Greg Thigpen, PsyD
Clinical 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: (______)____________________

(707) 494 - 6462
www.drthigpen.com
P.O. Box 2996
Santa Rosa, CA 95405

GREG THIGPEN, PSYD
CLINICAL PSYCHOLOGIST
LICENSE PSY19198

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: ________________________

(707) 494 - 6462
WWW.DRTHIGPEN.COM
P.O. BOX 2996
SANTA ROSA, CA 95405