Ann E. McNeer, Ph.D.
1004 Bombay Lane
Roswell, GA 30076

Welcome to the Office!

This packet contains information for our first meeting. Please read through everything and complete the forms. If you have any questions, bring them to my attention when we meet, and I will be happy to go over them with you.

From whom did you learn about my services: (circle one)

Insurance Company Attorney Doctor Friend Other ________________

May I contact the person who referred you to thank them for the referral? Yes No

If so, please complete a **release of information form** in this packet so I may contact them.

Are you currently working with another professional, such as a doctor or attorney with whom I should coordinate? Yes No

If so, please provide complete a copy of the **request for information form** for this person to receive.

Symptom Checklist:

There are 3 symptom checklists attached. Please choose **the one appropriate for the age of the patient** and bring it with you, completed.

Attached documents include a **HIPAA Privacy Notice and a Psychotherapist Patient Agreement**. Please review these carefully and sign for/acknowledge their receipt.

Patient Information Form

Patient's Name:____ Birth date: ____/____/____
(First) (Initial) (Last) Age: _____ Grade: ________
Address:____

City/State/Zip: ____Home Phone: _________________

Occupation or School: ______________________________________ Work Phone: _________________
Employed: Fulltime Part-time Unemployed Disabled
Student: Fulltime Part-time

Best number to contact you: ___________________________________ ***Cell Home Work*** **(circle one)**
May I leave a confidential message on the voicemail? Y N
Would you like to receive secure email from my office? Y N
Email Address: ____

Marital status: Single Married Other ____

Other People Living in the Home:

Name	Age	Relationship	Work Phone
1)			
2)			
3)			
4)			

Person Responsible for Bill: (or "same")

Name: ____ Birth Date:___________________________
Address: ____
City/State/Zip: ___________________________________ Work Phone: ________________________

Insurance Information:
Policyholder's Name: ____

Address: ____

Policy Holder's Employer: _____________________________Birthdate: ___________________________

Insurance Name: ____Phone:______________________________

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: ____
City/State/Zip: ____

Member ID # _________________________Group #:______________________

Patient's Relationship to Policy Holder: Self Spouse Child Other

In a few words, what is bringing you in to see me today?

What **symptoms** would you like me to be aware of?

Current **prescription or nonprescription** medications:

Who prescribes these?

Have you been in psychotherapy or counseling before? Yes No

If so, give the name of your therapist and approximately when/how long seen:

Do you have a primary care physician? Yes No

If so, please provide your physician's name and telephone number.

May I provide treatment information to them if your insurance company wants me to? Yes No

Are you currently being treated for any medical conditions? Yes No

If so, what are they?

Please list any allergies you have.

Family History:

Has anyone in your family experienced problems in the areas of mental health, alcohol or drug abuse? If so, please list their relationship to you and the problem area.

ADULT Checklist: 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

Amount of alcohol you consume: _________________ drinks per day/week/month (circle one)

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

Are you having marital or relationship problems: Y N

TEEN Checklist: 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				
Easily overwhelmed				
Don't enjoy the activities you used to				
Weight Gain/Loss (not intentional) or appetite change				
Unusual sleep patterns (too much/little, waking up often, less need for sleep)				
Easily angered, explosive, fighting with friends or parents a lot				
Agitated				
Feeling worthless or guilty				
Anxious, nervous, jumpy				
Racing thoughts, unusually talkative, change topics randomly				
Intrusive recurring thoughts or impulses				
Excessive sexual activity/impulsive plans for which you will get in trouble				
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				
Tired all the time				
Difficulties concentrating				
Problems with organization or procrastination				
Problems following multi-step directions				
Hearing intrusive voices				

Are you currently sexually active? Y N

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

How much alcohol do consume? ___________ drinks per day/week/month (circle one)

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

Child Checklist: **Please indicate to what extent your child has experienced these symptoms in the past month.**

(1= None; 2= A slight problem; 3= A problem I need to address; 4= this is REALLY a big one)

	1	2	3	4
Feeling sad, blue				
Easily overwhelmed				
Doesn't enjoy the activities he used to				
Weight Gain/Loss (not intentional) or appetite change				
Unusual sleep patterns (too much/little, waking up often, less need for sleep)				
Easily angered, explosive, fighting with friends or parents a lot				
Bullying or cruel to animals				
Feeling worthless or guilty				
Anxious, nervous, jumpy, can't sit still				
Racing thoughts, unusually talkative, change topics randomly				
Intrusive recurring thoughts or impulses				
Refusing to attend school, eat certain foods, or other typical activities				
Facial or vocal tics				
Trembling/shaking/sweating/palpitations				
Does not listen when spoken to				
Dizziness, headaches, stomachaches				
Poor peer relationships and social interactions				
Change in attitude towards school or in grades				
Thoughts of harming herself				
Preoccupation with restricted interests				
Tired all the time				
Difficulties concentrating				
Problems with organization or procrastination				
Problems following multi-step directions				
Lying, rule violation, property destruction, stealing				

Is this child adopted? Y N If so, at what age and from what country? ____________________

Does he have a history of self-harm or suicide attempts? Y N

Has she been exposed to domestic violence, sexual abuse/rape? Y N

Does this child have a history of head injury? Y N

Does this child have any learning disabilities or a 504 Plan/IEP at school? Y N

Were there complications with the pregnancy, delivery, or early developmental stages? Y N

If yes, describe briefly:____

Ann E. McNeer, Ph.D.
1004 Bombay Ln.
Roswell, GA 30076

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) a day or two before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **https://www.annmcneerphd.com** to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: ____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Your email address: ____

Your cell phone number: ____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

--- --------------------------
Signature Date

Please Read and Sign Below:

Acknowledgements:

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

Signature Date

Agreements:

I have read and agree to the terms of the **Psychotherapist-Patient Services Agreement**.

Signature of Patient, if over age 12 Date

Signature of Legal Guardian, if consenting for a minor Date

For Parents of Teens: As the legal guardian, I agree to waive my access to my minor child's clinical record and receive, instead, updates on progress and attendance.

Signature Date

Summary of Account Information:
I understand that all charges are due at the time services are rendered and that I am fully responsible for missed appointment charges incurred. These charges will be in the amount of one full therapy session as insurance does not cover missed sessions. I am responsible for all missed appointment charges unless the therapist is notified a minimum of 24 hours in advance.

Attendance is important and 2 consecutive missed appointments or 3 cancelled appointments will constitute an interruption of treatment. My file will be closed until you call to reinstate treatment services.

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. I understand that, if I procure services through a managed care company, this information may be specific or substantial. (Insurance companies may have the right to review my files.)

The initial session is an evaluation session to see what services are needed. If my insurance company fails to authorize such a service (e.g., CPT code 90791), I will be responsible for this initial cost.

I authorize payment of insurance benefits to Dr. Ann McNeer if full payment is not made at the time of service.

Signature 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

Ann E. McNeer, Ph.D.

REQUEST FOR INFORMATION

I, ______________________________________, hereby request that the person/entity listed below release to Dr. Ann E. McNeer information contained in my/my child's protected healthcare records.

____

Name Phone/Fax

____

Address

I am releasing this information for the purpose(s) of :

____

____

The information I would like released includes:

Intake information _____
Discharge information______
Medication history _____
Family history_____
Psychosocial background _____
Progress Notes _____
Prognosis _____
Educational history _____
Results of testing _____
Legal history _____

Dr. McNeer would like this information in the following form:

Telephone consultation _______
Written Summary ______
Copies of actual notes/reports _____
Other: (state below)

____

I understand that this release of information is good for six months or until ___________ __________________________________. I may withdraw my consent for the release of information at any time, however information already released will not be affected.

Patient Name: ____

Signed by: ____

Print Name: _______________________________Date: ________________

Relationship to Patient: ____

Witness: ____

1004 Bombay Lane ◊ Roswell, GA 30076 ◊ 770-667-9559

Ann E. McNeer, Ph.D.

Consent to Release Information

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

____

The information to be released includes:

Behavioral observations | Results of testing
Family/Social information | Developmental history
Diagnosis/Prognosis | Report of an evaluation
Information about Family Members | Confirmation of appointments

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

1004 Bombay Lane ◊ Roswell, GA 30076 ◊ 770-667-9559

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and 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. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I 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 me unless I have taken action in reliance on it; if there are obligations imposed on me 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.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for **a very active effort on your part**. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have **benefits and risks**. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session per week at a time we agree on, although some sessions may be more frequent. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If it is possible, I will try to find another time to reschedule the appointment.

It is very important to attend sessions if you want to get the benefits of psychotherapy. Your active participation in your healthcare is encouraged. However, patients who miss two sessions in a row without canceling, or who have multiple (3) consecutive cancellations, will be considered to have interrupted their treatment and their file will be closed. Although you will be expected to pay for sessions not cancelled with 24 hours notice, you will have to call Dr. McNeer in order to reinstate yourself as a patient.

PROFESSIONAL FEES

My hourly fee is $160.00 for the first session and $140.00 thereafter. If you miss an appointment without at least 24 hours advance notice, I will charge a late cancellation fee of $50. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, 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 me. 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 I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $250.00 per hour for preparation and attendance at any legal proceeding.]

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone as I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I 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 me of some times when you will be available. In emergencies, you can call the emergency number given on the voicemail. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- I have a contract with outside businesses for billing and filing purposes. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient threatens to harm himself/herself, or another person, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

- 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 to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

- If I determine that a patient presents a serious danger of violence to another, I 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, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I 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. Except in unusual circumstances that involve danger to yourself and others or if it makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you or your legal representative may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I

recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of $.15 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others), which I will discuss with you upon request.

In addition, for some patients, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record [and information supplied to me confidentially by others]. These Psychotherapy Notes are kept separate from your Clinical Record. 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.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my usual 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, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. (In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.)

If your account has not been paid for more than 60 days, interest will be charged at the rate of 1.5% per month on outstanding balances. After 60 days, and if other arrangements for payment have not been agreed upon or met, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "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. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.]

You should also be aware that **your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you**. I am required to provide a clinical diagnosis. Sometimes I am required to provide

additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

Your signature on the **Patient Information Form** indicates that you have read this agreement and agree to its terms.

Rev 09/12

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

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. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I 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 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.

My signature on the **Patient Information Form** acknowledges that I have read this Notice.