



Intake Forms for PFPA

Powers Ferry Psychological Associates, LLC

Thank you for choosing Powers Ferry Psychological Associates (PFPA)

At PFPA, we believe that healing begins with feeling seen, heard, and supported.

Today's Date: *

Select your Therapist/ Provider *

If unsure the name of your therapist/
provider please select I DO NOT KNOW

Which location will you be seen at *

If you do not know which location you will
be seen please select Unsure

Patient's Full Name *

NO NICKNAMES

Date of Birth *

Age *

Sex *

Assigned at Birth

Last four of SSN *

Gender identity *

Preferred form of
Contact *

Appointment Reminder *

Phone: Home

Phone : Cell/Mobile *

Email address (if none, type the word None) *

If patient is a minor: Parent(s)/Guardian(s) Email

Mailing Address *

City *

State *

Zip Code *

If patient is a minor: Parent/Guardian Name(s)

Financial Responsible Party Information

Responsible Party Name *

Date of Birth *

Sex *

Last four of SSN *

No Nicknames

Assigned at Birth

Relation to the Patient: *

Same As
Above

Check box if mailing address and No. are the same as the patient's.

Select an option

Mailing Address

City

State

Zip Code

Phone No: Home

Phone No: Cell/Mobile

INSURANCE INFORMATION

Disclaimer Regarding Insurance Benefits and Payment: Please be advised that any quote of benefits and/or prior authorization received is not a guarantee of payment or a confirmation of eligibility. All claims are subject to the terms, conditions, limitations, and exclusions outlined in the members' insurance policy in effect at the time services are rendered. Verification of benefits is for informational purposes only and does not ensure coverage or payment by the insurance carrier. Ensure that you reach out to your insurance carrier as well for further information. PFPA will make commercially reasonable efforts to submit insurance claims and pursue payment from insurers and clients on behalf of the provider. ***However, PFPA does not guarantee reimbursement, nor does it assume financial responsibility for the collection of such payments.***

Yes **Will you be SELF-PAY with PFPA?** If so, please check the YES box to the left and enter 'N/A' in the fields marked as mandatory below.

Please send in the front and back of the insurance card to patientforms@pfpaga.com or the provider. If it does not apply, please enter 'N/A' in the fields where it is mandatory.

Policyholder's Name

Policyholder's DOB

Policyholder's SSN

Policyholder's Employer Name

Insurance Name

Insurance ID No.

Insurance Group No.

Insurance Provider No.

SECONDARY
INSURANCE: Is
the patient
covered under a
secondary
insurance policy?

Policyholder's
Name

Policyholder's
DOB

Policyholder's
SSN

Please send in the front and back of the insurance card to patientforms@pfpa.ga.com or the provider.

Insurance Name

Secondary Insurance Clamis
Address

Insurance Phone No.

Provider Department

Insurance ID No.

Insurance Group No.

Authorization Information/Employee Assistance Program (EAP)

Authorization Number /EAP

EAP Company Name

EAP Authorization No.(Auth)

If it does not apply, please enter 'N/A' in the fields where it is mandatory.

Who are we to submit EAP's to (Cigna, Aetna, United, etc)

This field MUST be Completed if using EAP's

EAP's Insurance Phone

EAP's End Date

EAP's Start Date

NO. Of Allowed Sessions

If an extension is needed for the EAP auth, please get in touch with your employer or the insurance company.

Notes

Powers Ferry Psychological Associates, LLC

1827 POWERS FERRY ROAD ♦ BUILDING 22 ♦ ATLANTA, GA 30339

PHONE: (770) 953-4744 ♦ FAX: (770) 953-4640

NOTICE OF PROVIDER'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.

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 refers to when I provide, coordinate or manage your health care, and provide other services related to your health care. An example of treatment is when I consult with another health care provider, such as your family physician or another provider.
 - 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 activities, such as audits and administrative services; and case management and care coordination activities.
- "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

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.

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.

Patient’s Rights and Provider’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.

Provider'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 make this information available either by mail or by request for a review of this information.

Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Steven Perlow, Ph.D., Privacy Officer, at 770-953-4744 x14.

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.

Effective Date

This notice will go into effect on April 14, 2003.

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NOTICE OF PROVIDER'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

I, the undersigned, acknowledge that I have received, read and understand the "Notice of Provider's Policies and Practices to Protect the Privacy of Your Health Information" form from Powers Ferry Psychological Associates (Version 1/22/2019).

This policy became effective April 14, 2003 as required by law under HIPAA (Health Insurance Portability and Accountability Act).

Signature of Patient or Parent(s)/Guardian(s)

Date

Name of Patient or Parent(s)/Guardian(s) *(Please print)*

If applicable, secondary party/ parties, 18 years of age or older, participating in treatment:

Signature of Secondary Party/Parties

Date

Name(s) of Secondary Party/Parties *(Please print)*

Relationship to Patient

Signature of Treating Provider

Date

Name of Treating Provider

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PROFESSIONAL SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) 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. 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.

I am a part of Powers Ferry Psychological Associates, L.L.C. (PFPA). We are a group of professionals who share office and administrative resources; however, we practice independently of one another. This means that I, alone, am fully responsible for providing you or your child with clinical services.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the provider and patient, and the particular problems you or your child 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 or your child 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. Before we begin working together, it is important to understand that I cannot guarantee that you or your child

will benefit from therapy. No provider can make such a guarantee because each client responds differently to this experience.

Our first few sessions will involve an evaluation of 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 provider 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 obtain an appropriate consultation with another mental health professional.

The goals of a psychological evaluation are: a) to provide insight into how you (or your child) is currently functioning, including possibly the evaluation of intellectual potential, academic achievement level, attentional abilities, and/or emotional/ behavioral functioning; b) to diagnose or rule out particular difficulties; and c) to identify strengths. An evaluation may involve the use of a number of procedures such as interviews, psychological tests and questionnaires.

Psychological evaluation can have benefits and risks. An evaluation may not answer the questions that motivated the assessment, or it may suggest something that you might find distressing. However, evaluations usually do provide insights that can be valuable in obtaining appropriate care.

Sessions

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you or your child need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45–50-minute session (one appointment hour of 45-50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours notice of cancellation (see details under Financial Arrangements section).

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. While I am generally in my office regular hours, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call as soon as possible. If you are difficult to reach, please inform me of some times when you will be available. To leave an urgent/emergency message, dial my extension and leave a message when prompted. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, call 911, call the Nation Suicide Hotline at 988, or call the nearest emergency room and ask for the provider or psychiatrist on-call. If I will be unavailable for an extended time, I will always have a colleague available for you to contact in case of emergency.

Confidentiality

The law protects the privacy of all communications between a patient and a provider. In most situations, I can only release information to others about your treatment (or your child's treatment) 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 current 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 it is important for our work together. I will note all consultations in your Clinical Record (which is called PHI in my notice of providers policies and practices to protect the privacy of your health information)

- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling, billing and communication with insurance companies. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient threatens to harm himself / herself, I may be obligated to seek hospitalization for him/her and/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 provider/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 Family and Children Services (DFCS). 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 him or her, other than by accidental means, or that he or she has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once I have filed such a report, 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 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

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you or your child in two sets of professional records. One set constitutes your Clinical Record. It includes information about: your reasons for seeking therapy, a description of the ways in which your or your child's problem impacts on your life, diagnosis, the goals that we set for treatment, progress towards those goals, medical and social history, treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, 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, your child, or others or 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 if information is supplied to me confidentially by others), you or your legal representative may examine and /or receive a copy of your or your child's 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 require 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. The exceptions to this policy are contained in the attached Notice Form. 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, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you or your child 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 or your child's therapy. They also contain particularly sensitive information that you or your child 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. They also 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 or your child's 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, as well as 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 typically my 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. The results of psychological testing of a minor typically will be shared with parents or guardians. They may also be shared with other entities such as schools or physicians with parental consent.

Financial Arrangements

Professional Fees

I have a set of hourly fees (please see fee schedule). In addition to weekly appointments, I charge this amount for other professional services you or your child may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report and letter writing, telephone or email conversations lasting longer than 5 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. **These services are not covered by your insurance company.** If you become involved in legal proceedings that require my participation, you will be expected to pay for all my professional time, including preparation and transportation costs, even if I am called to testify by another party. You will be charged for any sessions missed or cancelled with less than 24 hours notice unless due to an emergency. Please note that insurance companies do not pay for missed / cancelled appointments, so payment of the hourly fee is your responsibility.

Our office charges a yearly administration fee of \$10. This fee is a yearly fee that cannot be submitted to insurance and is patient responsibility.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless you have insurance coverage, or we agree otherwise. If you have insurance, you are required to pay your copay at the time of service. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, 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 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 assistance 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 benefits your insurance policy provides, such as copays, deductibles, maximum number of sessions allowed, etc.**

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. If it is necessary to clear confusion, I, or my staff, will be willing to call the company on your behalf.

Many insurance plans such as HMOs and PPOs require authorization before they provide reimbursement for mental health services. **It is your responsibility to call your insurance company and obtain authorization before your first appointment. If authorization was required and is not obtained, your insurance will deny payment and you will be responsible for the hourly rate.**

We will submit the appropriate bills to your insurance company one time and try to remedy any denial or payment problem related to billing one time. If after these billing attempts, the insurance company refuses to pay the bill, it will become your (the client's) responsibility to work with the insurance company to obtain appropriate reimbursement.

Out of network and secondary insurance claims are not filed by my office. You are responsible to pay for your service on the day of your visit unless prior arrangements have been made with the billing office. At time of check out please request a copy of your super bill in order for you to submit your claim to your insurance company for reimbursement.

Typical insurance plans such as HMO's and PPO's 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. It will typically be my responsibility to obtain authorization for further 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 insurance 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 BELOW INDICATES THAT YOU HAVE READ THE PROFESSIONAL SERVICES AGREEMENT, VERSION 1-22-2019, AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

PATIENT (or PARENTS/GUARDIANS, IF PATIENT IS A MINOR)

Signature of Patient or Parent(s)/Guardian(s)

Date

Name of Patient or Parent(s)/Guardian(s) *(Please print)*

Relationship(s) to Patient

OTHER ADULT PARTY/PARTIES INVOLVED IN TREATMENT

NOT APPLICABLE

Signature of Secondary Party/Parties

Date

Name of Secondary Party/Parties *(Please print)*

Relationship(s) to Patient

TREATING PROVIDER

Signature of Treating Provider

Date

Name of Treating Provider