



Stephen H. Hill, Ph.D., PLLC
Licensed Psychologist

hillpsychology.com

Thank you for choosing me as your psychologist.

To protect our full time together please complete these forms ahead of time or else arrive 20 minutes early to complete them in the waiting area.

Enclosed please find the following:

- Your Appointment Time is _____

All professional services are to be paid in full at the time of service. I will then work with you to receive reimbursement directly from your insurance afterwards according to your benefits.

The office address is 500 W Idaho Street, Ste 245. A map can be found at **HillPsychology.com** – just click “Contact” in the upper right corner of the homepage. If you are unfamiliar with the area I am to give further directions. The building’s free parking lot is entered from Idaho Street heading downtown, immediately past the Flying M Coffee storefront. Additional free streetside parking can also be found along the neighboring 400 block of Bannock Street heading back towards the hospital.

If you have any questions the office number is 495-4050, and I do return calls as promptly as possible. **To allow me to serve other clients in need, please remember to cancel all appointments with at least 24 hours notice, 48 hours is preferable. Otherwise, I will unfortunately have to bill you for the time you reserved.**

Until we can meet in person I invite you to explore my website **hillpsychology.com** where you’ll find your personal guide to the best mental health information online. You can also read about my professional specialties, educational background and my style in counseling. I look forward to meeting with you soon.

Sincerely,

Stephen H. Hill, Ph.D., PLLC

Personal Information Form

Stephen H. Hill, Ph.D., PLLC

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Telephone Home (____) _____ Work (____) _____ Cell (____) _____

Which number would you prefer we use to contact you? Home Work Cell Email _____

Birth date _____ Birthplace _____ Age _____ Gender/pronouns _____

Physician _____ Ethnicity (optional): _____

Referred by: ☐ Online: HillPsychology.com ☐ Online: Idaho Psychological Assoc. ☐ Google Search or Google Ad
☐ Word of Mouth ☐ Physician: _____ Other: _____

Medications: _____ Prescribed by: _____

Vitamins & Supplements: _____

Date of last medical exam: _____

Do you have any major allergies? ☐ yes ☐ no If yes, please list _____

Please list any significant health problems _____

In Case of Emergency, Whom May We Contact?

Name _____ Address _____

Relationship to you _____ Phone H) _____ W) _____

IF CLIENT IS AN ADULT

Occupation _____ Employer _____

Years of Education Completed _____ Highest Degree Attained _____

Current relationship status ☐ single ☐ married ☐ partners ☐ significant other ☐ separated ☐ divorced ☐ widow/widower

Number of times you have married _____ Number of years with current partner _____ If divorced, number of years since divorce _____

Current spouse/partner's name _____ Current spouse/partner's employer _____

Current spouse/partner's birth date _____

Children	Name _____	Age _____	Name _____	Age _____
	Name _____	Age _____	Name _____	Age _____
	Name _____	Age _____	Name _____	Age _____

IF CLIENT IS INSURED BY PARENT or UNDER 18

Father's Name _____ Date of Birth _____ Employer _____ Work Phone _____

Mother's Name _____ Date of Birth _____ Employer _____ Work Phone _____

Brothers & Sisters	Name _____	Age _____	Name _____	Age _____
	Name _____	Age _____	Name _____	Age _____

School you now attend _____ Grade _____ School you attended last year _____

Step-Father's Name _____	Employer _____	Work Phone _____
Step-Mother's Name _____	Employer _____	Work Phone _____

Step-Brothers & Sisters:

Name _____	Age _____
Name _____	Age _____
Name _____	Age _____

Therapeutic Goals for Couples

Name: _____

Average hours of sleep per night _____ Is your sleep restful? _____

Have you and your partner been in couple's counseling before? yes no

With whom? _____ Address _____

Have you previously been involved in individual counseling? yes no

With whom? _____ When? _____

Are you currently involved in an extramarital affair? yes no

Is your partner aware of this? yes no

Have there been other extramarital affairs? yes no

Comment: _____

Is there abuse present in any of your relationships? yes no
Type: physical sexual emotional drugs/alcohol other

Comment: _____

Number of alcoholic beverages per **week** _____ Number of caffeine beverages per **day** _____

Other mood altering substances used per **week** _____

Are you currently involved in 12-Step Program? yes no

Have you previously attended (AA, NA, SA, Alanon)? yes no

Have you ever tried to cut back or quit drinking, smoking or other substance use? yes no

Please describe the problem or concern for which you are seeking help:

When were you first aware of this problem?

Personal Information Form

Stephen H. Hill, Ph.D., PLLC

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Telephone Home (____) _____ Work (____) _____ Cell (____) _____

Which number would you prefer we use to contact you? Home Work Cell Email _____

Birth date _____ Birthplace _____ Age _____ Gender/pronouns _____

Physician _____ Ethnicity (optional): _____

Referred by: ☐ Online: HillPsychology.com ☐ Online: Idaho Psychological Assoc. ☐ Google Search or Google Ad
☐ Word of Mouth ☐ Physician: _____ Other: _____

Medications: _____ Prescribed by: _____

Vitamins & Supplements: _____

Date of last medical exam: _____

Do you have any major allergies? ☐ yes ☐ no If yes, please list _____

Please list any significant health problems _____

In Case of Emergency, Whom May We Contact?

Name _____ Address _____

Relationship to you _____ Phone H) _____ W) _____

IF CLIENT IS AN ADULT

Occupation _____ Employer _____

Years of Education Completed _____ Highest Degree Attained _____

Current relationship status ☐ single ☐ married ☐ partners ☐ significant other ☐ separated ☐ divorced ☐ widow/widower

Number of times you have married _____ Number of years with current partner _____ If divorced, number of years since divorce _____

Current spouse/partner's name _____ Current spouse/partner's employer _____

Current spouse/partner's birth date _____

Children	Name _____	Age _____	Name _____	Age _____
	Name _____	Age _____	Name _____	Age _____
	Name _____	Age _____	Name _____	Age _____

IF CLIENT IS INSURED BY PARENT or UNDER 18

Father's Name _____ Date of Birth _____ Employer _____ Work Phone _____

Mother's Name _____ Date of Birth _____ Employer _____ Work Phone _____

Brothers & Sisters	Name _____	Age _____	Name _____	Age _____
	Name _____	Age _____	Name _____	Age _____

School you now attend _____ Grade _____ School you attended last year _____

Step-Father's Name _____	Employer _____	Work Phone _____
Step-Mother's Name _____	Employer _____	Work Phone _____

Step-Brothers & Sisters:

Name _____	Age _____
Name _____	Age _____
Name _____	Age _____

Therapeutic Goals for Couples

Name: _____

Average hours of sleep per night _____ Is your sleep restful? _____

Have you and your partner been in couple's counseling before? yes no

With whom? _____ Address _____

Have you previously been involved in individual counseling? yes no

With whom? _____ When? _____

Are you currently involved in an extramarital affair? yes no

Is your partner aware of this? yes no

Have there been other extramarital affairs? yes no

Comment: _____

Is there abuse present in any of your relationships? yes no
Type: physical sexual emotional drugs/alcohol other

Comment: _____

Number of alcoholic beverages per **week** _____ Number of caffeine beverages per **day** _____

Other mood altering substances used per **week** _____

Are you currently involved in 12-Step Program? yes no

Have you previously attended (AA, NA, SA, Alanon)? yes no

Have you ever tried to cut back or quit drinking, smoking or other substance use? yes no

Please describe the problem or concern for which you are seeking help:

When were you first aware of this problem?

Welcome to my practice. Please carefully read this document about my financial policies and services, and jot down any questions so we can discuss them. Once signed, this document will represent a binding agreement between us. The American Psychological Association's ethical standards require that licensed psychologists provide clients with accurate disclosure information at the beginning of treatment, including the right of clients to refuse treatment, the responsibility of clients for choosing the provider and type of treatment, and the extent of confidentiality. Licensure of an individual by the State of Idaho does not imply endorsement by the psychologist licensing board nor can it guarantee the effectiveness of treatment. Stephen H. Hill, Ph.D., PLLC is a professional limited-liability corporation with all services provided by Dr. Hill, a Licensed Psychologist.

PROFESSIONAL FEES

\$185 for a 50-55 minute session	\$450 per hour for preparation, consultation or attendance at legal proceedings, <u>including</u> if I am called or consulted by another party. No checks for this service and prepayment required. Legal/forensic services are not voluntarily offered.
\$195 for the 60 minute Initial Appointment	
\$185 per hour prorated for extended phone calls, consultations, letters, chart review (occasional brief calls and letters are free).	\$40 for copying and mailing client records.
\$978 for complete Brown Scales ADHD testing with 4-6 page report. Can be made in two payments.	
\$1038 for complete Autism Spectrum testing with 4-6 page report. Can be made into two payments	

PAYMENT

You will be expected to pay in full the fees listed above at the time of service. To maintain my quick availability to you by phone or for added appointments, I do not accept insurance as a form of upfront payment, nor do I maintain direct contacts with insurance companies. Legally, this permits me to better guard your privacy even with your insurance carrier. I will, however, file claims on your behalf and work with you to ensure you receive the maximum benefits to which you are entitled. I accept cash, debit and credit cards (Visa, Mastercard) plus personal checks up to \$195. Debit cards are strongly preferred due to their radically lower transaction fees. A \$30 charge will apply for any returned checks or denied/reversed card payments.

CANCELLATIONS AND MISSED APPOINTMENTS

Please make every effort to keep your scheduled appointment. This practice respects my time and allows me to see other clients who are in need. Except for grave emergencies unless I hear from you at least 48 hours in advance, I will, unfortunately, have to charge you the full fee for a missed or uncancelled appointment. A week's notice is preferred since wait list clients will of course need to arrange childcare and time off work. If you or a child becomes ill on short notice or another conflict arises, I am happy to conduct a session by Zoom or phone so you can still take advantage of your reserved time. Cancellations can be made at any time by calling / texting 208-495-4050, and leaving a message.

TELEPHONE CALLS AND CONSULTATIONS

Occasional short phone consultations with you (5-7 minutes) are free of charge. Similarly, occasional short letters or phone calls with a school counselor, family physician or other professionals are included in my services to you, free of charge. If phone calls or other types of consultations become lengthier or more frequent, these services will be billed pro-rated to my hourly rate of \$185. I receive few "urgent calls" and do not expect excessive phone calls to be a problem.

TECHNOLOGY AND INFORMATION SECURITY

I use a remote, password-protected voicemail system with transcription service, and will access messages from a computer on a secure network, by cell phone or by landline phone. While I take careful measures to make such technology secure, there remains the remote possibility of someone hacking into the system or intercepting a transmission. Feel free to limit what information you leave in a voicemail since this has computer transcription.

APPOINTMENT TIMES, WAITING AREA & PARKING

Our initial meeting lasts 60 minutes and normal counseling visits afterwards last about 50 minutes, with the remaining time used for planning and case notes. Please arrive on time or a little early so we can take advantage of our full time together. If my door is closed please relax in the waiting area at the end of the hall (just outside my door), or if you prefer, you can enjoy something at the coffee shop downstairs before coming up. Please turn off cell phones in the office and waiting area. The building's free parking lot (2 hours) is accessed from one-way Idaho Street heading downtown, immediately past the Flying M Coffee storefront. Free street parking may also be found along Bannock Street from 5th St. towards St. Luke's.

EMERGENCIES

I receive very few urgent or crisis calls. I do return phone calls as soon as possible, but sometimes my schedule does not allow me to return calls on the same day. Please remember that Stephen H. Hill, Ph.D., PLLC is not a crisis response center with 24 hour coverage. If you have a life-threatening emergency please contact your personal physician, dial 911, or 988 for the national crisis hotline, or go to the nearest hospital emergency room.

DESCRIPTION OF COUNSELING SERVICES-- WHAT IS COUNSELING?

Counseling or therapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Counseling is not like a medical doctor visit. Instead, it calls for an active effort on your part. In order for the counseling to be most successful, you will have to work on things we talk about both during our sessions and at home. You will also maximize your experience by telling me periodically what portions of the counseling you are finding least and most helpful.

Counseling may have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration or loneliness. On the other hand, counseling has also been shown to have great benefits for those that go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in your distress. But, of course, there can be no guarantee of what you personally will experience. To be most effective, typically I need to meet with individuals, couples or families at least every other week, or occasionally weekly.

CONFIDENTIALITY

Idaho state law requires that communication between a licensed psychologist and client shall be confidential and privileged from disclosure (Chapter 23, Title 54-2314, Idaho Code). Our work together is confidential, and I must have your permission to reveal information about you to anyone else, except in the following situations:

1. If there is reason to suspect that abuse of a child or disabled adult has occurred, the law requires that it be reported to the authorities.
2. If I believe that you are a clear and imminent danger of causing serious physical harm to yourself (e.g. suicide) or someone else, I will notify appropriate others to assure the safety of those concerned.
3. If it becomes necessary to contact a lawyer or a collection agency, then your name and other identifying information as well as an account summary becomes available to those agents.
4. In a legal proceeding, patient-counselor communications may be revealed if: a) your mental status is an issue for the Court, i.e., in a commitment hearing, or b) the Court decides that knowledge of those communications is necessary to the proper administration of justice.
5. In a licensing board proceeding, or legal action or case regarding your services with me or our interaction.
6. Professionally I periodically consult with trusted colleagues and may wish to seek new ideas for our work together. Both you and I benefit from the input of other mental health professionals. These consultations are also strictly confidential, and typically can be done without revealing your name or identifying information. Unless you request otherwise, I will not specifically ask you before seeking other professionals' consultation.
7. If you want me to work with your insurance company for billings, I may have to reveal information about you including diagnosis, type of visit, prognosis, treatment plan and in rare cases, more complete information from your file.

OUR PROFESSIONAL RELATIONSHIP

Professional counseling, although personal in nature, is a professional relationship rather than a social one. Your contact with me will typically be limited to those counseling sessions you arrange with me. As a licensed psychologist, I will not barter for services or accept gifts or social invitations. You will be best served when our relationship remains strictly professional and when counseling sessions concentrate exclusively on your concerns. Counseling services will be rendered in a professional manner consistent with accepted ethical standards. If at any time you have questions or concerns, please let me know.

INSURANCE

If you chose to file insurance, I want to work with you so that you receive the maximum insurance benefits to which you are entitled. Included in my services to you, I will complete a universal insurance claim on your behalf. For companies accepting paper claims from providers I will also mail these claim forms for you. If your company does not accept paper claims from providers, I will regularly provide you my completed form to mail in—and I may also have blank member forms and addressed envelopes to give you. The fees listed above are collected in full at the time we meet, and insurance claims submitted on your behalf will later reimburse you directly.

To keep costs down and to maintain my phone/appointment availability to you, Stephen H Hill, Ph.D., PLLC does not maintain direct contracts with insurance companies. This practice also better protects your privacy, as insurance companies will not, by contract, have access to your full medical record. If you choose to file out-of-network claims, all insurance companies will require a diagnosis (and sometimes further information to process your claim). Although all insurance companies claim to keep such information confidential, I have no control over the information once delivered to them.

To find out exactly what mental health services your insurance policy covers with a licensed psychologist, please call the number printed on the back of your insurance card. For guidance on what specific questions to ask your insurance company, please see the article “Ending Insurance Surprises” under the “billing” section of my website **HillPsychology.com**. All plans are different, so it is your responsibility to understand any insurance requirements including any preauthorization or reauthorizations after a certain number of sessions. Please note that missed appointments and phone calls cannot be reimbursed by insurance, but phone calls or consultation might be payable by a health savings account.

Remember, you-- not your insurance company-- are responsible for full payment of my fees.

TO USE INSURANCE: CLIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process my insurance claim.

I also request payment of benefits to Stephen H. Hill, Ph.D., PLLC.

Printed Name: _____ Signature: _____ Date: _____

PAYMENT AGREEMENT- Revised 4-16-25

I have read and understand the Office & Financial Policies. I agree to comply with these policies, and understand it represents a binding agreement between myself and Stephen H. Hill, Ph.D., PLLC. **If paying by credit/debit card, I authorize this card to be used for future charges in accordance with the policies and fee schedule listed.** I agree to pay for all services rendered, and for any legal expenses incurred should this account be turned over to a collections agency or an attorney for collection (minimum \$50 fee). I have been offered a copy of this policy.

Person responsible for payment Address City Zip

Print client name (if different than payor) Signature of person responsible for payment Date