John P. Gallagher, Ph.D.
Clinical Psychologist, H.S.P.P.

5524 South Emerson Ave.
Indianapolis, IN 46237
Phone: (317) 781-1917

Application

Please provide the following information regarding the patient whether yourself, your child or your spouse..

Patient's Name _____ Maiden Name _____

Age ____ Date of Birth _____ Spouse _____ Soc Sec # _____

Marital Status: Single ☐, Married ☐, Divorced ☐, Widowed ☐. Date (Mo./Yr.) _____

Address _____
Street Apt. City State Zip

Contact Information _____ _____
Home Phone # Work with extension # (For a child patient indicate parents' work numbers)

_____ _____
Cell Phone # (Whose? For example. self, child's mother or father?)) E-Mail address (Whose?)

With whom may I leave information about matters such as scheduling appointments? _____

_____

Employer (or school and grade) of the patient _____

If you would like me to submit health insurance claims please complete the following this section:

Name of the policy holder _____ Soc. Sec. #: _____

Employer of the policy holder _____ Policy holder's date of birth: _____

Most insurance policies leave the patient responsible for copayments or deductibles. Would you prefer to guarantee payment with a credit card or to pay in full at the time of service? (Please indicate below).

Pay in full with check ☐ or guarantee payment with a credit card ☐ Type of card: Master Card ☐, Visa ☐

Credit card # ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ (Mo./Yr.) ☐☐/☐☐

Person or agency suggesting the referral _____

Physician _____ Address or Phone #: _____

Previous psychological counseling _____ _____
Where or with whom Approximately when

In case of emergency contact _____
Name Relationship Home phone Work phone

Please briefly list the problems you are primarily concerned about.

_____

_____

_____

Signature of responsible party _____ Date _____

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WELCOME:
I appreciate the confidence you have shown in coming to me for counseling. Starting treatment feels awkward for many people who have not been in counseling before. I'd like to assure you that any apprehension you might have at the outset is understandable, but that in all likelihood you will find the initial interview to be interesting and pleasant. My goal is to help you understand and develop practical solutions to the emotional, interpersonal or family problems which brought you here. I feel responsible for giving clear and concrete suggestions in a timely manner and I firmly believe that counseling does not have to be a prolonged or painful process.

APPOINTMENTS AND AVAILABILITY:
I routinely schedule appointments between 10:30 AM and 6:30 PM Monday through Friday. Appointments typically last 50 minutes. I can generally be counted on to start on time although unforeseen circumstances occasionally lead me to run over with a prior appointment.

Unless I'm otherwise occupied, I answer my own phone and schedule my appointments personally. If I happen to be on the phone or with a client when you call, you'll be asked to leave a message. I will return the call as soon as possible. Outside of office hours you can reach me in the same way by dialing the office phone number and leaving a message: (781-1917).

In the event of emergencies I am available to respond to calls 24 hours a day. Outside of office hours feel free to call me directly at my home (783-2399). You will get instructions for contacting me on my cell phone if I am not home when you call. For more routine matters, such as for rescheduling an appointment, please call the office and leave a message. I usually return such calls on the next business day.

CANCELLATIONS:
On the rare occasion that an emergency or other unforeseen circumstance arises and I need to cancel or change an appointment we have scheduled, I will whenever possible notify you well in advance. In the event that I am unable to do so with 24 hours notice I will credit your account $45. If you have to cancel an appointment, I will attempt to fill that appointment time with someone from my waiting list. If I am able to do so, I won't charge you the $45 ***Late Cancellation Fee for cancellations with less than 24 hours notice.*** However, this would also commit me to being available for ongoing sessions with that new person for as long as he or she needs the time slot. I would contact you to reschedule with you as soon as another opening in my schedule becomes available. Insurance companies do not pay for cancellation fees.

Please initial to acknowledge recognition of the cancellation fee. ☐
Initial

FEES AND INSURANCE:
For those who have insurance coverage my fees are specified at varying rates in numerous contractual agreements. Your cost will depend, in turn, on the terms of your policy. If there is a need for evaluative reports which insurance will not pay for, these would be charged at a rate of $90 per hour of preparation time.

CONFIDENTIALITY:
In the interest of providing competent psychological services at reasonable rates I limit my routine record keeping procedures to the professionally responsible minimum. This allows me to spend more time directly serving you and less time on paper work. In my experience there is rarely any legitimate need for other health professionals to request records regarding my patients' treatment, especially when no psychiatric medications are involved. If for any reason you would like a written summary of your treatment sent to another professional, I would be happy to prepare a narrative at the time of your request.

Generally speaking, the confidentiality of your records is assured by state and federal law and cannot be released without a written authorization from you. Other State laws may override confidentiality and mandate that critical situations be reported to governmental agencies in the following specific cases: 1) if a patient expresses a serious intention to harm himself or others, or 2) if there is a substantial concern that children, or elderly are being abused or neglected.

Apart from the mandatory reporting laws, confidentiality may be compromised if you are involved in litigation. If the court becomes aware that you have been in counseling and finds that to be pertinent to the legal proceedings (e.g., child custody disputes, etc.) then the release of your records could be ordered by the court. Also, in the event of non-payment of fees, after reasonable efforts to collect an outstanding debt have failed, I would turn the balance due over to a commercial agency for collection as an outstanding "medical expense" under the name of the patient or the responsible party.

If you have any questions regarding any of the information presented here, please bring them to my attention. I will be happy to explain further. If you are uncomfortable with any of these policies, please bring that to my attention as well.

I have read and accept the policies outlined above. I agree to assume the financial responsibility for the services which Dr. Gallagher will be rendering to myself, my spouse or my child. I authorize Dr. Gallagher to release the necessary information to my health insurance company for the purpose of filing medical claims and for my health insurance to make payments on my behalf directly to Dr. Gallagher.

Patient's Signature (if over 18) otherwise, responsible party	Date