, contraceptive use, sexually transmitted diseases, or medical history.

Contacting You: You will be asked in the Client Intake Form how you would like to be contacted for confidential messages. All information and appointment requests need to be communicated in voicemail or email. Dr. Ferguson cannot respond by text. Use of email means that you accept the risk of electronic communication. There is no guarantee that information in an email or attached to an email remains private. This includes but is not limited to encrypted information, "secure" email services such as Gmail, or cloud-storage services such as Drop-Box.

Social Media: To help protect your confidentiality and preserve therapeutic boundaries, I do not "friend," follow, or search clients online. If you happen to receive a "friend" request from me, it is an error (please contact me to let me know). Posting a review of my services is your right, but to protect your confidentiality, I will not respond online. I welcome any comments about our work and hope we can communicate in person. I maintain two professional media services (Twitter and a Facebook page), which you are welcome to follow for psychology-related articles and information. Following my professional media accounts is not an endorsement of my services.

Emergency Information: Dr. Ferguson does not provide emergency services. If you are experiencing a life threatening emergency, call 911 or go to your nearest emergency room. Mobile Crisis can be called for non-life threatening services 24 hours, 7 days per week at 800-838-1381. The SLO Hotline is also available 24 days, 7 days per week for resources and suicide prevention at 800-783-0607.

I have received and understand the above Information regarding Policies and Fees.

Printed name of patient	Signature of patient (only needed if age 18+)	Date
Printed name of parent/guardian	Signature of parent/guardian	Date

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CLIENT INTAKE FORM

The Client is the person coming for therapy, assessment, support, or consultation

This information is very helpful in supporting and/or evaluating the client. Any information shared with Dr. Ferguson may be subject to court subpoena, therefore, there are limits to confidentiality.

Client's full legal name: _____ Today's date: _____

What name do you prefer to be called? _____ Date of birth: _____

Age: _____ Gender: _____ Pronouns: _____ Who referred you? _____

Home street address: _____ City: _____

State: _____ Zip: _____ Ethnicity / Religion: _____

Profession: _____ Employer: _____ City: _____

If Client is a minor (under age 18) or a conserved adult: Is the client a conserved adult? ❑ Yes ❑ No
Who has legal custody for health care decisions? (this is different than physical custody): _____

Emergency Contacts (or Parent / Guardian if Client is a minor or conserved adult)

#1 Name: _____ Address: _____

Employer: _____ Occupation: _____

#2 Name: _____ Address: _____

Employer: _____ Occupation: _____

Contacting you: Check the YES box if it is ok to leave confidential information. Check the NO box and only Dr. Ferguson's name and phone number will be left in messages. By checking "Yes," you agree to accept the risks of electronic communication that is not guaranteed secure.

Is it ok to leave confidential information?

Client's (or Parent's if a minor) Home Phone: _____ ❑ Yes ❑ No

Client's (or Parent's) Cell: _____ ❑ Yes ❑ No

Alternate Phone: _____ ❑ Yes ❑ No

Email: _____ ❑ Yes ❑ No

If you are here for an assessment, choose the way(s) you would like your report sent to you:

❑ **Email** ❑ **Regular Mail** ❑ **Fax:** _____

Current or Last School Attended: _____
City: _____ What year in school is the client or highest degree/year achieved: _____
Has the Client ever had any of the following: ❑ 504 Plan ❑ IEP ❑ SST ❑ Special Education ❑ Audiology ❑ Psychoeducational or Psychological Testing ❑ Occupational Therapy ❑ Physical Therapy ❑ Vision Therapy ❑ Speech/Language Eval/Services ❑ Neurology ❑ Regional Center ❑ Tutoring ❑College Disability Supports ❑ ADA Accommodations at work ❑ Other: _____

Current Medical Concerns & Medications:_____
_____
_____
_____
_____

Physician's name: _____ City: _____
Therapies, past and current: Provider Name / Purpose / Dates: _____
_____
_____
_____
_____

Who Lives With The Client?: Client's Marital Status: _____
Household Members: (Name / Relationship / Age / Does this person live with the client full-time?)
_____
_____
_____
_____

What are your main concerns?_____
_____
_____
_____
_____

What are your goal(s) for therapy / assessment?_____
_____
_____
_____
_____

Primary language(s) / Does the client require an interpreter?: _____
Does the client uses assistive technology (AAC device, wheelchair, etc.): _____
_____

How can Dr. Ferguson make your appointment more comfortable and accessible? (sensory needs, breaks, written communication during our sessions, etc.) _____
_____
_____

Limitations on services: *Please note that if the client has been involved in, or anticipates being involved in, child custody matters, a worker's compensation claim, arrest/probation, or other legal matters, it is important that you work with a therapist or evaluator who specializes in these areas to protect your legal rights. Dr. Ferguson's services are not designed to support clients with these concerns. By signing below, you acknowledge these limitations to Dr. Ferguson's services.*

Client's Signature: _____ Date:_____

Parent's or Guardian's Signature (if applicable): _____ Date:_____

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OPTIONAL SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

Guesses and estimates are ok! This information is very helpful to support the client. Any information shared, either written or verbal, may be subject to court subpoena and there are limits to confidentiality.

GENERAL INFORMATION: ***The Client is the person coming for therapy, assessment, or support***

Client's full legal name_____ DOB_____

Client's strengths and interests:_____

Have there been any significant stresses / changes in the client's life? How has the client adjusted to this? (marriage, deaths, births, moves, work changes, divorce, traumatic experiences, etc.)_____

EDUCATIONAL HISTORY:

Briefly describe client's academic performance, behavior, social factors, and any concerns:

Preschool/Daycare_____

Elementary School_____

Middle School_____

High School _____

College _____

Are there services/supports you would like the school/college to provide: □ additional time on tests □ quiet room for tests □ help with organization or study skills □ note taking help □ aide in the classroom (K-12) Other: _____

WORK HISTORY □ The client does not have job experience / employment

Current or Latest Employer: _____Position Title: _____

Length of time at current job: _____ Does the client enjoy the job? □ Yes □ No

Is work difficult for the client? □ Not a struggle □ Sometimes a struggle □ Often struggles Why? _____

Are there accommodations you would like the employer to provide: □ work from home □ modified schedule □ time to sit down □ breaks □ clearer instructions □ visual schedule Other: _____

BIOLOGICAL FAMILY MEMBERS' HISTORY: (parent, sibling, aunt/uncle, grandparent, cousin, etc.):

□ Learning Difficulties _____
□ Formally diagnosed with Dyslexia / Reading Disorder _____
□ Attention problems _____
□ Hyperactivity _____
□ Formally diagnosed with ADD or ADHD _____
□ Speech or Language problem _____
□ Diagnosed or suspected (circle) Autism (including Asperger's) _____
□ Intellectual Disability or Cognitive Delay_____
□ Depression _____
□ Anxiety _____
□ Obsessive Compulsive symptoms _____
□ Formally diagnosed with Bipolar Disorder _____
□ Schizophrenia _____
□ Drug or alcohol problem _____
□ Other concerns: _____
Highest grade or education level achieved by biological parents:_____

CLIENT'S DEVELOPMENT:

Pregnancy of Client's Biological Mother: Biological mother's age at birth? _____
Did mother receive routine prenatal care? □Yes □ No Any medications, fertility treatments? _____
During pregnancy was there any use of: □ nicotine/cigarettes □ marijuana □ illegal drugs □ other: _____
Child was born at City/State: _____Pregnancy was □full-term □other:____weeks/months
Child's birth weight: _____pounds _____ounces APGAR score at 1 minute____ at 5 minutes_____ □ unknown

Mother's pregnancy	Child's Delivery	Child's Condition at Birth
□ No complications	□ Normal	□ Normal
□ Diabetes	□ Induced labor	□ Breathing problem
□ Injury	□ C-section	□ Jaundice
□ Hypertension	□ Breech birth	□ Birth injury/defect
□ Excessive bleeding	□ Very long labor (>12 hours)	□ Newborn ICU
□ Emotional stress	□ Other problem:	□ Other problem:
□ Other problem	_____	_____

Client's Development: Estimates are ok □ Ages unsure, but milestones probably met typically

Age walked alone: _____ Age fully potty trained:_____
Age spoke first words: _____ Age when there were no longer toileting accidents: _
Age spoke short phrases: _____ _____

Communication and Motor Skills: Any concerns with the following?

□ Eye-hand coordination (catching a ball)
□ Dressing self
□ Running, jumping, riding a trike or bike
□ Spins, rocks, paces, other repetitive movements
□ Does not pick up on typical social cues
□ Eye contact is less frequent than expected
□ Using a crayon / pencil, other fine motor skills
□ Trouble with balance or "clumsy"
□ Seeks out wrestling, rough play frequently
□ Trouble with communicating
□ Articulation trouble or hard to understand
□ Repeats words or phrases, or "echoes" others

Behavior and Emotions: Any concerns with the following?

□ □ Fidgets, has a hard time staying seated
□ □ Has difficulty waiting their turn
□ □ Talks excessively, interrupts often
□ □ Poor concentration or daydreams too much
□ □ Eye contact is difficult or less frequent
□ □ Often loses things
□ □ Disorganized
□ □ Difficulty making decisions
□ □ Needs lots of prompts or help to do things
□ □ Difficulty starting or finishing tasks
□ □ Difficulty following instructions
□ □ Trouble with time management
□ □ Impulsive
□ □ Hyperactive, "driven by a motor"
□ □ Often argumentative
□ □ Blames others for own mistakes
□ □ Defiant to authority figures or rules
□ □ Has been teased or bulled by others
□ □ Teases or bullies other people
□ □ Lies or steals (circle)
□ □ Fascinated by fire or sets fire (circle)
□ □ Physically or verbally aggressive (circle)
□ □ Doesn't have age typical stranger danger
□ □ Wanders off or runs away
□ □ Problems with social interactions
□ □ Masks or hides true self in social settings
□ □ Avoids new activities
□ □ Transitions or changes are difficult

□ □ Often depressed
□ □ Often irritable, frustrated, or agitated
□ □ Mood swings or meltdowns
□ □ Explosive temper
□ □ Crying frequently
□ □ Feelings of worthlessness or low self-esteem
□ □ Avoiding spending time w/ others or self-isolates
□ □ Hopelessness or feeling like there is no point to life
□ □ Has hurt self (scratching, head banging, biting, cutting)
□ □ Suicidal thoughts (circle)
□ □ Low energy/fatigue
□ □ Sleep problems
□ □ Picky eating
□ □ Lots of physical complaints (stomach aches, headaches)
□ □ Feels stressed out, overwhelmed, or overworked
□ □ Anxious or worried
□ □ Panic attacks
□ □ Specific fears (crowds, heights, objects, future events)
□ □ Excessive difficulties separating from others/caregivers
□ □ Frequently wants to stay home from school/work
□ □ Saying the same thing over and over
□ □ Obsessions (can't stop thinking about something)
□ □ Compulsions (can't stop doing something)
□ □ Overly sensitive to (circle): sound, light, touch, food textures, clothes, smells, crowds, other: _____
□ □ Sensory seeking (touch, sound, etc.)
□ □ Excessively low or high pain tolerance (circle)
□ □ Uses electronics too much

Anything Else You Would Like Dr. Ferguson to know? What led you to seek assessment, therapy, or a consultation? Add pages if you like! _____

_____

_____

_____

_____

_____

_____

_____

_____

Person completing this form: Relationship to Client: □ Self □ Parent □ Guardian □ Conservator □ Other: _____

_____

Signature **Name** **Date**