**THE BRAIN CENTER**

5605 Princeton Ave. Ste. A

Columbus, GA 31904

(706) 221-0112

Fax (706) 221-0114

# New Patient Instructions

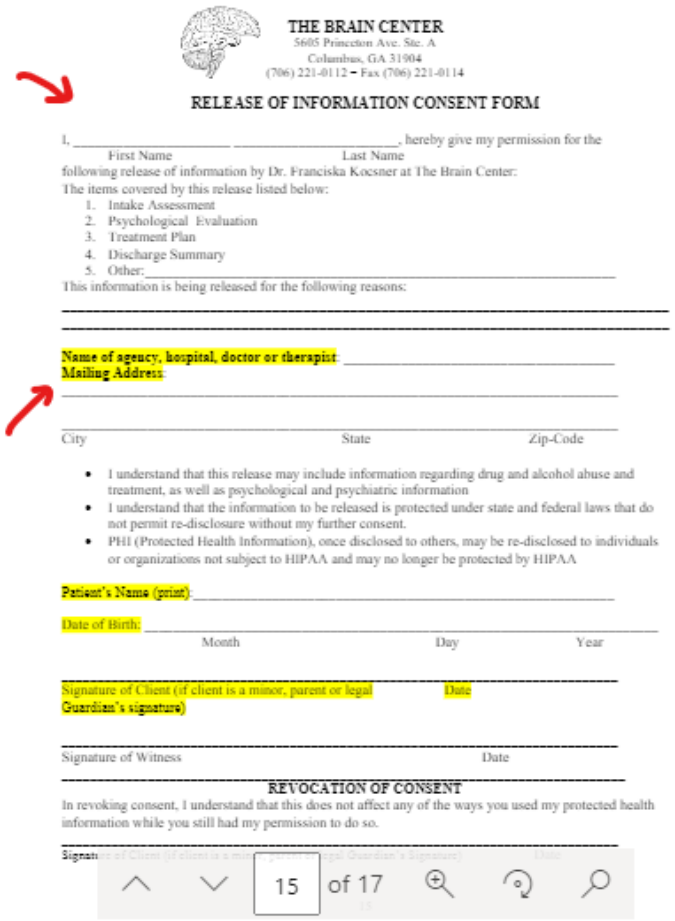
***Please read through the steps carefully and feel free to call our office with any questions.***

- **Please print every document under the appropriate section. (Choose child or adult)**
- **Fill out every section to the best of your ability: Dr. Kocsner will use the paperwork during the report writing process. Fill out every section, if the questions do not apply, please put "N/A" or "None" that way we know you have not skipped the section.**
- **Once all paperwork is completed, please either drop it off at the office or mail it in.**
- **When the paperwork is completed and received by the office, we will be able to schedule the initial appointment. We cannot schedule the initial until all paperwork is received.**
- **LEGAL DOCUMENTS: Please note that we must have a copy of any legal documents pertaining to the custody/guardianship/adoption of the patient. Please bring these documents in when dropping off the packet so that we can make a copy for our file.**

**~~SEE EXAMPLE BELOW~~**

## Frequently Asked Questions

**On the page titled "Release of Information Consent Form" (pictured below), please write the <u>parent's name</u> at the top and the referring <u>doctors name</u> in the section labelled "Name of Agency, hospital doctor or therapist". If there are multiple locations or people that you would like us to fax the final report to please fill out a separate release form. We must have one release form per location/person. We cannot accept a release form that has multiple people/locations listed.**



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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.

_____
Signatu

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**For Example: Your psychological report must be sent to the doctor that referred you here and the school/workplace also needs a copy. Therefore, you will need to fill out <u>two separate</u> release forms - one for the doctor and one for the school/workplace.**