

TONJA H. KRAUTTER, Psy.D, L.C.S.W
Child, Adolescent, Adult, and Family Psychotherapy

51 East Campbell Ave Suite 170
Campbell, CA 95008
Voice Mail: 408-808-1580 Fax: 408-370-6196

Getting Started:

Thank you for contacting the office of Dr. Tonja H. Krautter. I appreciate your interest in my services. This letter tells you about getting started with my evaluation and therapeutic services.

The more information I have before your visit, the better I can plan for your child's evaluation and treatment plan. The first step in the diagnostic process is the completion of the enclosed application, and questionnaire(s). Please return these forms to me at the above address as soon as possible so we may begin our arrangements. I need pages 3, 4, 6, and 7 back. If the first appointment is soon, you can bring them with you.

REPORTS: It is important for me to have reports from schools and any other agency(ies) you may have contacted regarding your child's development and/or difficulties. Please sign the enclosed "Authorization for Release of Information" forms (page 8) and send them directly to each person and/or agency. You may make additional copies of these forms as needed. All information and procedures related to services are confidential. Medical information from your child's pediatrician or family physician and a complete psychiatric evaluation if your child is taking medication or planning on taking medication from your child's psychiatrist will be needed. Please sign the enclosed "Authorization for Release of Information" labeled Child's Physician (page 9) and forward it to the appropriate physician/psychiatrist.

FEES: Payment in full at the time of service is required. At the same time I will provide you with a statement to submit to your insurance carrier for reimbursement. Some insurance companies will not cover outpatient psychotherapy. Therefore, it is your responsibility to contact your insurance company prior to our initial appointment to inquire about reimbursement. Your estimated fees and a payment schedule were discussed during our initial phone interview. If arrangements have been made for partial payment for a session at the time of service, there will be the customary 1.5% finance service charge on the remaining balance. There will be a \$25 fee for all returned checks. Standard fees may be raised on an annual basis. You will be notified in writing at least one-month prior to any changes in fee if they occur. At this time a new contract will be signed.

MEDICATIONS: Medications need to be prescribed by a psychiatrist. A referral to a psychiatrist for an evaluation can be made if needed.

Getting Started : (continued)

APPOINTMENTS: If you are unable to keep an appointment, please be sure to cancel at least 48 hours in advance, or you will be charged my usual fee for that session. I can more easily fill time slots for everyone who would like appointments if I know of cancellations in the future. It is your responsibility to keep track of the appointments you have made.

PLEASE NOTE: Insurance companies do not pay for missed appointments. Therefore, I must charge for the costs incurred, as I cannot double book as do my physician colleagues in other specialties. My voice mail will take your message when I am not available to speak to you. I retrieve messages regularly on weekdays only. I must keep to a 50 minute session time in order to respond to voice messages in a timely manner.

Phone consultations lasting over 5 minutes are subject to a fee. Consider the need for a more immediate appointment if a longer conversation is necessary. My usual business hours are Monday – Friday from 9:00am to 9:00pm. I have obligations at other sites besides Los Gatos, which requires me to be out of the office on certain days and times. These days and times will be noted on my voice mail system. All consultations outside of my usual business hours are subject to an emergency service fee. **NOTE:** Insurance companies frequently will not reimburse you for emergency pages and phone sessions.

DIRECTIONS:

1. **From East Bay:** 880 (or 17) south, Camden exit to the left, under the freeway, right lane, right on Bascom Avenue, last business complex on right before Hwy 85, two story building with darkly tinted windows, closest building to Hwy 85.
2. **From West Bay:** 280 south, 85 south (towards Gilroy), Los Gatos Blvd./Bascom Ave exit, left over freeway, first business complex on left, two story building with darkly tinted windows, closest building to Hwy 85.

If you have any questions regarding any of this information, please do not hesitate to call. I look forward to meeting you and your child soon.

Thank You,

Tonja H. Krautter, Psy.D., L.C.S.W

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APPLICATION FOR SERVICES

CONSENT FORM

Name of Patient _____ Date of Birth _____

In making application for services at the office of Tonja H. Krautter, Psy.D., L.C.S.W, it is understood that:

1. My child may be administered diagnostic and treatment procedures at the office of Dr. Tonja H. Krautter, as may be determined necessary by Tonja H. Krautter and as approved by myself, the parent or guardian.
2. Medical and other records concerning my child may be maintained by Tonja H. Krautter's office and may be made available to Tonja H. Krautter and her staff when needed in the assessment or treatment of my child. These records will be kept confidential and are for the use of Tonja H. Krautter's needs only.
3. Tonja H. Krautter may communicate with my child's physician and /or the professional who referred us to her concerning this evaluation.
4. I have read and understand the enclosed statement of Policies Concerning Privacy, Confidentiality, and Patient's Rights. (Page 5)
5. In case of an emergency, when it is the opinion of the professional staff that my child be seen by a doctor promptly, and it is impossible to reach my physician, a doctor known to the clinical staff will be called and treatment provided.

Child's Physician _____

(name, address, and phone # of physician and/or medical agency)

Call in Emergency _____
(name, address, phone #, and relationship to child)

APPLICATION FOR SERVICES (continued)

6. Tonja H. Krautter will endeavor to safeguard the children in her care, but Tonja H. Krautter is not responsible for accidental injuries and assumes no liability for injuries occurring without fault or negligence of any member of the staff.
7. Tonja H. Krautter accepts a patient into treatment in an effort to determine whether he or she can benefit from the services available. If in the opinion of Tonja H. Krautter, he or she is not able to benefit, withdrawal will be recommended and other plans discussed.
8. In service of providing the best possible treatment, Tonja H. Krautter may communicate with a consultant regarding my child and his/her treatment taking care to maintain my anonymity.
9. I have agreed to a set fee of \$ _____. I understand that Tonja H. Krautter's standard fees may be raised on an annual basis and that I will have at least one-month prior notice to any such changes. At this time a new contract will be signed.
10. I have read and understand the section entitled Getting Started and will abide by those guidelines for services.

Signature of Parent/Guardian

Date

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Policies Concerning Privacy, Confidentiality, and Patients' Rights

Your application for services at the office of Tonja H. Krautter, Psy.D., L.C.S.W, includes questionnaires that I request you complete and return to me about your child and family. In receiving subsequent services at Tonja H. Krautter's office, additional information will be requested. This information is necessary for us to have in order to offer and provide appropriate and indicated diagnostic and treatment services. My policy and practice attempts to safeguard your family's rights to privacy and confidentiality of this information are the following:

1. All information, both written and oral, which your family provides to Tonja H. Krautter, will be maintained in confidential files.
2. This information, as well as all of Tonja H. Krautter's diagnostic and treatment reports or other information concerning you and your child, will NOT be made available to other individuals or agencies without your written consent, except in the case of legal order or subpoena.
3. All information concerning your family will be utilized within the office of Tonja H. Krautter, by professional staff, in order to determine indicated and appropriate diagnostic and treatment services to be offered and provided to your child.
4. If I determine it appropriate, you may have access to Tonja H. Krautter's reports and information concerning your child and may review them with Tonja H. Krautter at a mutually convenient time. You may have copies of particular reports at your expense.
5. By law and for patient safety, certain items are not to be kept confidential including: reports of abuse to children or elders, report of neglect, intent to harm someone, and domestic violence. Reasonable suspicion is all that is necessary. Although confidential, if a child or adult reports intent to harm themselves or someone else, or reports grave disability, I consider that to be important enough to act upon to ensure safety, which at the least includes alerting the parent or guardian. I consider significant drug or alcohol use and prostitution as self-harm.

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Child's Name: _____
Your Name: _____

1. Please describe in your own words the concerns or problems you wish to discuss:

2. How long has the problem existed?

3. What ways have you tried in the past to handle this problem? Have you sought other help, and if so, with whom?

4. How do you hope I can be of help?

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AUTHORIZATION FOR RELEASE OF INFORMATION:

School, Other Agency, Other Treatment Provider
(make a copy of this form for each place or provider)

I authorize Tonja H. Krautter, Psy.D., L.C.S.W and :

Provider name: _____

Address: _____ Phone: _____
_____ Fax: _____

to exchange information about:

Child's name: _____ Birthdate: _____

Including, but not limited to medical records, lab results, psychological testing, medication records, school reports, etc. This information is to be used solely for the purpose of evaluation/diagnostic workup/treatment planning/preparing court report/treatment, other:

_____ This authorization has the following exceptions: _____
This authorization is valid for _____ time from the date signed.

Signature (patient) Date

Signature (parent or guardian) Date

Signature (parent or guardian) Date

* Note: If divorced or separated parents with custody difficulties, both signatures will be needed please.

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AUTHORIZATION FOR RELEASE OF INFORMATION:
CHILD'S PHYSICIAN/PSYCHIATRIST
(Make copy for each one if needed)

Date: _____

Physician/Psychiatrist's name and address:

Medical or Psychiatric (please circle)

Dear Dr. _____,

My child, _____, is currently being seen by Tonja H. Krautter, Psy.D., L.C.S.W for a diagnostic evaluation and psychotherapy treatment.

I give my permission for: (check all that apply)

_____ an exchange of information between Tonja H. Krautter and yourself.
_____ release of records to Tonja H. Krautter.

Tonja H. Krautter, Psy.D., L.C.S.W may be contacting your office for pertinent records in order to better help my child. Please send all requested information to the above address. Thank you for your help.

Parent Signature, Date