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Consent to Receive Psychological Services, Confidentiality Statement & Payment 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

Please review the following information. With your signature and submission of this form, you are agreeing to the following:

For adult patients: I consent to receive psychotherapy, psychological testing, or other professional services from the above noted clinician at Atlanta Psychological Services.

For child patients (and patients with legal guardians): I consent for my child (or individual I am legally responsible for) to receive psychotherapy, psychological testing, or other professional services from the above noted clinician at Atlanta Psychological Services (APS).

Confidentiality & Records: I understand that communications with me (or my child) will become part of a clinical/medical record, and this information is referred to as Protected Health Information (PHI). I understand that all information disclosed by me (or my child) in therapy or during a psychological evaluation is maintained in strict confidence and this information will be kept private and secure according to HIPAA procedures and standards.

Any information about me (or my child) that is stored electronically in any means will be encrypted and otherwise stored and maintained in compliance with HIPAA requirements.

In the event of the clinician's death or disability, my (or my child's) clinical record will be maintained by Atlanta Psychological Services. If records are requested, or desired, and the office can legally and ethically provide those to you, the Practice Manager will make those records available.

I understand that no information pertaining to my (or my child's) therapy or evaluation will be released to other parties without my consent, with the following exceptions:

- I have signed a **"Release of Information"** form allowing my (or my child's) clinician to release information.
- My clinician is **ordered by a judge** to disclose information about me (or my child).
- If my (or my child's) clinician determines that I (or my child) am a **danger to myself or to others**, confidentiality may be broken to ensure you (or your child) are safe.
- **Mandated Reporting:** If my (or my child's) clinician receives information that suggests a child, an elderly person, or a disabled individual has been **abused or neglected** and is at substantial risk of being harmed, the clinician is legally and ethically required to report such concern to the Division of Family and Children Services (DFCS) for that individual's protection.

- **For billing purposes**, I am authorizing necessary disclosures to be made to my (or my child's) insurance company related to billing for any services furnished.
- I understand that I am authorizing the release of any information contained in my (or my child's) medical record to any relevant third party, or to its assignees, as requested by such third parties as necessary to pay any particular claim.

Psychotherapy and Counseling

Psychotherapy: I understand that information that I (or my child) provide to a clinician in therapy is legally termed “**privileged communication**,” meaning that it is my (or my child's) right as a client to have a **confidential relationship** with a therapist. However, I understand that in very rare circumstances, a court may order the disclosure of my (or my child's) private information. I understand that if I am receiving couples therapy or family therapy, my therapist does not agree to keep secrets, and any information revealed in any context may be discussed with other family members involved.

Professional Relationship: Psychotherapy is a professional service, and the relationship between you (or your child) and the clinician must remain professional, as there is the potential for harm if your clinician were to interact with you (or your child) in other, non-professional ways.

Statement Regarding Ethics, Client Welfare & Safety: The services provided to you (or your child) will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that we are not performing in an ethical or professional manner, please discuss this with your (or your child's) clinician immediately so we can work to resolve your concern.

Psychotherapy Considerations: Due to the nature of psychotherapy, your (or your child's) therapist cannot guarantee specific results regarding therapeutic goals. However, with active participation, we will work to achieve the best possible results for you (or your child). Please also be aware that changes made in therapy may affect other people in your life (or your child's life).

At times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you (or your child) begin discussing certain sensitive areas of your life. However, a topic usually is not sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success.

Psychotherapy with children: If I am bringing my child for psychotherapy, I agree to allow my child to have some degree of privacy in his or her relationship with the therapist. It is my expectation that I will be made aware of my child's general progress in therapy, but I understand that I may not be informed of specific details of what is discussed in therapy. However, I do expect that the therapist will inform me of any serious health or safety issues of which my child may be at risk, with the understanding that this determination will be made by the therapist.

Please speak with your child's clinician at the onset of treatment, and as necessary, with any questions or expectations you may have about privacy and disclosure of information shared in therapy.

Termination of treatment: If I (or my child) am an ongoing therapy client, I understand that if I miss a scheduled appointment, and a session is not re-schedule within 60 days, my clinician will understand that as notice that I have voluntarily terminated services for myself, and the therapeutic relationship and case file will be closed or terminated. However, I can have the file re-opened and services resumed by calling the office and scheduling an appointment with my clinician.

Psychological Evaluation and Testing

I understand that if I (or my child) am receiving a psychological evaluation for diagnosis and treatment planning (without court involvement), the outcome of the report will be discussed with me, and I will be asked to sign a

release of information form if the report is to be released to any other individual or agency.

Professional Relationship: Psychological evaluation is a professional service, and the relationship between you (or your child) and the clinician must remain professional, as there is the potential for harm if your (or your child's) clinician were to interact with you (or your child) in other, non-professional ways.

Statement Regarding Ethics, Client Welfare & Safety: The services provided to you (or your child) will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association. If at any time you feel that we are not performing in an ethical or professional manner, please discuss this with your clinician immediately so we can work to resolve your concern.

Psychological Evaluation Considerations: The goal of a psychological evaluation is generally to answer questions regarding your (or your child's) functioning in a variety of areas, depending on the reason for referral. This may include assessment of your (or your child's) cognitive, academic, neuropsychological, emotional, personality, parental, psychosexual, developmental, and/or social functioning.

Psychological evaluation is generally accomplished through in-depth interviews, collection of collateral information, review of records, observation, and administration of standardized and non-standardized testing measures.

The results of the assessment include a description of functioning and are usually interpreted and integrated into a psychological report, which reviews the history, provides test data, and provides a detailed analysis of results.

Diagnostic impressions are usually offered, as are recommendations for further direction. However, diagnoses are not always clearly defined and may be provisional as symptoms continue to emerge.

Psychological evaluation is generally a low-risk process. It is, however, possible that clients may feel some discomfort or anxiety at the prospect of being tested and during the evaluation itself.

Additionally, the possibility exists that the clinician's findings, diagnoses, opinions, and recommendations may not necessarily be on par with what you expect or desire, and you may not agree with conclusions drawn. This is especially true for forensic evaluations.

Payment Agreement and Fees

By my signature below, I acknowledge that I am ultimately responsible for payment of all fees in the event that payment is not received by a third party for any reason.

Acceptable forms of payment: Cash, checks, and credit cards.*

- Unless alternative payment arrangements have been made prior to the delivery of services, payment is due at the time services are delivered.
- This office will provide, upon request, a receipt of payment.
- There is a \$25 fee for any returned checks.
- *There is a 4% convenience fee added if you choose to use a credit card.

Health Insurance: The billing specialists at our office will do their very best to determine the benefits of your (or your child's) insurance and any costs you may be responsible for before completing the service. However, insurance companies have many rules and requirements specific to certain plans, and the cost for services may be higher or lower once the service is billed to the insurance.

After the insurance receives the bill for service, the resulting Explanation of Benefits (EOB) from the insurance company customarily outlines any patient costs or responsibilities that were due for the completed services.

If I (or my child) have health insurance, with my signature below I am giving permission for appropriate charges to

be billed to the insurance company.

If I choose for my (or my child's) insurance not to be billed, I will discuss that with the provider.

Psychotherapy/Counseling Fees

- All therapy services are billed at \$200/hour, including the initial intake and subsequent session.

Doing psychotherapy by telephone is not ideal, and I understand that needing to talk to my therapist between sessions may indicate that I need extra support, but I understand that any telephone calls that exceed 10 minutes in duration will be billed at \$10.00 for every 6 minutes.

Psychological Testing and Evaluation Fees

The fee for psychological evaluations is:

- \$200* per hour, which includes:
 - The clinicians total time for interviewing,
 - Records review (if applicable),
 - 3rd party/collateral contact interview(s) (if applicable),
 - Testing materials, scoring, interpretation of tests, and
 - Preparation of the written report.

**\$275 per hour for custody-related and court/legally-related evaluations.*

Evaluation and Testing fees include retroactive billing for any substantial professional time required from the time of the initial referral or inquiry (e.g., phone calls and/or e-mails related to case coordination) prior to the first appointment.

Psychological evaluation reports will not be completed and/or released until payment for the evaluation is made in full, regardless of the source of payment.

If it is expected that an insurance company will pay for an evaluation, we will make every reasonable and possible effort to obtain payment from that insurance company. However, a pre-authorization for payment from an insurance company is not a guarantee of payment. **If the insurance company does not pay for an evaluation for whatever reason, the report will not be completed and/or delivered until the service is paid for by the client.**

Feedback: You are encouraged to ask questions and seek feedback on your psychological evaluation report. This can be done in one of several ways. If you have questions that can be answered in a brief e-mail response or brief telephone conversation (less than 10 minutes), this will be provided free of charge. If you desire a feedback session, these are \$200 for a one hour session (*\$275 for custody-related evaluations).

Depositions and court testimony are \$375/hour, which includes all time required out of the office (i.e., including drive time) and/or time scheduled that the clinician otherwise would not be able to schedule or see clients. All preparatory time needed prior to the date of testimony is billed at \$275/hour, including for example all time needed in reviewing the file, preparation with the attorney, and/or needed communications related to preparation for testimony. I understand that if I request court testimony, I will be advised at that time of additional policies, such as retainer amount needed, minimum billable time that is applied to retainer, cancellations, or potential refunds.

I understand that the fees noted above are subject to future increases.

Cancellation Policy: I understand that if I do not show for an appointment, or if I cancel an appointment with less than 24 hours notice, I will be financially responsible for that session. I understand that insurance companies do not reimburse for missed sessions. I further understand that repeated late cancellations or failure to show for scheduled appointments may result in my (or my child's) termination as a client.

In Case of an Emergency: Atlanta Psychological Services is an outpatient facility. The clinicians at this office are not available at all times. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, we will return phone calls or emails within 24-48 hours during the workweek.

If you have a mental health emergency, we encourage you not to wait for a call or email response, but to do one or more of the following:

- Call Ridgeview Institute at 770-434-4567
- Call Peachford Hospital at 770-454-2302
- Call the Georgia Crisis and Access Line at 1-800-715-4225
- Call 911
- Go to your nearest emergency room.

Privilege and Court Related Services

- If you are receiving a psychological evaluation or therapy at the request of an attorney or agency (e.g., court system or other agency like DFCS), it is customary to give that referring individual or agency “privilege” to the final report, conclusions of the evaluation, and/or therapy notes and findings.
- When you give privilege to someone or an agency, this means that only that individual or agency will be able to receive the final report/therapy notes and conclusions, and this information will be sent directly from your clinician to the referring individual/agency designated as holding privilege.
- Designating privilege over the evaluation/treatment findings also means that person or agency must give your clinician permission to release the findings to anyone (including you).
- Your evaluation/treatment findings could also be disclosed by the clinician if the clinician is court-ordered to release this information.
- In court-related evaluations/therapy, you are also agreeing that anything you disclose to the clinician is subject to being included in the evaluation/therapy report.

I understand that by receiving an evaluation/therapy for any court or other legal or administrative related purpose, I am paying for the clinician’s professional time involved, regardless of the clinician’s ultimate diagnoses, findings, opinions or recommendations and the impact that those diagnoses, findings, opinions or recommendations have on my case.

Please choose one: (required)

____ My evaluation/therapy is not court related, and I am not designating privilege over the results to an individual (i.e., attorney) or agency (i.e., DFCS). I wish to receive the results directly from the clinician.

____ My evaluation/therapy is court related, and I understand that I am giving “privilege” over my evaluation/therapy findings to the following individual (i.e., attorney’s name) or agency (i.e., DFCS):

Individual/Agency Name: _____
Name or agency you give privilege of the report to (i.e., DFCS, attorney name, court)

3rd Party Release: Do you give this clinician permission to release information in the future to anyone that the above named holder of privilege allows the clinician to send information to? (circle one) YES NO

Client's Name (Please Print)

My signature below indicates that I have:

- 1) Read, been advised of, and understand the above information and that I give informed consent for me to receive psychological services under these conditions,
- 2) Read and I understand the [HIPAA Georgia Notice](#) form,
- 3) Read and I understand the [Social Media Policy](#) form.

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