THE BRAIN CENTER
5605 Princeton Ave. Ste. A
Columbus, GA 31904
(706) 221-0112 – Fax (706) 221-0114

Psychotherapist-Patient Contract

Welcome to my practice! This document contains important information about my professional services and business policies. Please read it carefully! When you sign this document, it will represent an agreement between us.

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 bring forward. 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 benefits for people who go through it. 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.

Comprehensive Psychological Evaluations are another service offered at The Brain Center. Psychological Evaluations consist of several individual sessions in which various tests are administered to help in the diagnostic process and treatment planning. Once Psychological testing has been completed Dr. Kocsner will then gather all the data and put into a form of a Psychological Report which you will receive a copy. Due to the individual nature of psychological testing and the insurance companies unique process of such services your financial responsibilities regarding psychological testing will be communicated with you specifically by office staff. Additional fees/co-payments may be included. **It is each patient's responsibility to verify his or hers benefits with the insurance company prior to Psychological testing.**

Dr. Kocsner does not do custody or workman's compensation evaluations.

Billing and Payments
You will be expected to pay the applied responsibility at the time of service, unless we agree otherwise. If your account has not been paid for more than 60 days, we have the option of using legal means to secure the payment. We are in contract with a Collection Agency for which your account will be turned over to after 120 days.

Professional Fees
You will be charged a $80 no show fee for not arriving to your appointment in a timely manner. We allow a 15-minute grace period; however after 15 minutes the no show fee will apply. Canceling an appointment without a **24-hour business day notice** will also result in a $80 no show fee. **After the second no show appointment you will be discharged from the practice**

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- Patients with an outstanding balance over 60 days will be charged a late fee of $10 for every 30 days the account is past due. Accounts with a balance of 30 days or older will not be scheduled any future appointments.
- We charge $1.00 per page for copying of your medical records. However, if you have an outstanding balance on your account this must be resolved before any medical records are released.
- We charge $15 for an additional copy of the psychological report. Additional paperwork that is to be filled out by the doctor there is a $40 charge; paperwork requiring more time involved may have additional fees. You must come in to the office to complete a request form. Specific fees for such services will be communicated with you and must be paid in full before services are rendered. Fees will depend on the length of the required paperwork. And again, all outstanding balances must be resolved.
- We charge $30 to send medical records to Social Security. Social Security typically pays $15 for the records and you are responsible for the remaining balance of $15. Records will be sent once the $15 fee is paid in full in the office or over the phone.
- Dr. Kocsner does not get involved in any legal proceedings including divorce/custody. A $200 hourly fee goes into effect for any court-related activities including travel, appearance, preparation of materials. This fee is not reimbursed by your insurance company.
- You will be charged a fee of $35 for any returned checks we receive in reference to your account.
- At times, Dr. Kocsner will release some test materials for you or the teachers to complete. You will be charged a fee of $20 for the loss of such materials.

All professional fees are subject to change at any time.

Phone Calls to the Doctor

Our physician will not be doing telephone medicine; if you need to talk to the doctor we can arrange an appointment for you. Calling the doctor after hours with a non emergency issue will result in a charge; insurance companies do not pay for this service, therefore this charge is your responsibility. Non-emergency phone calls will be returned within a 24 hour period.
If you need medical care or in case of an emergency when the office is closed, please go to the nearest hospital or contact the Bradley Center 2000 16th Avenue Columbus, GA 31901 (706) 320-3700.

Insurance Reimbursement

Our staff will file an insurance claim as a courtesy to you; however, you (not your insurance company) are responsible for full payment of the fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Before the initial visit can be scheduled, you will need a referral authorization from your primary care physician. **It is your responsibility to obtain the referral for this visit and/or any additional visits. Any outstanding balance over 120 days old will be turned over to our collection agency Receivable Management Group Inc.**

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Minors
A parent or legal guardian must accompany patients who are minors on all visits. This accompanying adult who consents to treatment is responsible for the payment of the account. The accompanying adult must have the correct documentation to be able to consent to the treatment. Because privacy in psychotherapy is often crucial to progress, the release of any treatment records will be subject to the clinician's judgement.

Confidentiality
The law protects the privacy of all communications between a client and a psychologist. In most situations I can only release treatment information to others if you sign a written authorization according to HIPAA.

There are situations where I am permitted/required to disclose information without your consent/authorization:

1. If you are involved in a court proceeding and a request is made for information concerning the professional services, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your written authorization, or a court order.
2. If a government agency is requesting the information for health oversight activities, we may be required to provide it;
3. If a client files a complaint or lawsuit against our office, we may disclose relevant information regarding the client in order to defend ourselves;
4. If a client files a worker's compensation claim, and we are providing treatment related to this claim, we must, upon appropriate request, furnish copies of all medical reports and bill. You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies for the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we 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. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your insurance carrier

Note: Our practice does not provide worker's compensation evaluations.

Though unusual, there are situations in which we are legally obligated to take action that we believe will protect others from harm, and may have to reveal some treatment information about the client:

1. Any reasonable suspicion of suicide, homicide, child abuse, abuse of a disabled or elderly person, or if a client presents a serious danger or violence to another. Such a situation arises, we will make every effort to fully discuss it with you before taking action and we will limit my disclosure to what is necessary and to authorities (police, hospital staff, DHR) who are necessary.

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Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature of Client (if client a minor, parent or legal Guardian's signature)

Date

_____

Print Parent/Guardian

_____

Print Client Name

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Welcome to our practice! Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

Today's Date: _____

Patient Information

Name: _____ Date of Birth: _____
Age: _____ Sex: _____ Social Security #: _____
Address: _____ City: _____
State: _____ Zip: _____
Home Phone: _____ Cell: _____
Occupation: _____ Employer: _____

Name of School Currently Attending (if applicable):
_____ Grade: _____
Referred By: _____ Phone: _____
Address: _____

Please list phone numbers that we may contact you at and/or leave a message:

Phone Number:	Leave a Message (circle one):
_____	Yes / No
_____	Yes / No
_____	Yes / No

Client Family History

Is patient adopted/foster child? ( ) YES ( ) NO

Biological Mother's Name: _____ DOB: _____
SS#_____
Education/Occupation: _____

Biological Father's Name: _____ DOB: _____
SS#_____
Education/Occupation: _____

Who has legal Physical/Medical custody of above client? Be advised, answer this question based on legal documentation.
( ) Mother ( ) Father ( ) Both ( ) Other

If patient is adopted/foster court documentation must be on file with our office before patient can be treated!

Please print name(s) of legal custodian(s) of above client:

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Legal Guardian Contact Information
Name: _____
Address: _____
Work Phone: _____ Home Phone: _____
Cell Phone: _____ Relationship to Client: _____

Emergency Contact Information
Name: _____
Address: _____
Work Phone: _____ Home Phone: _____
Cell Phone: _____ Relationship to Client: _____

Financial Information

Name of Person Responsible for Bill: _____
Relationship to Client: _____ Social Security #: _____
Date of Birth: _____ Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

****Responsible Parties Signature:** _____

Primary Insurance Company (Insurance Company that we file the claim with first.)

Name of Insurance Co.: _____
Name of Policy Holder:_____
Policy Holder's Address: _____
Insured's Date of Birth: _____ Relationship to Client: _____
Policy # of Insured: _____ Group #: _____
Insured's Employer: _____

Secondary Insurance Co. (if *applicable*)

Name of Insurance Co.: _____ Policy # of Insured:_____
Name of Policy Holder:_____ Insured's Date of Birth:_____

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Authorization to Release Information and Assignment of Benefits

I hereby authorize Dr. Franciska Kocsner, or any member of The Brain Center's Staff, to release to my insurance company or companies any information acquired in the course of my examination or treatment.

You are hereby authorized to pay to The Brain Center (Dr. Franciska Kocsner), Basis Benefits and/or Major Medical Benefits for medical expenses otherwise payable to me for treatment.

In making this assignment, I understand and agree any unpaid balance not covered by this policy will be paid by me. I understand that filing of insurance does not guarantee payment.

_____ _____

Clients Name (Printed) Date

_____

Signature of Client (if client is a minor, parent or legal Guardian's signature)

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Financial Policy and Agreement

The following guidelines have been established in order to clarify any questions:
If you have health insurance, we will be glad to assist you in determining coverage, filing claims and seeking reimbursement. However, we cannot guarantee insurance reimbursement. All fees charged are the direct responsibility of the client.

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is your responsibility to follow up with your insurance company to make sure they pay your claims.

If your insurance coverage for mental health services requires pre-authorizations, you must call for authorization. Your insurance company will not pay for services that have not been authorized.

Payment for co-pays and deductibles is due at the time services are rendered. Payments may be made by cash, check, or credit cards (Visa or MasterCard).

We cannot and will not become entangled with various arrangements set forth in divorce decrees and the like. Therefore, payment for any and all services rendered will be expected from the guardian that escorts the patients to his/her appointments. If your insurance company does not pay within 90 days, the unpaid balance is due from you.

Financial Agreement: I understand the above financial arrangements. I, also understand I will receive a statement each month, if there is a balance due from me.

_____ _____

Clients Name (Printed) Date

_____

Signature of Client
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Counseling, Confidentiality and Private Practice Agreement

I am aware, and I acknowledge that no guarantees have been made to me as to the results of treatment at The Brain Center.

I agree to collaborate with Dr. Franciska Kocsner and other appropriate professional staff members for the purpose of assessments and evaluation of my current situation and to work together to identify appropriate goals and methods of achieving them.

I understand that over the course of therapy, whatever assessments, tests, or other clinical care that is recommended will be fully explained to me, and that I have the option to accept or reject such care.

I understand that the office may call my home or another designated location and leave a message on voice mail, or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and any call pertaining to clinical care.

I have read the above and give my consent to the counseling process. I have also read and understand the office of The Brain Centers statement regarding the limits of confidentiality.

I have had an opportunity to ask questions to seek any clarification I needed about these important materials.

_____ _____

Clients Name (Printed) Date

_____

Signature of Client
(if client is a minor, parent or legal Guardian's signature)

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Reprocessing Claims Fee Policy

The initial packet that you are completing upon your first visit at The Brain Center is an important document and is required by your insurance company. **Withholding insurance information or falsely reporting the patient's insurance information is not only illegal but also causes unwanted delays in services requested.** When insurance companies become aware of another coverage they request a refund of ALL previous payments made to The Brain Center creating an unwanted financial situation.

It is your responsibility as the patient/parent or guardian of the patient to know the patient's insurance coverage and to report it to our office correctly before the scheduled appointments.

If you are unsure of the patient's insurance coverage, it is your responsibility prior to your appointment to contact your insurance company for the needed information. This includes becoming knowledgeable of your Behavioral Health Benefits. It is also your responsibility to notify our office of any changes in the patient's insurance coverage immediately!

If for any reason during your treatment at The Brain Center a claim is denied due to incorrect insurance information there will be a $25.00 reprocessing fee that will be charged to your account and is NOT payable by the insurance company. There are no circumstances that would justify excusing you from being responsible for this fee. The Brain Center staff will be happy to assist you with any concern or questions, but we cannot take the responsibility of investigating the patient's correct healthcare coverage at the time of service.

The Full payment of the Reprocessing Fee is required before further treatment!

I agree and promise to abide by the above terms of the Reprocessing Claims Fee policy of The Brain Center. I fully understand the necessity of such a policy.

_____ _____

Clients Name Date

_____

Signature (Guardian)

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Late Cancellation/Missed Appointments Policy

Please, take your time to read our missed appointment and late cancellation policy to reduce the chance of any misunderstandings.

We reserve a set time frame for each of your scheduled appointments. Our income is based entirely on the time the doctor sees patients. If someone cancels late or misses an appointment, we incurs a loss of income for that time and are not able to offer our services to someone who may be waiting. As part of your treatment, you are required to abide by The Brain Center's Cancellation/ Missed Appointment Policy. This policy requires you to keep your appointment, or if you must cancel do it within a reasonable amount of time. Missing half or more of your scheduled appointment time will prevent our clinician from being able to perform the necessary procedures to the best of her ability.

Regardless of cause our office requires a **24 business hours** notice (excluding Saturday and Sunday) on a cancellation in order to release you from your responsibility for that time scheduled. Otherwise, you will be billed **$80.00**for late cancellations/missed appointments. Please be advised that insurance companies do not reimburse for cancelled/missed sessions. **Full payment of the No Show fee is required within 30 days in order to avoid cancellation of all scheduled appointments.**

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

_____ _____

Clients Name Date

_____

Signature (Guardian)

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Billing of Psychological Report Scoring/Writing

Producing of psychological reports is something that is unique within the mental health field and it is a procedure that operates differently than a regular doctor's visit. This notice pertains to the writing of psychological reports. After Dr. Kocsner has completed psychological testing with you or your child, she will still need to score all of the tests that were administered during the testing process. She will also have to interpret the scores and write a psychological report. Please be advised that the patient has the option to receive a short diagnostic letter or a comprehensive psychological report that contains more detailed information. The amount that is charged for the report will be based on the amount of testing that needs to be scored and interpreted. You are also given the option to self-pay for these services. However, If you choose for our office to bill your insurance company for the report writing, then you are being held responsible for your insurance provider and your specific policy. The completion of the report will most likely to on days that the patient is not physically in the office. Therefore, you may not be in the office at the time that your insurance has been charged for these services. All co- payments for the days that the report is written will apply and you will be responsible for paying any co-payments and/or fees that are determined by your insurance provider. If you have any questions about these co-payments, please contact your insurance provider.

Please complete only one of the following options:

I, _____, will be responsible for any balance that is associated with report scoring and writing. Please DO NOT bill my insurance provider.

I,_____, would like The Brain Center to bill my insurance provider and I will be responsible for any co-pays that are associated with the report scoring and writing.

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NO AUDIO/VIDEO RECORDING OR STILL PICTURES OF ANY KIND ARE PERMITTED BY LAW!

Due to HIPPA laws and the privacy of others, we cannot permit any cell- phone usage on The Brain Center premises.

If these rules are being violated services will be discontinued and you will be asked to leave.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I, _____, agree that phones are prohibited in our office.

Print Name_____

Date _____

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Notice of Privacy Practices

Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____
Relationship to patient (if signed by a personal representative of patient):_____

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RELEASE OF INFORMATION CONSENT FORM

I, _____ _____, hereby give my permission for the
First Name Last Name
following release of information by Dr. Franciska Kocsner at The Brain Center:
The items covered by this release listed below:

1. Intake Assessment
2. Psychological Evaluation
3. Treatment Plan
4. Discharge Summary
5. Other:_____

This information is being released for the following reasons:

_____

_____

Name of agency, hospital, doctor or therapist: _____
Mailing Address:

_____

_____
City State Zip-Code

- I understand that this release may include information regarding drug and alcohol abuse and treatment, as well as psychological and psychiatric information
- I understand that the information to be released is protected under state and federal laws that do not permit re-disclosure without my further consent.
- PHI (Protected Health Information), once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA

Patient's Name (print):_____

Date of Birth: _____
Month Day Year

_____
Signature of Client (if client is a minor, parent or legal Guardian's signature) Date

_____
Signature of Witness Date

_____

REVOCATION OF CONSENT

In revoking consent, I understand that this does not affect any of the ways you used my protected health information while you still had my permission to do so.

_____
Signature of Client (if client is a minor, parent or legal Guardian's Signature) Date