



GREG THIGPEN, PSYD  
LICENSED PSYCHOLOGIST  
LICENSE PSY19198

## Adult Registration

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

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

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

Referral Source: \_\_\_\_\_

### Emergency Information:

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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

Current Medications: \_\_\_\_\_

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

Other Care Provider/Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_



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## Agreement for Adult Therapy

This agreement is a summary of information provided in Dr. Thigpen's full Agreement for Child/Adolescent Therapy handout. Your signature indicates that you have been offered the opportunity to read the handout, and that you understand the following information.

### **Evaluation and Treatment by Mutual Consent:**

Our first few sessions will involve an evaluation, followed by a discussion of how our work together might proceed. Treatment is voluntary and I have the right to discuss how it is proceeding and to seek a second opinion. If I decide I want to speak to another therapist about my concerns, Dr. Thigpen will be willing to provide me the names of other therapists I can speak with.

### **Fee and Responsibility for Payment:**

The hourly fee for my appointment is \_\_\_\_\_, due and payable by cash or check at the time of my appointment. I (not my insurance company) am responsible for the payment of this fee. This fee reserves Dr. Thigpen's time and I agree that I am responsible for payment, even if I do not show for my appointment, unless I provide 24 hours notice of cancellation. (There may be an exception if Dr. Thigpen and I agree that I was unable to attend due to circumstances beyond my control).

### **Dr. Thigpen's Availability and Crisis Procedures:**

Dr. Thigpen checks his voice mail several times daily during the week, and less often on weekends and holidays. He is available on a brief and occasional basis by phone, longer discussions indicate the need for an appointment to discuss the issues at hand.

If I am in crisis, I can call 911 (for a medical emergency) or Psychiatric Emergency Services, at (707) 576-8181.

### **Confidentiality and Privilege:**

In general, the things I discuss in therapy are confidential (private) and privileged (not to be divulged in a court of law). However, by law there are exceptions. Some circumstances in which a therapist may or must divulge information are (this is not an exhaustive list):

- in cases of child, elder, or dependent adult abuse
- where a client is a danger to self or others
- in some court proceedings (for example, involving child custody or where the client's mental state is at issue).

I have read, understood, and agree to the terms of the treatment agreement as outlined above.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_