PARTNERS
STEPHEN A. FELKER, Ph.D., ABPP
MAUREEN T. FORSTON, Ph.D.
JOHN P. McCANN, M.A.
MICHELLE M. MORRIS, Ph.D.
LINDA A. WILSON, Ph.D.

FOR OFFICE USE ONLY:

RECEIVED ON: _____
ENTERED INTO EHR: _____
INSURANCE VERIFIED: _____
GAVE TO CLINCIAN: _____

COLUMBUS PSYCHOLOGICAL ASSOCIATES, L.L.P.

2325 BROOKSTONE CENTRE PARKWAY / COLUMBUS, GA 31904
PHONE: (706) 653-6841
FAX: (706) 653-7843

INDEPENDENT CONTRACTORS

ANDREW KOLIANI, PSY.D.
ASHLEY MALCHOW, PH.D
CHRISTIE ANDERSON, PH.D.
DANIEL ROSE, PSY.D.
DAVID WALKER, PH.D.
DOLORES TARVER, PH.D.
FRANCES SUE ANTHONY, M.S., LPC
HEATHER LIPP, ED.S., LPC
JULIE ROSE, PSY.D.
KORINNE BABEL, PH.D.
LENN ARRINGTON, ED.S., LPC
ROBERT CARLSON, PH.D.
TRACIE PORTER, M.S.,LPC

Adult Patient Information
(please print clearly)

Date _____ Therapist _____

Full Legal Name _____

Address _____ City _____ State _____ Zip_____

Home Phone _____Work Phone _____Cell Phone _____

SSN _____ Date of Birth _____Sex _____ Marital Status _____

Place of Employment _____ Occupation _____

Education _____ Religion_____

Ok to leave message at home? _____ Ok to leave message at work? _____ Ok to leave message on cell? _____

How would you like your appointment reminder? Specify telephone number: _____ TEXT/VOICE

OR Email address: _____

Spouse _____ Date of Birth _____ SSN _____

Place of Employment _____ Occupation _____

Education _____

Work Phone _____ Cell Phone _____ Religion _____

Children (list names and ages) _____

_____

Name of your Primary Care Physician _____

how were you referred to us? _____

Person we should contact in case of an emergency:

Name	Phone Number	Relationship

Please tell us days/times that you are available for appointments: _____

_____

Please note: Cancellations require a 48- hour prior notice. Please see Policies and Procedures.

Diagnosis _____ Date _____ Policies and Procedures Discussed Date _____Initial _____

Briefly describe your reasons for seeking treatment, list your current symptoms and difficulties:

List significant previous or present physical problems/diagnoses and dates:

List current medications, including dosage, starting date and prescribing physician:

Any Allergies? _____

Are there any other special circumstances or problems you are concerned about (i.e., legal, work, family, financial)? List sources of stress:

Previous psychological and/or psychiatric treatment/hospitalization; List dates, therapists, reason for therapy and outcome:

Describe any drug/alcohol abuse; include 1) current use, 2) amount and 3) history of abuse/dependency treatment:

INSURANCE INFORMATION

Name of Primary Insurance	Name of Secondary Insurance
Policyholder's Full Name	Policyholder's Full Name
Policyholder's date of birth	Policyholder's date of birth
Policyholder's Social Security Number	Policyholder's Social Security Number
Policyholder's Employer	Policyholder's Employer
Policy/ID Number	Policy/ID Number
Group Number	Group Number
Insurance Telephone Number	Insurance Telephone Number

Patient's or authorized signature. I consent to treatment and I authorize the release of any medical information necessary to process my claim.

SIGNED_____ DATE_____

I authorize payment of medical benefits to the above named therapist.

SIGNED_____ DATE_____

Do we have your permission to send a letter of acknowledgement to the person who referred you to our office?
Yes _____ No _____

SIGNED_____ DATE_____

Columbus Psychological Associates
Consent to Release Information to Primary Care Physician (PCP)

I, _____, residing at:

_____

Address City State Zip

Hereby give my informed consent for _____ to
Name of Clinician

(Please circle)
1. Talk with and/or
2. release written documentation

Regarding my treatment to _____.
Name of Primary Care Physician

I understand that my records are protected under Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug Abuse and under the general laws of my state and cannot be redisclosed without written consent, except as specifically stated by law.

I understand that, under Federal law, the above-named provider may release information from my record without my consent when:

1. there is indication of child abuse or abuse of disabled adults;
2. given best clinical judgment, there is indication of dangerousness to self or others (suicidal or homicidal);
3. Required to present records to comply with a court order.

I understand that Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate state or local authorities.

This authorization remains in effect as long as I remain an active patient at Columbus Psychological Associates. I understand that I may revoke my authorization to release information at any time in writing and such revocation will be effective on the date of receipt of my revocation. In the event action already has been taken prior to said receipt of revocation, such prior actions are covered by the preexisting release.

_____ _____
Signature of Member Date

_____ _____
Signature of Witness Date

Policies and Procedures

Please read this information and feel free to discuss any questions you may have.

PLEASE KEEP A COPY FOR YOUR RECORDS.

Health Insurance Portability and Accountability Act

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Georgia Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Independent Contractors

Some of the mental health clinicians providing mental health services at Columbus Psychological Associates are independent contractors and are not agents or employees of Columbus Psychological Associates. Independent contractors are responsible for their own actions and Columbus Psychological Associates shall not be liable for the acts or omissions of any such independent contractors.

Confidentiality

All communications between client and therapist will be held in confidence, and will not be revealed to anyone unless you (or parent, in the case of a minor) give written authorization to release this information. Your legal right to privileged communication between a licensed psychologist and a client will be upheld unless overruled in a court of law during a legal proceeding. Georgia law requires that confidentiality be waived when the patient's or other's personal safety is threatened or when disclosure of child abuse is made to the therapist. If we determine that a patient presents a serious danger of violence to another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

Occasionally, your therapist may choose to consult colleagues about your case. Your identity will be protected during these consultations. Consultations will be noted in your PHI or clinical record. We request that you complete a Release of Information form so that we may be in contact with your personal physician. Information routinely released to insurance companies for reimbursement for services shows only a diagnosis, the dates of service, charges and payments. In order to file your insurance, it is necessary for you to sign the Release of Information form.

You may recognize other people here. We expect you to maintain confidentiality concerning the identities of these people. If it is necessary to contact you at home or work we will be discrete. You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Contacting Us

Due to our work schedules we are often not immediately available by telephone. While we are usually in the office between 9 AM and 5 PM, we probably will not answer the phone when we are with patients. When we are unavailable, our staff, our voice mail or our answering service answers our telephone. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If we will be unavailable for an extended time, we will provide you with the names of colleagues to contact, if necessary.

Professional Records

You should be aware that, pursuant to HIPAA, we keep **Protected Health Information** about you in two sets of professional records. One set constitutes your PHI. It includes information about your reasons for seeking therapy, a summary description of the ways in which your problem impacts on your life, your diagnosis, the goals we set for treatment, your progress towards goals, your pertinent medical history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

In addition to the PHI, we also may keep a set of Psychotherapy Notes. These Notes are for our own use and are designed to assist us in providing you with the best treatment. Notes are kept separate from your PHI. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Medical Support Services

Sometimes the most effective and efficient treatment of psychological problems requires the use of medication and/or hospitalization. Your private physician or a psychiatrist may be consulted to assist in these matters.

Minors and Parents

Unemancipated patients under 18 years of age and their parents should be aware that the law allows parents to examine their child's treatment records unless we believe that doing so would endanger the child or be counter therapeutic. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is [sometimes] our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Termination of Treatment

Termination of treatment should always be discussed with your therapist. Termination will occur automatically if you have not been seen in a therapy session for 4 weeks from the date of your last scheduled session, unless there is a prior agreement to leave your case open for a specified amount of time.

Financial Arrangements and Insurance

During your initial visit to our office, we will discuss the hourly charge for our services the terms of payment, filing for health insurance, reimbursement and any other questions you may have regarding our administrative and financial procedures. Our primary concern is to provide you with the best professional service that we can offer you. New clients are required to see the Business Office before exiting the premises. Further, we feel that everyone benefits when definite financial arrangements are agreed upon.

Accordingly, the following procedures are provided for your information:

1. For therapy, your initial consultation is **$215.00** with subsequent 53+ minute individual sessions being billed at **$200.00,** 60-minute individual or family sessions being billed at **$200.00,** and 45-minute family sessions being billed at **$175.00.** **Co-payments/ Deductibles/ Co-Insurances are due at the time of each session.**

   For psychological assessment, you will be billed **$130.00** per hour for testing and reports. Co-payments or deposits based on the estimated cost of the assessment are due at the time of your appointment.

2. It is your responsibility to pay your bill. Our office will be glad to file your primary and secondary insurance for you (please provide our office with a copy of your insurance card). We cannot file tertiary insurance. A statement will be mailed to you monthly. Exceptions are made for those who have insurance carriers that are contracted with our office. **Inevitably, if your insurance company is unwilling to pay, it is your responsibility to make payment and contact the insurance company.**

3. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, **you (not your insurance company) are responsible for full payment of our fees.** It is very important that you find out exactly what mental health services your insurance policy covers and if you need to

obtain a preauthorization. You should carefully read the section in your insurance coverage booklet that describes mental health services. If your employer offers an Employee Assistance Program (EAP), it is your responsibility to inform our office of this coverage prior to being scheduled. **Our practice does not participate in the EAP program.** You must provide the billing address, telephone number and number of covered visits. Please note, we cannot guarantee payment for EAP services that are contracted through another facility and our office is not contracted with all EAP programs. If you have questions about the coverage, call your plan administrator.

"Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Personal Health Information. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. By signing this Agreement, you agree that we can provide requested information to your carrier. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above [unless prohibited by contract].

4. Interest charges may be added to the balances on accounts beyond 60 days past due. Collection procedures may be pursued after 60 days.

5. Since your time is reserved exclusively for you, you will be billed for any appointment cancelled without prior notification. ***Please see attached Cancellation/No Show Policy.***

6. In addition to weekly appointments, we charge **$200.00** per hour for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, any telephone conversations that are clinical in nature, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. **If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the complexity of legal involvement, we charge $250 per hour for preparation and attendance at any legal proceeding as well as consultation time with attorneys.**

7. We accept Visa/MasterCard.

8. Checks that are returned for Non-Sufficient Funds will carry a $35.00 penalty or be turned over to a collection agency if payment is not made to this office in cash or money order within 10 days of notification.

9. Our office hours are 8:00 a.m. – 6:00 p.m. If you are seen after 6:00, you are responsible for leaving your co-payment with your therapist, dropping payment in the drop box or you may contact our Business Office the following day for clarification on any insurance or billing matters.

10. You are encouraged to ask questions regarding any aspect of your treatment in this office.

11. In respect to minor children, the custodial parent or legal guardian needs to provide signatures on all documents.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF COLUMBUS PSYCHOLOGICAL ASSOCIATES AND AGREE TO ABIDE BY ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE AND HEREBY GIVE CONSENT TO BE TREATED.

_____ _____

Signature **Date**

Late Cancellation/Missed Appointment Policy

Our current late cancellation/missed appointment policy is unique to psychotherapy practices. We ask that you read it and consider it carefully to reduce the chance of misunderstandings that may hinder your progress in therapy.

We reserve a therapeutic hour for each person(s) scheduling an appointment; and our income is based entirely on the hours we see patients. If someone cancels late or misses an appointment, we incur a loss of income for that hour and are not able to offer that time to someone who may be waiting, possibly in crisis. **Therefore, we must have an agreement that the appointment will be kept or, if you must cancel, we need to have ample notice in order to avoid this type of loss.**

Regardless of cause, COLUMBUS PSYCHOLOGICAL ASSOCIATES, requires a 48-hour notice on a cancellation in order to release you from your responsibility for that time scheduled. **You will be billed $150.00 for late cancellations and missed appointments.** Please note that insurance companies do not reimburse for cancelled sessions.

If you have circumstances that may make it difficult for you to keep your appointments, please discuss this with your therapist during your intake session.

I/we agree to the above terms of the late cancellation/missed appointment policy of Columbus Psychological Associates and will make prompt payment on any charge I/we incur for a late cancellation or missed appointment. I fully understand the therapeutic and economic necessity of such a policy.

_____

_____ _____

Signature(s) Date

GEORGIA NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (PHI), for *treatment, payment and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment" Payment and Health Care Operations"*
  -*Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  -*Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  -*Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within our [office, clinic, and practice group] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our [office, clinic, practice group], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided that each revocation is in writing. You may not revoke and authorization to the extent that (1) We have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

GEORGIA NOTICE FORM, continued

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse-* If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.

- *Adult and Domestic Abuse-* If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authorities.

- *Health Oversight Activities-* If we are the subjects of an inquiry by the Georgia Board of Psychological Examiners, we may be required to disclose protected health information regarding you in proceedings before the Board.

- *Judicial and Administrative Proceedings-* If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety-* If we determine, or pursuant to the standards of our profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

Guarantor Financial Responsibility

Every patient is responsible for knowing the specific requirements of their insurance companies. With so many different insurance plans, it is unrealistic for our staff to know the specific requirements for all policies. Please let us know if you are required to have or use one of the following:

1. **Authorization/Pre-certification** requirement for mental health treatment.

2. **A written referral from your Primary Care Physician (PCP).** It is the patient's responsibility to obtain referral prior to their appointment.

If you are unsure about your insurance requirements, please contact your employer's personnel/human resources representative at your work or your insurance agent prior to your appointment.

I have read the above and understand that it is my responsibility to make sure all insurance requirements are fulfilled. It is also my responsibility to notify this office of any changes in my insurance. I agree to be responsible for all charges incurred with Columbus Psychological Associates that result from non-covered services or patient's failure to meet insurance requirements.

_____ _____

Date **Signature**

Email Policy

1. RISK OF USING EMAIL

Provider offers clients the opportunity to communicate by email. Transmitting client information by email, however, has a number of risks that clients should consider before using email. These include, but are not limited to, the following risks;

- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email can be immediately broadcast worldwide and received by many intended and unintended recipients.
- Email senders can easily misaddress an email
- Email is easier to falsify that handwritten or signed documents.
- Backup copies of email may exist even after the sender or recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.
- Email can be used as evidence in court.

2. CONDITIONS FOR THE USE OF EMAIL

Provider will use reasonable means to protect the security and confidentiality of email information to be sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the clients must consent to the use of email for client information. Consent to the use of email includes agreement with the following conditions:

- Provider may forward emails internally and securely to Provider's staff but only as may be necessary for diagnosis, treatment, or reimbursement. Provider will not, however, forward emails to independent third parties without client's prior written consent, except as authorized or required by law.
- Although Provider will endeavor to read and respond promptly to an email from a client, Provider cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus the client shall not use email for emergencies, crises or other time sensitive matters.
- If the client's email required or invites a response from Provider, and the client has not received a response within a reasonable time period, it is the client's responsibility to follow up to determine whether the intended recipient will respond.
- The client should not use email for communication regarding sensitive information unless both parties use encryption.
- The client is responsible for protecting his/her password or other means of access to email. Provider is not liable for breaches of confidentiality caused by the client or any third party.
- Provider shall not engage in email communication that is unlawful, such as practicing medicine across state lines.
- It is the client's responsibility to follow up and / or scheduled an appointment if warranted.

3. INSTRUCTIONS

To communicate by email, the client shall:

- Inform Provider of changed in his / her email if necessary.
- Put the client's name in the body of the email.

- Include the category of the communication on the email's subject line, for routing purposes (e.g. billing question, appointment change, and etc.).
- Review the email to make sure it is clear and that all relevant information is provided before sending to Provider.
- Inform Provider that the client received and email from Provider.
- Take precautions to preserve the confidentiality of email, such as using screen savers and safeguarding his / her computer password.
- Withdraw consent only by email or written communication to Provider.

4. CLIENT ACKNOWLEDGEMENT AND AGREEMENT

Client initiation of contacts with Provider via e-mail will constitute consent for e-mail communication, within the above guidelines, unless otherwise communicated in writing.

_____ **Date:** _____

Patient Acknowledgement