Atlanta Psychological Services
2308 Perimeter Park Drive • Suite 100 • Atlanta, GA 30341
AtlantaPsychological.com
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Client Information & Communications Agreement

Check the clinician you will be seeing:

___ J. Todd George, PsyD. ___ Andrew Gothard, PsyD
___ Carolyn Johnson, PhD ___ Yoshitaro Oba, PhD
___ Jessenia Rodriguez, PsyD ___ Angela Stewart, PhD, LPC

Date: _____

Who referred you to our office? _____
(Or how did you find us?)

Name of person completing this form: _____

Relation to client: _____

CLIENT INFORMATION

Client's Name: _____ **Client Date of Birth:** _____
(First Name, Last Name)

Client Address: _____

City: _____ State: _____ Zip Code: _____

Circle most appropriate option:

Gender Identity: Male - Female - Transgender - Choose not to disclose - Other:_____

Sexual Orientation: Lesbian, gay, or homosexual - Straight or heterosexual - Bisexual - Unknown

Choose not to disclose - Other:_____

Race/Ethnicity: American Indian or Alaska Native - Asian - Black or African American - Hispanic or Latino

Native Hawaiian or other Pacific Islander - White or Caucasian - Choose not to disclose

Other: _____

Relationship Status: Single - Married - Divorced - Partnered - Other:_____

Client Status: Full-time employed - Part-time employee - Student - Unemployed/Other

(For Children)
Parent/Guardian's Name: _____

Guardian's relationship to client: _____
(i.e., mother, father, foster parent, case manager, etc.)

Insurance and Payment Information

Client Social Security Number: _____

Payment Source (Check or initial only one from below):

___ Insurance (only one plan): The client has only one insurance plan (and I am authorizing this clinician to bill this insurance plan for services received).

___ Insurance (multiple plans): The client has primary and secondary insurance plans (and I am authorizing this clinician to bill these insurance plans for services received).

___ Self-Pay: The client will pay for services via cash, check, or credit card.

___ 3rd Party Pay: The services will be paid for by another party or agency (i.e., DFCS, Court, etc.).

(If applicable) Primary Insurance Information:

Insurance Company Name: _____Policyholder's Member ID #: _____

Policyholder's Name: _____Policyholder's Date of Birth: _____

Relationship to Client: _____
(child, spouse, mother, father, etc.)

(If applicable) Secondary Insurance Information:

Insurance Company Name: _____Policyholder's Member ID #: _____

Policyholder's Name: _____Policyholder's Date of Birth: _____

Relationship to Client: _____
(child, spouse, mother, father, etc.)

Primary Care Provider (PCP) or Pediatrician Information (required)

Primary Care Provider Name: _____ PCP Phone Number: _____
(Physician or Pediatrician's Name)

PCP Fax Number: _____ PCP Email (if known): _____

COMMUNICATIONS AGREEMENT

Check preferred contact method:

☐Home Phone #: _____ Voicemail Ok? (circle) YES or NO

☐Cell Phone #: _____ Voicemail Ok? (circle) YES or NO
Text OK? (circle) YES or NO

☐Work Phone #: _____ **Email Address:** _____

**Only include contact information you approve for us to use to reach you (Text messaging is limited to appointment reminders only, and will not to be used for treatment or other services)*

By signing and submitting this form, you are agreeing to the following acknowledgment:

My clinician and/or other employees of Atlanta Psychological Services may contact me using the electronic contact information I entered above.

My clinician and APS employees will limit their disclosure of my medical information and Protected Health Information (PHI) when communicating with me indirectly (via phone or otherwise).

I understand that I am responsible for the device or platform I use in communicating electronically with APS employees and my clinician. I know that I should communicate only on a device that I know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password-protected, not accessing the internet through a public wireless network, etc.).

If an email address is provided above, you give APS employees and your clinician permission to contact you through this means.

> *Our email platform is hosted by Google Suites with Paubox Encryption, which meets federal standards for protecting medical information and is HIPAA compatible. A Business Associate Agreement (BAA) has been signed with both companies, meaning they have attested to HIPAA compliance and assume responsibility for keeping your medical information secure.*
>
> *If email is authorized, we encourage you to also use encrypted email for protection on your end (several options are available at www.TeleHealth.org). Otherwise, when you reply to one of your clinician's emails, everything you write in addition to what he/she has written to you (unless you remove it) will no longer be secure. Our encrypted email service only works to send information and does not govern what happens on your end.*
>
> *For evaluation reports, providing your email address allows you to receive the report as soon as possible.*

I understand that if I (or my child) am experiencing an emergency situation and need to contact someone immediately to help, I will call any of the emergency numbers that are listed on the consent for treatment form. **If you are in a crisis, please do not communicate this to us via email or electronic means because we may not receive it in a timely matter.**

I understand that I can revoke or amend this agreement at any time.

Any revocation or change will not apply to communications already completed.

_____

Client's Name (Please Print)

For Adults:

_____ _____

Client's Signature **Date**

For Children:

_____

Parent's or Legal Guardian's Name (Please Print)

_____ _____

Parent's or Legal Guardian's Signature **Date**

FOR OFFICE USE ONLY

Your clinician's signature below indicates that he or she has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Psychologist's or Therapist's Signature **Date**