

Randy Frazier, Ph.D.
Psychologist

Client Name (Please Print)	Marital Status	Date of Birth		
S M W D P Sep.				
Home Address	City/State	Zip Code	Home Phone #	Cell Phone #
Client Driver's License #		E-mail		
Employer	Occupation (Indicate if Student)	How long employed?	Business Phone #	
In case of emergency, contact (name, relationship and phone number):				
Who referred you to this practice?		Primary Care Physician		

INSURANCE INFORMATION

Please provide insurance information only if you have made arrangements with our office to file your insurance.

Person responsible for payment, if not above Address/City/State/Zip Code		Phone #
Insurance Company Name	Policy Holder Name	Date of Birth
Insurance Phone #	Insurance Authorization #	
Insurance ID #/Subscriber #	Insurance Group #	

POLICIES AND AGREEMENTS

Appointments: Your appointment time is reserved for you. Appointments missed or cancelled without 24 hours notice will be charged a cancellation fee of \$125.00.

Fee Responsibility: Payment is customarily required at the time of service and is the responsibility of the client. Fees are applied as listed except in a limited number of cases in which fees are reduced due to financial hardship (pre-approved on an individual basis by Dr. Frazier). It is the responsibility of the client to know and track insurance benefits. Clients are responsible for all balances not covered by their insurance.

Fees:

Individual, couple or family session	50-60 minutes	\$165.00	Couple session	90 minutes	\$225.00
Group session	90 minutes	\$ 55.00	Cancellation fee		\$125.00

(subject to above arrangements)

Emergencies: Dr. Frazier does not provide 24-hour emergency mental health services. If you feel you are in a crisis situation, you may call Dr. Frazier's after-hours number (512-560-5279) for a consultation. In the event that he cannot be reached after-hours and you feel there is a crisis situation, Dr. Frazier recommends you call the MHMR hotline 512-472-4357 or 911 for emergency mental health services.

Consent: I have read these policies and understand them. I agree to the arrangements as outlined. I am voluntarily requesting and authorized Dr. Frazier to deliver psychological assessment, consultation treatment or referral based upon his clinical judgment.

Signature

Date