

*Dr. Georgann Norton, Psy.D.*

*Licensed Psychologist*

*239-261-1514*

## TREATMENT CONTRACT

Welcome to my practice. I would like to take this opportunity to thank you for choosing me for your professional services.

This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them when we meet. When you sign this document, it will represent an agreement between us.

### **Professional Services**

I deliver outpatient mental health services. Treatment is confidential and designed to meet the therapy needs of adults. Services may also include psychological testing, assessment and therapy with other family members as deemed important by you. My services are provided via Telemental Health which includes video conferencing and telephone therapy.

You and I will develop a plan which will be modified regularly depending on the needs and progress of your treatment. There is a small risk that your condition may worsen during treatment. If at any point you are unhappy about your progress, the process or the outcome of your treatment, please discuss this with me so that together we can attempt to resolve any difficulties to better meet your needs. Therapy requires a commitment and consistent effort on your part to secure the best results. Open and honest communication between us will be necessary for our success.

As part of your treatment, I may recommend a referral to your physician or another professional for evaluation/management of medication or additional treatment options. Your first several sessions with me will include information gathering on my part in an effort to get to know you and better understand your situation and background. During sessions please silence your phones so we can have uninterrupted time together.

I will be available to you through my 24-hour voicemail service. Due to my work schedule, I am often not immediately available. I am generally in session and unable to answer the telephone. I will attempt to return telephone calls to my office within 24 hours during the work week, if not sooner. I am in Eastern Standard time zone. Weekend calls will be returned by the next weekday. If you ever have a clinical emergency, please call 911 or go directly to the nearest emergency room for help.

You may discontinue therapy at any time. My clients who have not had a session with me in over 30 days (or after that time without a mutually agreed upon appointment) will be considered inactive and no longer under my professional care. It is always preferable to have a final session before ending your therapy in order to evaluate and review progress and any remaining issues. Be assured that if you wish to return to active therapy, you may do so by making a new appointment with me to resume therapy.

### **Telemental Health:**

Telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. This form of communication allows for greater convenience and availability for my clients. The telehealth videoconferencing platform I use is Doxy.me.com, a secure, encrypted website. Please understand the following with respect to your telemental health:

*950 N. Collier Blvd., 4<sup>th</sup> Floor, Marco Island Florida 34145*  
*nortontherapy.com*

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1. I understand that I have the right to withdraw consent at anytime.
2. I understand that there are risks and consequences associated with telemental health, including but not limited to, disruptions of transmission by technology failures, possible interruption and/or breaches of confidentiality by unauthorized persons, and/or my limited ability to respond to emergencies.
3. I understand that there will be no recording of any kind of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and /or required by law.
4. I understand that confidentiality is very important and that I will be in a private room with the door closed or area where I am alone and free to talk without interruption. I will announce anyone who is in the room or who enters the room. I will turn off any digital apps in the room such as Siri, Alexa, Google Now, etc.
5. I understand that the privacy laws that protect the confidentiality of my protected health information also apply to telemental health unless an exception to confidentiality applies by law.
6. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
7. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, you can end and refresh the session. If we are unable to reconnect within five minutes, please call me at 239/261-1514 to continue our session.
8. I understand that all other terms in this treatment contract such as but not limited to HIPAA, payment, insurance, confidentiality, etc., apply to our telehealth sessions.

**Emergency Protocols:**

I understand and agree to provide my location in case of emergency to Dr. Norton. I also give her permission to call 911 or contact the person below in a life-threatening emergency to assist me or take me to the hospital. If I am in danger of hurting my self or someone else I will call 911 or go to the nearest emergency room immediately.

Contact Person: \_\_\_\_\_

Cell Number: \_\_\_\_\_

Home/Office Number: \_\_\_\_\_

Relationship to You: \_\_\_\_\_

Nearest Hospital Name: \_\_\_\_\_, City: \_\_\_\_\_, Tel. No. \_\_\_\_\_

Nearest Local Police Tel. No. (not 911) \_\_\_\_\_

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**Appointments and Cancellations:**

My sessions are 53 minutes in length and are by appointment only. If you chose to reschedule or cancel an appointment, you must provide a minimum of 24 hours advance notice. If you do not provide proper advance notification, you will be charged the full fee for late cancellations or missed appointments.

If you happen to arrive late for an appointment I cannot extend our time as this would interrupt other appointments. The number and frequency of our sessions are determined on your and my availability. Please understand that regular and consistent sessions are necessary for effective therapy.

**Fees:**

My fees are set within the usual and customary range for this community. My fee per session is two hundred twenty-five dollars (\$250) for the first clinical interview and two hundred five dollars (\$225) per session thereafter. Payment is required at the time of service.

By agreeing to participate in treatment provided by me, you agree to pay for these services according to the above fee schedule. Any unpaid balance will be charged to your credit card on file with me. Any insurance claim filing will be your responsibility to send into your insurance company if you choose.

**Additional Fees:**

If you request that I write reports or attend meetings on your behalf to schools, to agencies or with other professionals, I will charge my hourly fee for time incurred in these activities including travel time. These charges are payable at the time of service.

A pro-rated hourly fee will be charged for telephone consultations which are fifteen (15) minutes in length or longer to you or on your behalf to other professionals.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time and services even if I am called to testify by another party. Due to the difficulty of legal involvement, I charge three hundred dollars (\$300) per hour for all preparation and attendance at any legal proceedings, including travel time, which must be paid prior to my participation or attendance in this process. It is my strong advice to keep my involvement out of these proceedings to protect your privacy, information and due to the high financial and emotional cost of these issues.

**Unpaid Balances:**

If financial difficulties arise, a payment schedule may be discussed with me. If for any reason unpaid balances are incurred, the balance will be paid from the credit card you have on file with my office. If the balance is not satisfied within three (3) months, a collection agency may be contracted. The collection agency fees, court costs and attorneys' fees will be added to the unpaid balance. I reserve the right to terminate the doctor-patient relationship for non-payment.

**Insurance:**

Be aware that I am a self-pay provider; which means I do not accept insurance. For those clients who wish to obtain reimbursement from their insurance after payment I will complete an insurance form for you to send into your insurance company. Some insurance companies do cover psychotherapy but limit the number of sessions for which they will pay. Some insurance companies will not cover psychotherapy services. You should check with your insurance company for details.

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It is also important to note that insurance companies require a written or verbal clinical diagnosis from me. They may also require progress reports, treatment goals, a prognosis and other clinical information from me before they reimburse for these services. These requirements mean that therapy is not confidential, and that this information will become part of your insurance company's files. It is important to remember that when you pay directly for these services you avoid experiencing any limits to your confidentiality.

**Confidentiality:**

The confidentiality of communication between a client and a psychologist is very important and is protected by the ethical practices of the psychologist as well as state and federal law. I may occasionally find it helpful to consult with another professional about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.

Reports and other information are not sent outside of my practice without written consent by you to do so. After you approve my releasing a report/information, I cannot be responsible for the confidential information once it leaves my office.

**Exceptions to Confidentiality:**

There are exceptions to confidentiality by federal and state law. Information about a crime committed by a client, an emergency situation or information about a person who might be a danger to him/herself, or who might be a danger to another person is not protected by client confidentiality per federal regulations. Information about suspected child or elder abuse or neglect is also not protected by confidentiality by way of legal regulations.

If you become involved in certain types of court proceeding wherein you have placed your mental health as an issue in your claims or defenses, your records and information may be subject to disclosure in this matter. Please see the HIPAA Notice of Privacy Practices which is in your packet of information.

**Exceptions to Confidentiality with Minors:**

If you are under eighteen (18) years of age, please be aware that the law may provide your parents the right to receive general information on your treatment, especially if the information concerns your safety. It is my policy to request a consent from parents that they agree to give up access to information discussed in therapy by you, the minor, unless I feel there is a high risk that you will seriously harm yourself or someone else.

**Contact Information:**

Sometimes it is necessary to contact you outside of the session to return your telephone call, reschedule appointments, or send you information. Due to confidentiality, I would like to know how I may contact you.

Do I have your permission to call you and leave a message if necessary:

On your cell phone number # \_\_\_\_\_

On your office number # \_\_\_\_\_

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Email (in case of emergency): \_\_\_\_\_

Mail billing information, etc. to your home address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Social Media:**

For your protection, I do not use text messaging, email, Facetime, Facebook, LinkedIn or other social media sites for client communication as these modes of communication are not confidential. I cannot protect your privacy through these means therefore, I do not use them. Whenever you would like to contact me to discuss any non-emergency issue or make/cancel an appointment, please call me at my confidential office number at: 239-261-1514 and I would be happy to speak with you.

**Agreement:**

I have read the above information on all 5 (five) pages of this Treatment Contract and I understand and agree to its contents. My signature indicates my consent to receive treatment by Dr. Georgann Norton, Psy.D.

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_

Minor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If Client is over 12 years old)

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT INFORMATION FORM**

Client Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status S M W D

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Permanent Address if different from above: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Tel No: \_\_\_\_\_ ok to call? \_\_\_\_\_

Cell No: \_\_\_\_\_ ok to call? \_\_\_\_\_

Work Tel No: \_\_\_\_\_ ok to call? \_\_\_\_\_

Employer Name: \_\_\_\_\_ City: \_\_\_\_\_

Referred by: \_\_\_\_\_

Please read the information below then sign and date this page.

All new clients, please include a copy of your Driver's License or State I.D.

I understand that I am responsible for any unpaid balances from session appointments, cancellation fees and missed appointments that I may incur. I understand that I am required to give a 24-hour cancellation notice for an appointment cancellation and that I will be charged a full session fee for this or a missed appointment. My credit card will be used to pay for these fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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**CLINICAL INFORMATION**

In order to have as full an understanding of your history as possible, please complete the following questions thoroughly. Thank you for your help.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Referral Source: \_\_\_\_\_

**History of Presenting Problem:**

Chief Complaints:

\_\_\_\_\_  
\_\_\_\_\_

**Mood:**

How would describe your mood over the past 4 weeks: \_\_\_\_\_ Difficulty concentrating:  
\_\_\_\_\_ Hopeless/Helplessness: \_\_\_\_\_ Fatigue: \_\_\_\_\_ Crying: \_\_\_\_\_

Anxiety: \_\_\_\_\_ Other Symptoms: \_\_\_\_\_

When did these problems first start: \_\_\_\_\_

Have you experienced these symptoms before: \_\_\_\_\_ When: \_\_\_\_\_

How long do these symptoms last: \_\_\_\_\_

How would you rate these symptoms on a 1 -10 scale, with 10 being the worst: \_\_\_\_\_

Have you been in therapy previously: \_\_\_\_\_ When: \_\_\_\_\_

For how long: \_\_\_\_\_

**Sleep:**

Do you have sleep issues: \_\_\_\_\_ How many hours of sleep do you get at night: \_\_\_\_\_

Do you have problems falling asleep or staying asleep at night: \_\_\_\_\_

**Appetite:**

Have you had recent weight gain or weight loss: \_\_\_\_\_

Have you had appetite changes or dietary changes recently: \_\_\_\_\_

Have you had any bariatric surgery in past: \_\_\_\_\_

Do you consider yourself to be underweight or overweight: \_\_\_\_\_

Any history of an eating disorder: \_\_\_\_\_

**Risk Factors:**

Have you had suicide/homicidal thoughts in the past 4 weeks: \_\_\_\_\_ Have you had these thoughts in the past: \_\_\_\_\_ Do you have a plan: \_\_\_\_\_ Attempt: \_\_\_\_\_ Please explain

\_\_\_\_\_

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### **Psychiatric History:**

Have you ever had psychiatric hospitalizations: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Have you had hallucinations: \_\_\_\_\_ Delusions: \_\_\_\_\_

Victim of violence: \_\_\_\_\_ Victim of bullying: \_\_\_\_\_ Victim of Sexual Abuse: \_\_\_\_\_ Please explain: \_\_\_\_\_

### **Domestic Violence:**

Do you feel safe with your current partner: \_\_\_\_\_ Have you been hit \_\_\_\_\_ pushed \_\_\_\_\_ shoved \_\_\_\_\_ spit upon \_\_\_\_\_ slapped \_\_\_\_\_ strangled \_\_\_\_\_ threatened \_\_\_\_\_ raped \_\_\_\_\_ or fear for your life: \_\_\_\_\_ Please explain: \_\_\_\_\_

### **Substance Abuse History:**

Do you drink alcohol: \_\_\_\_\_ Number of drinks on weekdays: \_\_\_\_\_ On weekends: \_\_\_\_\_ Do you use recreational drugs: \_\_\_\_\_ Which drugs: \_\_\_\_\_ Do you use prescription painkillers, narcotics, or opioids: \_\_\_\_\_ Which type: \_\_\_\_\_ Do you use medical marijuana: \_\_\_\_\_ Have you had any arrests or DUI's: \_\_\_\_\_ Do you drink caffeine: \_\_\_\_\_ How many cups per day: \_\_\_\_\_ Do you smoke cigarettes/vape: \_\_\_\_\_ How many packs per day: \_\_\_\_\_

### **Medical History:**

Physicians Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ May I contact your physician about your physician regarding your symptoms, treatment, diagnosis and treatment plan: \_\_\_\_\_

Current Medical Issues:

\_\_\_\_\_  
\_\_\_\_\_

Previous medical issues:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any pain issues: \_\_\_\_\_ Please explain: \_\_\_\_\_

Previous surgeries: \_\_\_\_\_

Allergies: \_\_\_\_\_

### **Current Medications:**

Name	Dosage	Times Per Day	Purpose of Medications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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**Current History:**

Any legal involvement with DUI's, lawsuits, custody issues: \_\_\_\_\_ Please explain: \_\_\_\_\_

Hobbies \_\_\_\_\_

Groups and Organizations to which you belong: \_\_\_\_\_

**Previous Social History:**

Where were you born: \_\_\_\_\_ Where did you grow up: \_\_\_\_\_

Have you lived in any other states: \_\_\_\_\_

What is your educational level: (GED, HS, AA Degree, BA, MA, Doctorate, Vocational School): \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Previous Position: \_\_\_\_\_ Are you retired now: \_\_\_\_\_

Military Experience: \_\_\_\_\_ Rank: \_\_\_\_\_ Did you see combat: \_\_\_\_\_

Describe your childhood years:

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Describe your adolescent years:

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**Mother's History:**

Is your mother living: \_\_\_\_\_ If not, when did she die: \_\_\_\_\_ Her age at death: \_\_\_\_\_

Cause of death: \_\_\_\_\_ Did she have any anxiety: \_\_\_\_\_ Any depression: \_\_\_\_\_ Any alcohol abuse or addiction: \_\_\_\_\_ Any drug use: \_\_\_\_\_ Treatment for any of these issues: \_\_\_\_\_

Highest level of education: \_\_\_\_\_ Occupation: \_\_\_\_\_ How would you describe your mother: \_\_\_\_\_

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How would you describe your relationship with your mother:

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Mother's ethnic or cultural background: \_\_\_\_\_

**Father's History:**

Is your father living: \_\_\_\_\_ If not, when did he die: \_\_\_\_\_ His age at death: \_\_\_\_\_

Cause of death: \_\_\_\_\_ Did he have any anxiety: \_\_\_\_\_ Any depression: \_\_\_\_\_ Any alcohol abuse or addiction: \_\_\_\_\_ Any drug use: \_\_\_\_\_ Treatment for any of these issues: \_\_\_\_\_

Highest level of education: \_\_\_\_\_ Occupation: \_\_\_\_\_ How would you describe your father:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you describe your relationship with your father: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Father's ethnic or cultural background: \_\_\_\_\_

\_\_\_\_\_

**Family:**

Describe the relationship between your parents:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Siblings Names

Ages

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Relationship Status:**

Are you married, single, coupled, separated, widowed or divorced: \_\_\_\_\_

Have you been married previously: \_\_\_\_\_ How long were you married/coupled: \_\_\_\_\_

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If married, coupled or widowed, name of your spouse: \_\_\_\_\_

How would you describe your relationship with your spouse/significant. other:

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Spouse/Significant Other's occupation: \_\_\_\_\_

Do you currently own or rent: \_\_\_\_\_

**Children:**

Children's Names	Ages	Occupation	Relationship Status (Married, Single, Coupled, Divorced)
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**Your Goals in Therapy:**

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**HIPAA NOTICE OF PRIVACY PRACTICES**

**I acknowledge receipt of Dr. Norton's HIPAA Privacy Notice**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Please sign the above and return to Dr. Norton. Thank you.



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**GOOD FAITH ESTIMATE OF SERVICES**

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Diagnosis Code \_\_\_\_\_

Primary Service Provided: Individual Psychotherapy (90791, 90837) Office Location: Telehealth  
The “No Surprises Act” was enacted by Congress to reduce the likelihood that patients would receive a surprise medical bill by their medical providers. The Act requires providers to inform patients of expected charges for the services they will receive.

The following are the expected charges associated with my services. My individual session fee is \$250.00 for the initial session and \$225.00 for every session thereafter. My session fees are also in your Treatment Contract and on my website, NortonTherapy.com.

There may also be additional services that I may recommend as part of your treatment which are not included in the above estimate and at your discretion to attend. This estimate does not include any unknown or unexpected costs that may arise during treatment including but not limited to a new diagnosis or additional crisis sessions.

You have the right to initiate a patient-provider dispute resolution process if you feel your charges unexpectedly exceed the good faith estimate above. If you have any questions regarding my services or charges, please do not hesitate to contact me immediately. You may also contact [cms.gov/nosurprises](https://cms.gov/nosurprises) for more information. Any questions that you have will in no way impact the quality of your health care treatment provided by me. This letter is a good faith estimate and not a contract and does not require you to maintain a certain number of sessions or obtain the above services from me.

Let’s talk if you have any questions. I look forward to speaking with you again soon.

Sincerely,

Dr. Georgann Norton, Psy.D.  
NPI 1518035674