






# Dr. Jenny Shields

PSYCHOLOGY & CONSULTING

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WE'RE SO GLAD YOU'RE HERE

## Welcome to the Practice

This secure intake form is the first step in our work together. Please take your time to complete it thoroughly. The information you provide will help us tailor an effective approach to care that meets your unique needs and goals. We appreciate you completing this prior to our first meeting. It allows us to focus our valuable time on what matters most **(you!)**

### CLIENT & CONTACT INFORMATION

CLIENT'S NAME

DATE OF BIRTH

AGE

GENDER

OCCUPATION

EMPLOYER

HOME ADDRESS

EMAIL ADDRESS

PHONE NUMBER

### EMERGENCY CONTACT

NAME & RELATIONSHIP

PHONE NUMBER

# Current Symptoms Checklist

<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Racing Thoughts	<input type="checkbox"/> Excessive Worry
<input type="checkbox"/> Unable to Enjoy Activities	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Anxiety Attacks
<input type="checkbox"/> Sleep Pattern Disturbance	<input type="checkbox"/> Increased Risky Behavior	<input type="checkbox"/> Avoidance
<input type="checkbox"/> Change in Appetite	<input type="checkbox"/> Increased Libido	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Excessive Guilt	<input type="checkbox"/> Decreased Need for Sleep	<input type="checkbox"/> Suspiciousness
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Excessive Energy	<input type="checkbox"/> Suicidal Ideations <sup>1</sup>
<input type="checkbox"/> Loss of Interest	<input type="checkbox"/> Increased Irritability	<input type="checkbox"/> Homicidal Ideations <sup>1</sup>
<input type="checkbox"/> Concentration/Forgetfulness	<input type="checkbox"/> Crying Spells	<input type="checkbox"/> Other

OTHER SYMPTOMS

SYMPTOMS FIRST NOTICED

I'M HOPING DR. SHIELDS WILL HELP WITH...

REFERRED BY?

## COMMUNICATION PERMISSIONS

Please indicate how you would like to receive communications. Note: Standard email and SMS are not encrypted, and privacy cannot be guaranteed. Carrier rates may apply. For details about privacy risks and appropriate use of email/text, see the 'Client-Initiated Communication & Shared Responsibility' section

Contact Method	Yes, I Consent	No, Do Not Contact
Email	<input type="checkbox"/>	<input type="checkbox"/>
Phone Call & Voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Text Message (SMS)	<input type="checkbox"/>	<input type="checkbox"/>
Privacy Concerns (Optional): I have additional privacy/security needs (e.g., limiting use of electronic records) to discuss with Dr. Shields at our first appointment.		<input type="checkbox"/>

<sup>1</sup> If you check these items and you are currently at risk, please contact 911 immediately.

# Client Services & Informed Consent

## BEFORE WE BEGIN: UNDERSTANDING OUR WORK TOGETHER

This Agreement outlines the scope of behavioral health services provided by Dr. Jenny Shields, clarifies the roles and responsibilities of both client and provider, and defines the rights and expectations associated with care. It includes important information about confidentiality, session fees, scheduling policies, treatment expectations, emergency procedures, and communication practices. By reviewing and signing this document, you are providing informed consent and establishing the foundation for our work together in a transparent and collaborative manner.

If at any point something doesn't feel right, you are encouraged to ask questions or express concerns. You also have the right to contact the governing bodies listed later in this agreement.

## WHAT YOU CAN EXPECT FROM YOUR WORK WITH A LICENSED PSYCHOLOGIST

As a psychologist licensed in Texas and Oklahoma and practicing under PSYPACT, Dr. Shields follows the APA Ethical Principles of Psychologists and Code of Conduct. Here's what that means for you:

- **COMPETENCE:** You'll receive care that's within her scope of training and experience.
- **INFORMED CONSENT:** You'll always be informed about treatment plans, risks, and alternatives.
- **CONFIDENTIALITY:** Your privacy is protected, with clear exceptions outlined in this document.
- **BOUNDARIES:** Dr. Shields will avoid dual roles or relationships that could impair her clinical judgment.
- **RECORDKEEPING:** Your records are handled securely and professionally.
- **FAIRNESS AND RESPECT:** You'll be treated with dignity, free from discrimination or exploitation.
- **HONESTY:** No false promises will be made about treatment outcomes or services.

## EMERGENCY & CRISIS PROCEDURES

As an outpatient therapy practice, this practice does not provide 24-hour emergency services. If you experience an emergency or require immediate assistance, please follow these guidelines:

- **Emergency Contact:** If you are experiencing a mental health emergency, call 911 or go to the nearest emergency room.
- **Crisis Resources:** For non-emergency crisis support, call or text the Suicide & Crisis Lifeline at 988.
- **After-Hours Communication:** After-hours communication is for non-urgent matters only, such as scheduling. Messages will be responded to during regular business hours. This practice cannot guarantee an immediate response and is not a substitute for emergency services.
- **Consent for Emergency Actions:** By signing this form, you authorize Dr. Shields to contact your listed emergency contact and/or emergency services (e.g., 911) if she determines there is a serious concern for your health or safety during a session.

# Nature of Therapy Services

Our practice is dedicated to providing evidence-based behavioral health services tailored to meet your unique needs. Dr. Shields uses a variety of scientifically supported treatment approaches, including Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), Exposure and Response Prevention (ERP), and other evidence-based modalities. These methods are designed to address a wide range of mental health concerns and support overall well-being.

## INTAKE SESSION

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Your initial session will involve a comprehensive assessment lasting about 60 minutes, depending on your specific needs. During this intake, Dr. Shields will review your history, current symptoms, and treatment goals, and discuss the therapeutic approach that may work best for you. This initial assessment helps set the foundation for a personalized treatment plan that aligns with your goals and priorities.

Therapy requires a commitment of time, effort, and resources, so this intake session is an opportunity for you to assess whether Dr. Shields is the right provider for your journey. Please ask any questions or share concerns during this session to ensure clear communication and mutual understanding.

## STANDARD SESSION LENGTH & DURATION

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After the intake session, individual therapy sessions are typically scheduled for 45–60 minutes, with longer sessions (90–120 minutes) as clinically appropriate. The frequency of sessions will be determined based on your treatment goals and needs. Weekly sessions are most common, although biweekly or more intensive options may be recommended depending on your progress and clinical presentation.

## ACTIVE PARTICIPATION IN THERAPY

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Psychotherapy is an active process that requires your full commitment both during and outside of sessions. For treatment to be successful, it is essential that you work on agreed-upon goals and complete any assigned homework or exercises between sessions. Your active engagement helps build momentum and can significantly enhance therapeutic outcomes. Dr. Shields will work closely with you to set realistic, actionable goals and will review your progress regularly to ensure that your treatment remains aligned with your evolving needs.

## HOW CAN THERAPY HELP?

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Engaging in therapy is a personal process, and while outcomes can never be guaranteed, it has the potential to offer many significant benefits. Through our collaborative work, clients may experience positive changes in their well-being. The process of therapy can help you:

- Develop deeper self-awareness and a better understanding of your thoughts, feelings, and behaviors.
- Build resilience and learn healthier coping skills to manage life's challenges more effectively.
- Reduce feelings of distress and find a greater sense of emotional balance.
- Strengthen relationships by improving communication patterns and interpersonal skills.

## ARE THERE ANY RISKS OF THERAPY?

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The process of healing and growth can be challenging. It is important to be aware of the following possibilities:

- **Emotional Discomfort:** Confronting difficult issues can bring up uncomfortable or painful feelings. It is not uncommon to feel worse before you start to feel better.
- **Changes in Relationships:** As you grow and change, your relationships with others may shift, which can feel disruptive in the short term.
- **No Guaranteed Outcome:** While our approach is evidence-based, therapy is a collaborative process and does not guarantee a specific outcome. Your active participation is a crucial factor in success.
- **Investment of Resources:** Therapy requires a consistent investment of your time, energy, and finances to be effective.

Please know that these experiences are often a normal part of therapy. Dr. Shields is committed to working at a pace that feels safe for you, and open communication is essential so we can navigate any challenges together.

## CHECKING IN ON YOUR PROGRESS

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Dr. Shields may use standardized assessments, progress measures, or brief surveys to monitor your treatment progress. These tools help track your symptoms, functioning, and overall experience, and allow her to make informed adjustments to your treatment as needed. If this information is ever used for research or educational purposes, all identifying details will be omitted or disguised to protect your privacy. If you have questions about these assessments or their purpose, please feel free to discuss them with Dr. Shields.

## HOW DOES THERAPY END?

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Ideally, therapy concludes when both you and Dr. Shields agree that your treatment goals have been met and that you feel equipped to manage your mental health independently. However, there are other circumstances in which therapy may end, including:

- **Client Choice:** You may choose to end therapy at any time. A final session is encouraged to review your progress and plan for ongoing support.
- **Clinical Judgment:** If another provider or level of care would better meet your needs, Dr. Shields will discuss this with you and provide referrals.
- **Non-Compliance:** Failure to attend sessions regularly or engage in agreed-upon therapeutic work may result in termination and referral.
- **Behavioral Reasons:** Aggressive, threatening, or inappropriate behavior (including attending under the influence of substances) may lead to termination of services.

At the conclusion of your work, Dr. Shields can provide resources for continued support.

**IMPORTANT NOTE:** Dr. Shields is committed to providing evidence-based, high-quality mental health care within the scope of her training and licensure. Please understand that submitting intake paperwork or completing an initial session does not guarantee ongoing service. Dr. Shields maintains the right to determine whether services can be provided based on clinical appropriateness, therapist availability, and your location within a legally authorized jurisdiction. If your needs fall outside the scope of this practice, Dr. Shields will provide referrals to qualified professionals to help ensure you receive the most appropriate and effective care for your specific situation.

# Nature of Assessment Services

Psychological assessment is a structured, time-limited service designed to clarify diagnostic questions, understand cognitive or emotional functioning, and offer concrete recommendations. Evaluations may include clinical interviews, rating scales, collateral information (with your consent), and standardized testing. A written report is prepared based on all of the data collected.

Assessment is not the same as ongoing psychotherapy. Engaging in an evaluation does not create a psychotherapy relationship or imply ongoing treatment unless this is specifically discussed and agreed upon in a separate treatment plan. Dr. Shields provides assessment services only within her areas of competence and will refer you to another provider if your needs fall outside her scope.

## WHAT TO EXPECT FROM THE ASSESSMENT PROCESS

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The assessment process is generally time-limited and goal-directed. It may include:

- One or more clinical interviews to review your history, current concerns, and goals for the evaluation
- Standardized tests or rating scales to measure specific areas (e.g., attention, learning, memory, mood, anxiety)
- Collateral information, when appropriate, from parents, partners, or others (with your written consent)
- A feedback session to review the results, discuss diagnostic impressions, and talk through recommendations
- A written report summarizing the findings and outlining practical next steps

You are encouraged to ask questions throughout the process so that you understand what is being assessed, how the results will be used, and what the recommendations mean for you.

## INTENDED USE AND LIMITATIONS OF REPORTS

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Assessment reports are prepared solely for the purposes discussed at the start of the evaluation (for example, diagnostic clarification, treatment planning, school accommodations, or testing accommodations). Unless specifically contracted otherwise:

- These reports are not forensic evaluations and are not intended for use in litigation, custody disputes, or legal testimony.
- The report will not include legal conclusions or formal opinions about capacity, fitness-for-duty, or similar questions.

If you choose to share your report with a third party, please be aware that Dr. Shields cannot control how that party interprets or applies the results. Different organizations may have their own criteria or thresholds that differ from clinical judgment. You are encouraged to schedule a feedback session before releasing the report so you can ask questions and feel comfortable with how it may be used.

## NON-COMPLETION OF ASSESSMENT

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Assessments depend on full participation. If you cancel, no-show, or disengage and do not complete all required steps (such as testing sessions, questionnaires, or collateral forms):

- Dr. Shields may be unable to reach valid conclusions or produce a final report.
- In such situations, no partial or draft report will be provided unless legally required.
- Because significant preparation and professional time are invested in advance, the **full assessment fee is non-refundable**, even if you choose not to finish the process.

If you are having difficulty completing any part of the evaluation, please discuss this with Dr. Shields as early as possible so that options can be explored.

## REQUESTS FOR LETTERS OR ADDENDA

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Sometimes additional documentation is requested after an evaluation (for example, a customized letter to a testing board, school, employer, or licensing body). These types of letters, forms, or tailored addenda are not included in the standard assessment fee. Any such requests must be discussed in advance and may incur an additional charge based on the time required. Dr. Shields will only provide documentation that is consistent with the data gathered and with ethical guidelines for psychological assessment.

## ASSESSMENTS RELATED TO HIGH-STAKES TESTING

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Some evaluations are completed to help determine whether accommodations are appropriate for standardized or high-stakes examinations (such as the LSAT, MCAT, GRE, bar exam, or professional licensure exams). If your assessment is being used in this way, please note the following:

- **Objective Evaluation.** The assessment is conducted as an independent, objective evaluation. Conclusions and recommendations are based on clinical data and standardized instruments—not on personal goals, anticipated needs, or desired outcomes.
- **No Guarantee of Accommodations or Diagnosis.** While Dr. Shields is committed to ethical, thorough evaluation, **no guarantees can be made that a particular diagnosis will be made**, or any third party (e.g., testing authority, licensing board) will grant requested accommodations.
- **Third-Party Interpretation.** Once you submit your report to an outside organization, that entity may interpret the findings according to its own criteria and policies. These criteria can differ significantly from clinical judgment or diagnostic standards.
- **Scope of the Evaluation.** Unless explicitly contracted otherwise, this is **not a forensic evaluation, legal capacity evaluation, or fitness-for-duty exam**. The report will not include legal conclusions or endorsements meant to support legal claims.
- **Emotional Impact of Results.** Assessment findings may confirm or rule out conditions you expected. This can affect how you see yourself and how others might see you. It is normal to have emotional reactions to these results, and you are encouraged to discuss them with Dr. Shields in a feedback or follow-up appointment.
- **Transparency and Integrity.** Recommendations are made only when they are supported by the assessment data and aligned with best practices in psychological evaluation. If the data do not support a diagnosis or accommodation request, that will be clearly reflected in the report.
- **Documentation Standards and Deadlines.** Testing organizations often have very specific documentation requirements and deadlines. You are responsible for confirming what each organization requires and submitting your materials on time. Requests for additional forms, letters, or clarifications may be considered at the provider's discretion and may involve additional fee

## LEGAL PROVISIONS & GOVERNING AUTHORITIES

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Dr. Jenny Shields is a licensed psychologist practicing under the authority of the following state licensing boards and national credentialing bodies.

### **Texas Licensed Psychologist (License #40268)**

Texas State Board of Examiners of Psychologists

[www.bhec.texas.gov](http://www.bhec.texas.gov) | 1-800-821-3205

333 Guadalupe St., Suite 3-900, Austin, TX 78701

### **Oklahoma Licensed Health Service Psychologist (License #1359)**

Oklahoma State Board of Examiners of Psychologists

[www.ok.gov/psychology](http://www.ok.gov/psychology) | 405-522-1333

421 NW 13th Street, Suite 180, Oklahoma City, OK 73103

## INTERJURISDICTIONAL PRACTICE

Dr. Shields holds PSYPACT credentials (#10309) that authorize her to provide psychological services across state lines in participating jurisdictions. This includes the authority to conduct secure telepsychology (video) sessions with clients located in these states, as well as authorization to provide limited in-person services without requiring a separate state license. For a current list of participating states, please visit [psypact.org](http://psypact.org). If you are in a state where Dr. Shields is not licensed or PSYPACT-authorized at the time of session, she cannot legally provide services.

## COMPLAINTS AND CONCERNS

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If you have concerns regarding Dr. Shields's services or conduct, you may contact any of the above regulatory bodies. They are available to provide information on filing complaints or learning more about the professional standards governing Dr. Shields's practice.

Additionally, the Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. To file a complaint: Call 1-800-821-3205 or visit [www.bhec.texas.gov](http://www.bhec.texas.gov).

## GOVERNING LAW

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This Agreement and the services provided by Dr. Shields are governed by the laws of the State of Texas. By entering into this Agreement, you consent to Texas law as the controlling authority for any legal matters that may arise. If any provision of this Agreement is found to be unenforceable under law, all other sections remain valid and enforceable.



# Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Confidentiality is foundational to the therapeutic and assessment process. Information shared during session is kept strictly confidential and will not be disclosed without your written consent, except under specific legal and ethical circumstances detailed in this Notice. Protecting your privacy is essential to fostering a trusting therapeutic relationship, and Dr. Shields is committed to upholding these standards at all times. This Notice of Privacy Practices explains how your protected health information (PHI) may be used and disclosed, and what rights you have regarding your information.

## UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI)

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Your PHI includes any information related to your mental health care—such as symptoms, diagnoses, treatment plans, progress notes, results from assessments, and billing information. This information is essential for providing effective treatment, managing your care, maintaining records, and meeting legal and quality standards. We are committed to protecting the privacy and security of your health information in compliance with federal and state laws.

## HOW YOUR INFORMATION MAY BE USED AND SHARED

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We use your health information in three main ways required by HIPAA.

- **For treatment**, we use it to understand your history, document your progress, and, when needed, consult with or share limited information with other providers involved in your care (with your permission, unless the law requires otherwise).
- **For payment**, we use it to bill you for services, process payments, and create receipts or statements.
- **For health care operations**, we use it to run the practice responsibly—for example, keeping accurate records, obtaining legal or accounting support, and meeting licensing and quality standards. For all of these purposes, we use or share only the information that is reasonably necessary.

## OUR RESPONSIBILITIES TO PROTECT YOUR INFORMATION

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This practice takes your privacy seriously and is required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices, and any updates to it
- Follow the terms of the Notice currently in effect
- Notify you as soon as reasonably possible if there is a breach of unsecured PHI
- Never sell your PHI or use it for marketing without your explicit written authorization

## EXCEPTIONS TO CONFIDENTIALITY AND REQUIRED/PERMITTED DISCLOSURES

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While confidentiality is the default, there are situations in which Dr. Shields is legally or ethically required or permitted to disclose information without your written consent. These include:

- **Threats of Harm.** If you express a clear and serious intent to harm yourself or someone else, Dr. Shields may be required to: 1). Notify appropriate authorities, emergency services, or other necessary parties, 2). Contact your emergency contact, if needed, 3). Take reasonable steps to prevent or lessen the risk of harm. These actions are taken to protect your safety and the safety of others.
- **Child, Elder, or Dependent Adult Abuse or Neglect.** If there is reason to suspect that a minor, elderly person, or dependent adult is being abused, neglected, or exploited, Dr. Shields is legally required to report this to the appropriate protective or law enforcement agencies.
- **Court Orders and Legal Compliance.** If a court issues an order, subpoena, or warrant for your records or testimony, Dr. Shields may be required to comply. In such cases, only the minimum necessary information will be disclosed. For clients residing in PSYPACT states outside Texas and Oklahoma, Dr. Shields must follow the laws of both her home state and your state of residence. This may affect what must be reported or disclosed.
- **Health Oversight Activities.** Information may be disclosed to government agencies or professional licensing boards for activities authorized by law, such as audits, investigations, inspections, or disciplinary proceedings related to health care providers.
- **Law Enforcement.** In certain situations, PHI may be disclosed to law enforcement, for example, in response to a valid subpoena, warrant, or court order or to report a serious crime, or in other situations where disclosure is required by law. Only the minimum necessary information will be provided.
- **Workers' Compensation.** If you file a workers' compensation or similar claim, information relevant to your condition or treatment may be disclosed as allowed by workers' compensation laws.
- **Organ Donation, Medical Examiners, and Funeral Directors.** We may share information to respond to organ or tissue donation requests or work with a coroner, medical examiner, or funeral director, as allowed by law.
- **Disaster Relief and Involvement in Your Care.** In the event of a disaster, emergency, or similar situation, limited information may be shared with authorized organizations or individuals to help locate you, check on your safety, or notify family members or others involved in your care. This will only be done when permitted by law and when it appears to be in your best interest.
- **Research.** Your identifiable information will not be used for research without your written consent, unless allowed by law or after it has been de-identified so you cannot reasonably be identified.

## RISKS OF PHI RE-DISCLOSURE

Once we share information with others as allowed in this Notice, they may not be required to follow HIPAA. In those situations, your information could be shared again by that person or organization, and we cannot control how they use or disclose it.

## YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

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You have important rights about how your PHI is used and shared. To exercise any of these rights, please submit your request in writing to Dr. Shields.

### RIGHT TO ACCESS YOUR RECORDS

You have the right to inspect or request a copy of your treatment records. To do so, please submit a written request.

- Your request will typically be fulfilled within 7 business days and no later than 30 days, in accordance with law
- In very limited circumstances, Dr. Shields may deny access to a portion of your record if permitted by HIPAA and Texas law—for example, if access is reasonably likely to endanger your life or the life of another person

- If access is denied, you will be informed in writing and may have the right to request a review of the decision.

### **TREATMENT SUMMARY OPTION**

To protect your privacy, Dr. Shields may recommend providing a treatment summary instead of detailed session notes. A summary offers a general overview of your progress and treatment, can be shared with authorized parties (e.g., other health care providers) if you choose, and may be prepared for third-party requests (such as insurance or legal purposes) for a fee based on the time required to prepare the document.

### **RIGHT TO REQUEST A CORRECTION (AMENDMENT)**

If you believe that any part of your record is inaccurate or incomplete, you may request a correction. In some circumstances, your request may be denied (for example, if the information is already accurate and complete, or if it was created by another provider). If a request is denied, you will receive a written explanation and may choose to add a statement of disagreement to your record.

### **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS**

You may ask that Dr. Shields contact you in a specific way or at a specific location to help protect your privacy (for example, using only a certain phone number, avoiding voicemail, or using a different mailing address). Reasonable requests will be honored whenever possible. Please talk with Dr. Shields if you have specific privacy needs around how you are contacted.

### **RIGHT TO REQUEST RESTRICTIONS ON USE AND DISCLOSURE**

You may request that Dr. Shields place limits on how your protected health information is used or shared for treatment, payment, or health care operations. While the practice is not required to agree to every requested restriction, any restriction that is accepted will be followed, except in an emergency or when the law requires disclosure.

### **RIGHT TO RESTRICT SHARING WHEN YOU PAY OUT OF POCKET**

If you pay in full for a specific service out of pocket, you may request that information about that service not be shared with your health insurance company. This restriction will be honored unless a disclosure is required by law.

### **RIGHT TO AN ACCOUNTING OF CERTAIN DISCLOSURES**

You may request a list ("accounting") of certain disclosures of your protected health information made by this practice. This list will not include disclosures made for treatment, payment, or health care operations, or disclosures that you have already authorized in writing. There may be a reasonable fee for additional requests within the same 12-month period.

### **RIGHT TO A COPY OF THIS NOTICE**

You have the right to receive a paper or electronic copy of this Notice of Privacy Practices at any time, even if you previously agreed to receive it electronically. You may request an updated copy at any appointment or by contacting Dr. Shields.

### **RIGHT TO ACT THROUGH A LEGAL REPRESENTATIVE**

If you have a legal guardian, someone with medical power of attorney, or a personal representative under applicable law, that person may be able to exercise your privacy rights on your behalf. Dr. Shields may ask for documentation of this authority and may decline to work with a representative if there is concern that the person is not acting in your best interests.

## CLIENT-INITIATED COMMUNICATION & SHARED RESPONSIBILITY

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Dr. Shields will confirm your preferred communication methods (email, phone, text, or secure portal messaging) during intake, and you may update those preferences at any time. Please note:

- Standard email and text messaging are not fully secure and should not be used for sensitive clinical content or emergencies.
- If you choose to send clinical or sensitive information through non-secure means (e.g., regular email or text), you are accepting the privacy risks involved. Your use of those methods, along with your signature on this form, will be considered informed consent to communicate via the method you've used.

Dr. Shields will use her professional judgment to determine how and whether to respond, always prioritizing your privacy, safety, and clinical needs. Whenever possible, sensitive information is best discussed during sessions or via secure platforms. To help protect your information use passwords or passcodes on your personal devices, avoid shared accounts when possible, and be aware that using a work-issued device, work email, or employer-owned network may allow your employer to access your communications. Electronic communication with Dr. Shields is never appropriate for emergencies or urgent crises. If you are in crisis, call 911 or go to the nearest emergency room, and/or contact 988.

## PARTICIPATION IN TELEHEALTH & USE OF TECHNOLOGY

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Dr. Shields offers services both in person and through secure video platforms. Telehealth can increase access and flexibility, but it also carries inherent risks, such as potential technology failures and privacy concerns (e.g., others overhearing you if your environment is not private). To support privacy and safety, you are encouraged to use a secure internet connection when possible, attend sessions from a private location where you cannot be overheard, and keep your contact information up to date and notify Dr. Shields if it changes. Telehealth may not be appropriate for everyone. If Dr. Shields believes a different level or format of care would better meet your needs, she will discuss alternatives and provide referrals.

## LICENSING, LOCATION, AND PSYPACT

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To receive telehealth services, you must be physically located in a state where Dr. Shields is licensed or authorized under PSYPACT at the time of your session. Dr. Shields will verify that the address listed on your consent paperwork is within her jurisdiction to practice.

- You are responsible for notifying Dr. Shields at least 48 hours in advance if you will be in a different state at the time of your appointment.
- You are also responsible for confirming state participation at <https://www.psypact.org/psypactmap> and informing Dr. Shields if you plan to attend from a non-participating jurisdiction.

If you are uncomfortable with the inherent risks of telehealth or prefer not to engage in electronic communication at all, Dr. Shields may not be the right provider for your needs. Please discuss any concerns early so that alternatives or referrals can be considered.

## RECORDING OF SESSIONS

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To protect your privacy and maintain trust sessions may not be recorded (audio, video, or otherwise) by you without Dr. Shields's written consent. Unauthorized recording or sharing of any part of a session breaches the privacy and confidentiality essential to therapy and may result in ending services. Recordings made without written consent are considered unauthorized and may not be used, shared, or introduced in any legal, administrative, or professional setting involving Dr. Shields or her practice.

Dr. Shields may occasionally make brief, secure recordings to ensure that clinical documentation is accurate and complete. These recordings are stored only on encrypted, HIPAA-compliant systems, are deleted as soon as documentation is finalized, and are never used for training, research, or supervision without your explicit written consent.

## USES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

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Certain uses and disclosures of your information will only occur if you choose to give written permission:

- **Psychotherapy Notes (if maintained separately):** If Dr. Shields keeps separate psychotherapy notes as defined under federal law—notes kept solely for personal clinical use and not part of your standard record—these notes have special protections and will not be shared without your written authorization, except in very limited situations required by law.
- **Marketing Communications:** Your information will not be used for marketing purposes without your explicit written authorization. You will not be required to agree to marketing in order to receive services.
- **Sale of Your Health Information:** Your PHI will never be sold. If a situation involving the sale of health information were ever contemplated, it would only occur with your explicit written authorization and in compliance with applicable law.
- **Other Uses Not Described in This Notice:** Any other use or disclosure of your PHI that is not described in this Notice will require your written authorization.

You may revoke (take back) your authorization at any time by submitting a written request. Revoking authorization does not affect any uses or disclosures that have already occurred based on your prior permission.

## ADDITIONAL PRACTICE PRIVACY PROVISIONS

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### PARTICIPATION OF OTHERS IN THERAPY

If you choose to include a family member, friend, or partner in a session, Dr. Shields will first assess whether it is clinically appropriate. These individuals are considered “collaterals” and are not protected by therapist–client privilege. A signed release of information is required if you wish Dr. Shields to communicate with others about your care outside of session.

### PUBLIC ENCOUNTERS

If you see Dr. Shields in a public setting, she will not acknowledge you unless you initiate contact. This protects your privacy and avoids unintentionally disclosing your therapeutic relationship. If you do choose to acknowledge her publicly, it will be assumed to be at your discretion.

### SOCIAL MEDIA AND REVIEWS

To protect therapeutic boundaries, Dr. Shields does not accept friend or contact requests on social media with any current clients. You are welcome to leave a review if you choose, but doing so may disclose your therapist–client relationship publicly. Please do not use social media to communicate clinical or appointment-related information.

### TREATMENT PARTICIPATION FOR MINORS

For minor clients (under 18 years), treatment generally requires the consent of a parent or legal guardian. If the minor's parents are divorced or separated, the parent authorizing treatment must have legal custody or consent authority as per the custody agreement. If both parents share legal custody, Dr. Shields may require both parents to consent to treatment, unless otherwise stipulated by a court order. Please provide a copy of the most recent custody decree to establish the right to authorize treatment.

Confidentiality is crucial to building trust in therapy, especially with minor clients. While parents and guardians have the legal right to certain information, Dr. Shields aims to protect the therapeutic process by providing only general updates regarding the minor's progress, attendance, and overall treatment goals, unless the minor consents to additional disclosures. Dr. Shields may disclose specific information if she believes the minor poses a risk of harm to themselves or others. To promote a safe therapeutic space, we ask that both parents agree not to use Dr. Shields's records or testimony in custody-related matters. Therapy is focused solely on the minor's well-being and is not intended for use in legal proceedings. Dr. Shields is ethically obligated to avoid involvement in custody disputes and will not testify or provide records for these purposes, unless legally compelled. If required to participate in legal proceedings, standard legal fees will apply.

## STATE-SPECIFIC PRIVACY PROTECTIONS

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Because Dr. Shields practices in Texas and may see clients in other PSYPACT states, additional privacy protections may apply. Some states provide extra protections for certain types of information, such as:

- Mental health and psychotherapy
- Substance use or addiction treatment
- HIV status or certain communicable diseases
- Reproductive health care
- Services provided to minors

When the laws of your state offer stricter privacy protections than federal law, Dr. Shields will follow the more protective standard. If you have questions about how your state's laws affect your privacy, please ask during session.

## QUESTIONS, CONCERNS, AND COMPLAINTS ABOUT PRIVACY

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If you have questions or concerns about how your information is used or shared, or if you believe your privacy rights have been violated, please bring this to Dr. Shields's attention so it can be discussed and addressed. You may contact Dr. Shields directly by phone at (713) 482-1925 or by email at [hello@drjennysields.com](mailto:hello@drjennysields.com). You also have the right to file a complaint with the U.S. Department of Health & Human Services, Office for Civil Rights, using the instructions provided at: [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints). There will be **no retaliation** or change in your care if you choose to file a complaint or raise a concern about your privacy.

## CHANGES TO THIS NOTICE

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This Notice of Privacy Practices may be updated from time to time to reflect changes in laws, regulations, or office procedures. Any revised Notice will apply to all PHI maintained by this practice, including information gathered before the change. The most current version of this Notice will be available on the practice website and provided to you in paper or electronic form upon request.

# Good Faith Estimate for Health Care Services

PROVIDER NAME	PRACTICE NAME	PROVIDER NPI #1
Jennifer D. Shields, PhD	Shields Psychology & Consulting (DBA: Dr. Jenny Shields)	1558998377
PRACTICE NPI #2	TIN	STATE LICENSE
1235972886	99-3445383	Texas #40268
APIT LICENSE	LOCATION	EMAIL
#10309	Telehealth, Private Address	<a href="mailto:hello@drjennyshields.com">hello@drjennyshields.com</a>
MAILING ADDRESS		
8708 Technology Forest Pl., Ste. #175, The Woodlands, TX 77381		

**NEW CLIENTS:** The estimate below includes the cost of your initial intake and a range of costs that are typical for new patients. Because each person’s needs are unique, your provider will not have a full understanding of your diagnosis or treatment goals until after the initial evaluation. The length and frequency of therapy are influenced by many factors, including your schedule, attendance, completion of outside-of-session work (if applicable), ongoing life stressors, and the nature of your referral concerns. Most providers recommend weekly sessions for the first 8–12 weeks, after which frequency is often adjusted collaboratively. Some treatments may require 12–24 weeks or longer. You and your provider will work together to determine what’s most appropriate.

**CONTINUING CLIENTS:** For continuing clients, the estimate below reflects a typical range of service costs over time. The number of sessions you need may vary depending on your progress, needs, and evolving circumstances. This estimate is not a contract or offer for services. It also does not reflect any insurance reimbursement, if applicable. Please check with your insurer for coverage and out-of-network reimbursement information, as some or all services may not be covered. The final cost of your care may be higher or lower than this estimate.

## ESTIMATE OF WHAT YOU COULD PAY

This Good Faith Estimate outlines expected costs of services based on what is known at the time of issue. You may be charged more if complications or special circumstances occur. All session rates are consistent across diagnoses, if the diagnosis is eligible for treatment by this provider.

### IMPORTANT NOTES ABOUT THIS ESTIMATE

- This estimate is based on current information and does not include any unexpected costs that may arise.
- You are not required to obtain services from this provider.
- This estimate does not include any health plan payments or reimbursements.
- Contact your health plan to confirm what may be covered and what you may owe.

PSYCHOTHERAPY SERVICES THAT COULD BE EXPECTED BY THIS PROVIDER

SERVICE TYPE	CODES	QTY	PER UNIT	EXPECTED COST
Initial Evaluation	90791	1	\$280	\$280
Psychotherapy	90837	1	\$250	\$250
Ongoing Psychotherapy for 8 Weeks After Intake	90837	8	\$250	\$2,000
Ongoing Psychotherapy for 12 Weeks After Intake	90837	12	\$250	\$3,000
Ongoing Psychotherapy for 24 Weeks After Intake	90837	24	\$250	\$6,000
Ongoing Psychotherapy for 48 Weeks After Intake	90837	48	\$250	\$12,000

ASSESSMENT SERVICES THAT COULD BE EXPECTED FROM THIS PROVIDER

ASSESSMENT TYPE	CODES	EXPECTED COST
Personality Assessment	96130, 96131, 96136, 96137	\$2,000
Core Mental Health Assessment	96130, 96131, 96136, 96137	\$3,500
Autism Spectrum Disorder Assessment	96130, 96131, 96136, 96137	\$5,000
Individualized Assessment	Variable	Variable (Detailed breakdown provided)

If your final bill is \$400 or more above this estimate, you may:

- Contact Dr. Shields to request a corrected bill or negotiate payment.
- Initiate a dispute resolution process through the U.S. Department of Health & Human Services (HHS) within 120 days. There is a \$25 fee to use the dispute process. Visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 1-800-985-3059 to begin.

SUBPOENA AND COURT-RELATED POLICIES

Dr. Shields’s role is clinical, not forensic. Her primary focus is on your mental health, not legal strategy or courtroom involvement. If your therapy intersects with litigation or administrative processes, please read the following carefully:

- **Subpoenaed Testimony and Document Production:** Should Dr. Shields be required to provide testimony or documents in any legal matter, a minimum retainer fee of \$3,500 is required in advance for court-related services. This fee covers preparation time, court appearances, and any associated travel. Additional time is billed at \$500/hour.
- **Advance Notice Required:** Please provide a minimum of ten (10) business days’ notice for any subpoena or legal request.
- **Limits of Participation:** Dr. Shields does not serve as a forensic evaluator or expert witness and will not provide custody, fitness-for-duty, or capacity evaluations unless explicitly contracted under a separate agreement.
- **Ethical Boundaries:** Regardless of fees, Dr. Shields will provide only opinions consistent with her clinical judgment, ethical obligations, and evidence-based standards. For additional policies related to minors and custody disputes, please see 'Treatment Participation for Minors.

IMPORTANT NOTICE FOR MEDICARE BENEFICIARIES

Dr. Shields has formally opted out of Medicare under federal law. This means that if you are eligible for Medicare, you cannot submit claims to Medicare for reimbursement for any services provided by Dr. Shields. **You agree to pay privately for all services and understand that no Medicare reimbursement will be available for these services.**



# Payment Authorization

Dr. Jenny Shields requires a card on file for contactless payments. This helps keep things safe and simple and allows us to focus more on you, rather than payment processing after your session.

NAME ON CARD

CARD NUMBER

EXPIRATION (MM/YY)

CVC

ZIP CODE

## AUTHORIZATION FOR CHARGES REQUIRED

I authorize Dr. Jenny Shields, PLLC, to charge my credit card for professional services as outlined in this form and in accordance with the established payment policies of Dr. Jenny Shields, PLLC. I understand charges may be processed through a third-party provider, such as Stripe, Square, or another authorized payment processor. I also understand that a paper copy of this authorization is available upon request.

## 48-HOUR CANCELLATION POLICY REQUIRED

I understand and agree to the following:

- **Notice Requirement:** Appointments must be canceled or rescheduled at least **48 hours in advance** to avoid fees.
- **Late Cancellation / No-Show Fee:** If I do not provide 48-hour notice, my card will be charged the **full session fee**, including for intake appointments. I understand this policy ensures availability for others and respects the time and resources held for me.

## DURATION OF AUTHORIZATION REQUIRED

This authorization remains in effect until I cancel it in writing. I agree to notify Dr. Jenny Shields of any changes to my credit card information or if I wish to terminate this authorization.

## NON-DISPUTE AGREEMENT REQUIRED

I certify that I am an authorized user of the card provided and agree not to dispute valid charges that comply with this agreement, including charges related to the cancellation policy.

- **Responsibility for Valid Charges:** I understand that initiating chargebacks or disputes on valid charges may result in administrative action that could impact my care.
- **Acknowledgment of PHI:** I recognize that transactions may include Protected Health Information (PHI) due to their association with healthcare services.

## PAYMENT PROCESSOR DISCLOSURE REQUIRED

I understand that Dr. Jenny Shields, PLLC may process payments through various third-party processors, including but not limited to Stripe or Square. This authorization applies to all processors used by the practice.

# Agreement & Signature

This form confirms that I have reviewed and agreed to the information contained in Dr. Shields's full intake materials, including the Client Services & Informed Consent Agreement, Notice of Privacy Practices, Good Faith Estimate & Payment Agreement, Telehealth Policies, and Medicare Opt-Out Notice. This signed document will be stored securely in compliance with state and federal law.

## FURTHER:

- I give my informed consent to receive psychological services from Dr. Jenny Shields. I understand the goals, process, and limits of confidentiality, and that I may withdraw consent at any time.
- I understand that completing this paperwork and attending an intake appointment begins our process of deciding together whether this practice and approach are the right fit for my needs. I agree to provide accurate information about any medical, psychological, or personal history that could be relevant to my care.
- I have reviewed the Notice of Privacy Practices and understand how my health information may be used or shared, the limits of confidentiality, and my rights to access, restrict, or correct my record.
- I've reviewed the Good Faith Estimate and Direct Payment Agreement and understand that:
- Services are provided on a private-pay basis; Dr. Shields does not bill insurance directly.
- Some or all services may not be reimbursed by insurance.
- Payment is due at the time of service, unless other arrangements have been made in writing.
- The estimate outlines expected costs but is not a contract; final costs may vary depending on my needs.
- I understand that appointments must be canceled or rescheduled at least 48 hours in advance to avoid being charged the full session rate, as that time is reserved specifically for me.
- Dr. Shields will explain the purpose, risks, and benefits of recommended care and will always respect my right to ask questions or decline an intervention. I agree to communicate honestly about my progress, concerns, or discomforts in receiving psychological services so that we can address them together.
- I understand that Dr. Shields adheres to professional, legal, and ethical standards that safeguard client safety and confidentiality, and that I can contact her licensing boards if I ever have concerns about my care.
- If we meet by telehealth, I will give Dr. Shields at least 48 hours' notice if I plan to join from another state or location, since licensing laws vary. I agree not to record sessions without Dr. Shields's written consent, as this helps protect privacy and maintain trust in the therapeutic process.
- I have had the opportunity to ask questions and discuss anything that was unclear before signing this form.

By typing or signing my name below, I confirm that this electronic or handwritten signature is legally binding and that I understand and agree to the terms in this document and all referenced intake materials.

CLIENT'S NAME

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DATE OF BIRTH

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CLIENT'S SIGNATURE

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TODAY'S DATE

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