Ann E. McNeer, Ph.D.

Clinical, Consulting, and Forensic Psychology Services

Patient Information Form

Patient's Name: _____ Birthdate: ____/____/____

Address: _____

City/State/Zip: _____Home Phone: _____

Occupation or School: _____ Work Phone: _____

Yrs of Education/Highest degree:_____ Cell Phone: _____

Email Address: _____ Best place to contact you? _____

May I leave a message at this number? _____

Emergency Contact: (Name/phone)_____

Employer (Name/Address): _____

Other People Living in the Home:

Name	Age	Relationship	Work Phone
1)			
2)			
3)			

Person Responsible for Bill: (if not Patient)

Name: _____ Date of Birth: _____

Address: _____ Employer: _____

City/State/Zip: _____ Relationship: _____

Insurance Information:

Insurance Company Name: _____

Is this an HMO __ PPO __ What is the name of the company managing the behavioral health contract, if different?

_____

Were you given an authorization number? Y N If so, what was it? _____

Send Claims to: _____

Member ID # _____Group #:_____

1004 Bombay Lane ▪ Roswell, Georgia 30076 ▪ Phone/Fax (770) 667-9559

Please Read and Initial/Sign Below:

Acknowledgements:

_____ I have been provided with a copy of the **HIPAA Notice** to review.

_____ I have read and understand the Patient Memorandum regarding the terms of service for this evaluation.

_____ There is a 24 hour cancellation policy. I will be charged for any appointments cancelled with less than 24 hours notice.

_____ I understand that all charges are due at the time services are rendered and that I am fully responsible for missed appointment charges incurred as insurance does not cover missed sessions.

---------- Interest will be charged on outstanding balances more than 60 days old at the rate of 1.5% per month. In the unlikely event that my account balance remains unpaid, **I will be responsible for collection costs**. Dr. McNeer may use a collection agency, small claims court or other such entity to assist in collections.

Authorizations

I authorize the release of any medical information **necessary** to process insurance claims or authorizations. I understand that, if I procure services through a managed care company, this information may be specific or substantial.

The initial session is an evaluation session to see what services are needed. If my insurance company fails to authorize such a service (CPT code 90801), I will be responsible for this initial cost.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, automobile insurance, workers compensation, or any other health plan to Ann E. McNeer, Ph.D. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges as allowed in my insurance contract (if applicable) whether or not paid by insurance.

Signature Date

Pre-Surgical Psychological Evaluation Questionnaire

Current Height: _____ Current Weight: _____ Current BMI: _____

Highest adult weight (excluding pregnancy): _____
Age when you reached this weight? _____
How long did you stay at this weight? _____

Lowest adult weight: _____
Age you reached this weight? _____
Length of time you maintained this weight? _____

What is the most weight you have ever lost? _____

At what age did you begin having weight issues? _____
How old were you when you went on your first diet? _____
Number of supervised or formal diet attempts? _____
What plans have you tried? _____
_____
What was the most successful diet plan you tried? _____

How much would you like to weigh? _____
What procedure are you seeking? Gastric sleeve Lap band Roux-N-Y BPD/DS

Current Marital Status: Single Married Divorced Live-in Partner Widowed
Number of marriages: _____

Who will be your support person(s) for surgery and recovery?

On average, in the past 3 months, how often have you exercised? _____ times per week or _____ times per month?
Do you binge eat? (Eat unusually large amounts of food in one sitting) _____
How old were you when you began bingeing? _____
During the past 3 months, how often have you had an eating binge?
Monthly: _____per month
Weekly: _____per week
Daily: _____per day

Have you ever made yourself vomit after eating to get rid of food? Y N
Have you ever used laxatives to control your weight or get rid of food? Y N
Have you ever taken diet pills, diuretics or other weight control medications? Y N

If so, please list them:

Do you have a history of physical or sexual abuse as a child? Y N
Were you psychologically abused as a child? Y N
Were you exposed to domestic violence as a child? Y N
Have you been in a domestic violence situation as an adult? Y N
Do you have a history of mental health issues? Y N
Have you been in psychotherapy or counseling before? Y N
If so, for what types of problems?

Name of most recent therapist?

When did you last undergo treatment?

Have you ever taken (or been prescribed) medications for psychological problems? Y N
If yes, please list:

I use alcohol _____times per _____
Drug use history Y N
Tobacco use Y N
Prescription Drug abuse history Y N
Do you gamble? Y N

History of legal involvements: (type/year)

Please list any family members who have experienced mental health issues/drug/alcohol abuse.

Current Medical Problems: (list)

Do you have a history of any serious accidents/injuries/surgical procedures? Y N
If so, please list:

What medications are you currently taking? (list name and dosage)

Pre-Surgical Evaluation Consent Form

_____ I have read the Health Insurance Portability and Accountability (HIPAA) initial forms and have had an opportunity to seek any clarification needed.

_____I acknowledge that I am seeking this evaluation at the request of a third party. (The goal of this evaluation is to provide your surgeon with information about how you are functioning psychologically and issues which may affect your success following bariatric surgery. It is NOT therapy.)

Because of this, I understand that the results of this evaluation will be summarized and sent as a report directly to my surgeon. I agree to complete the authorization form releasing the report to my surgeon (see next page). I will not receive a copy of this report unless I request copy of it from my medical records after the report has been issued.

_____Payment is due at the time of the evaluation and no report will be written until the account is paid in full. The self-pay fee is $350.00 and Dr. McNeer accepts payment in the form of cash, checks or credit cards. If you are covered by an insurance plan and have obtained pre-authorization for the evaluation, Dr. McNeer will need to collect your copayment at each session.

This evaluation will consist of an interview, obtaining a psychosocial and medical history, and psychological testing. A follow-up session may be held towards the end of the process in order to clarify any lingering questions and provide general feedback and/or recommendations. If this is necessary, a separate fee will be assessed for this visit. If not covered by insurance, this session will be billed at $85.00.

_____If I am using insurance, I agree to release all information necessary to process the claim submitted to my insurance company.

I understand and agree to the above terms. I consent to participate in the pre-operative psychological evaluation.

_____

Name (Printed)

_____

Signature Date

Memorandum

To: Patients Receiving Weight Loss Surgery

From: Ann E McNeer, PhD

RE: Recommendations based on your pre-surgical psychological evaluation

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Your surgeon should receive my report within 1-2 weeks of your pre-surgical psychological evaluation. There are three basic types of recommendations regarding surgical candidacy. For most patients, I recommend that the person is a good candidate and ready to undergo surgery. For a smaller number of patients, I recommend that, if the patient undergoes surgery, she be followed closely through the process by a mental health provider. A third recommendation may be that the patient is not a good candidate for surgery, or should not have it until some other steps are taken. This last recommendation is rare.

Having worked with a large number of morbidly obese patients seeking surgery, I have concluded many things. I am impressed that almost all candidates have made repeated genuine efforts to lose weight with a frustrating lack of success. In many cases, a serious medical problem has developed placing the patients' lives at risk if weight loss is not achieved. I am also impressed that nearly all patients have learned a good bit about the surgery and considered its risks and benefits carefully. I do not see many patients with serious emotional instability or other problems severe enough to keep them from having surgery. However, I do see many patients who could use some degree of monitoring of their adjustment following surgery, an accessible resource to contact, and an expert resource able to respond to any serious adjustment problems personally.

A very important purpose in recommending approval for psychological follow-up is to enable an otherwise qualified person to have the surgery without delay, rather than have the surgery refused or postponed pending completion of other steps. **If your pre-surgical psychological exam results in a recommendation for the surgery contingent upon psychological follow-up, your cooperation will be needed.** You may get started with an appropriate mental health provider you know or you might call a referral service (such as the Georgia Psychological Association at (404) 634-6272 or www.gapsychology.org) to locate a provider in your area who is suitable for you. You should do this as soon as possible after receiving this recommendation and notify your surgeon so contact can be established. **Attached is an information page you should keep to give to your chosen provider, explaining your referral circumstances. Please fill in your name and your surgeon's name and phone number in the spaces provided.**

If you have any questions regarding your pre-surgical psychological exam, the recommendations made for you, or these instructions, please bring them up during your exam appointment or give me a call.

Memorandum

TO: Mental Healthcare Provider

FROM: Ann McNeer, PhD

RE: Patient Name: _____

Surgeon Name: _____

This patient has been seen for a pre-surgical psychological evaluation for weight loss surgery. He/she was recommended favorably for surgery contingent upon being followed closely by an appropriate mental healthcare provider. It was determined that there were some limited but important concerns which would have implications for his or her post-operative adjustment. This patient should receive relevant treatment, including at least an appropriate degree of monitoring and support following surgery.

Post-operative adjustment is often stressful as radical changes in eating behavior are imposed and there are painful consequences for overeating. This is often only discovered by the patient through trial and error. If the patient is the family cook or plays a central role in family eating patterns, this may cause additional stress.

Once substantial weight loss occurs, social relationships and/or marital relationships often change. These changes may be experienced as threatening or otherwise upsetting. If the patient has had an eating disorder rooted in an obsessive personality style, when the outlet of eating is removed there is likely to be distress and the potential for symptom substitution. It is not unusual for a different compulsion to develop.

Please be alert for these and other changes with which the patient may require support. This patient's surgeon has received my report and understands the importance of coordination of care with you.

Please secure a release from the patient and fax a copy to me in order to receive a copy of the report. Do not hesitate to call for any reason.

Consent to Release Information

I, _____, hereby request that Ann E. McNeer, Ph.D. release protected healthcare information from my medical file for the purpose of:

Surgical candidacy
Follow-up Psychological Care

The information to be released includes:

Behavioral observations	Results of testing
Family/Social information	Developmental history
Diagnosis/Prognosis	Report of an evaluation

I would like Dr. McNeer to release this information to the following person(s):

_____

Name Telephone

_____

Address

_____

Name Telephone

_____

Address

I understand that this release will remain in effect for six (6) months unless I rescind or extend it in writing. Should I choose to rescind it, the information already released will not be included in the rescission.

_____

Signature Date

_____

Witness Date

Pre-Surgical Evaluations and Psychological Testing

To Prospective Patients:

My office will file a claim with your insurer as a courtesy to you. However, due to ongoing changes that have occurred relating to Weight Loss Surgery procedures, you must be aware of your financial responsibility. It is required by insurance companies that patients have a full Psychological Evaluation but insurance payment for such services is often contingent upon the surgery meeting medical necessity criteria. Benefits quoted by the insurance company are based upon the insurer's determination of medical necessity and the benefits quoted are not a guarantee of payment. If the surgery turns out not to be "medically necessary", all services related to the surgery will be denied.

Please understand that the payment you have been quoted for your services today is only a partial payment unless your insurance company states otherwise. I am required to collect copayments and any known unmet deductible on the date of services. If additional payment is required per your insurance company, you will receive a bill for the balance.

Please sign below to indicate your awareness that you may receive an additional bill after claims have been processed, and that you agree to pay these charges. Payment will be expected within 15 days of receipt of your bill which will come from A/R Management Services. If you are unable to pay your balance in full at that time, please call my office to make payment arrangements.

_____ _____

Patient Name Date

Policy on Appointments: No Show/Late Cancellation

Statement of Understanding and Agreement

Dr. McNeer has a policy to charge for appointments that are not kept or cancelled less than 24 hours in advance. This will be charged directly to the patient. Insurance will not cover this.

When you schedule an appointment, Dr. McNeer sets aside a block of time just for you. If you give 24 hours of advance notice that you will not be in need of it, Dr. McNeer has a reasonable chance of scheduling another patient for that block of time. Without advance notice, it is very unlikely that she will be able to fill your slot. Please understand that, while most types of doctors charge for services they perform and may book several patients in a single time slot, Dr. McNeer's professional services involve a great deal of personal interaction with her patients and she schedules only one patient within a single large block of time.

Dr. McNeer understands that an emergency may make it impossible for you to cancel at least 24 hours in advance. However, she must still enforce this policy because she has committed her time for your appointment.

I have read and understand that I will be billed $50 for sessions which I miss or fail to cancel at least 24 hours in advance. I agree to pay those charges in full prior to the next session. I understand that insurance will not pay for this.

_____ _____

Signature (Patient, Parent, Guardian) Date

NOTICE FORM (HIPAA)

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.

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

I 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 I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 my 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 my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II._Uses and Disclosures Requiring Authorization

I 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 I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I 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.

III.__Uses and Disclosures with Neither Consent nor Authorization

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

- ***Child Abuse*** – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- ***Adult and Domestic Abuse*** – If I 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, I must report that belief to the appropriate authority.
- ***Health Oversight Activities*** – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I 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 I provided you or the records thereof, such information is privileged under state law, and I 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 I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- ***Worker's Compensation*** – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV._ Patient's Rights and Psychologist's Duties

Patient's Rights:

- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will post my new policies at my office. Current patients will also receive a copy by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me, Ann E. McNeer, Ph.D. at 770-667-9559.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to me at 1150 Upper Hembree Rd., Roswell, GA 30076.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. _Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by posted notice in my office. Current patients will also receive a mailed notification of the change.

Please indicate to what extent you have experienced these symptoms in the past month.

(1= None; 2= A slight problem; 3= A problem I need to address; 4= this REALLY gets in my way)

	1	2	3	4
Feeling sad, blue				
Overwhelmed				
Less pleasure in previously enjoyable activities				
Weight Gain/Loss (not intentional)				
Unusual sleep patterns				
Easily angered, explosive				
Agitated				
Feeling worthless or guilty				
Anxious				
Racing thoughts				
Intrusive recurring thoughts or impulses				
Excessive shopping/sexual activity/impulsive plans				
Unpredictable moodiness				
Trembling/shaking/sweating/palpitations				
Chest pain/nausea				
Dizziness				
Fear of losing control/dying				
Panic attacks				
Thoughts of harming yourself				
Thoughts of harming someone else				
Recurrent intrusive memories of a traumatic event				
Difficulties concentrating				

Problems with organization or procrastination				
Problems following multi-step directions				
Hearing intrusive voices				

Do you have a history of self-harm or suicide attempts? Y N

Have you been exposed to domestic violence, sexual abuse/rape, or combat? Y N

Do you have a history of using illegal drugs or misusing prescription or nonprescription drugs? Y N

Have you ever been in trouble with the law – or are you currently involved with the legal system for any reason? Y N