

Richard Born, Ph.D. LLC

LICENSED PSYCHOLOGIST

One Huntington Road, #205

Athens, Georgia 30606

Phone: 706.543.7605

FAX:706.543.2397

NEW CLIENT INFORMATION AND RESPONSIBILITY INFORMATION

This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner or the office manager about these or any other matters. We are here to assist you.

FOR YOUR FIRST APPOINTMENT, PLEASE ARRIVE FIFTEEN MINUTES EARLY SO THAT YOUR CHART CAN BE MADE AND WE CAN COLLECT ANY ADDITIONAL INFORMATION IF NEEDED. PLEASE HAVE THE ENCLOSED PAPERWORK COMPLETED WHEN YOU ARRIVE AND BRING YOUR INSURANCE CARD WITH YOU. THE CLINICIANS KEEP A TIGHT SCHEDULE AND WILL USUALLY START YOUR APPOINTMENT ON TIME.

OFFICE HOURS

Office hours may vary but are usually Monday - Friday, 9:00 - 6:00, and we are typically available during these times. The office manager is in the office typically from 10:00 a.m. until 4:00 p.m. Monday through Thursday, and 10:00 until 2:00 p.m. on Friday. If you need to contact us and no one is available to take your call, please either leave a message on voice mail on the office phone, or with the answering service and we will return your call as soon as possible. The first priority and our primary concern is your well being. **In an emergency or life threatening situations, please go to the nearest hospital emergency room for help.**

APPOINTMENTS:

Appointments are most commonly scheduled with the front desk person at the completion of each visit. At times however it is recommended that the patient schedule a block of appointments in advance since the schedule can become very busy. Individual, couples, and family therapy are billed on the basis of a 45-50 minute hour. Biofeedback treatment sessions typically run 45-50 minutes also. Group therapy is based on a 75-90 minute session. If an appointment runs significantly longer than initially scheduled, there may be an additional charge for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

CONFIDENTIALITY and PRIVACY OF INFORMATION:

The Confidentiality and Privacy of information regarding you and your treatment with my practice is very important. There are laws and legislation that govern this topic that we must abide by. I apologize for the lengthiness of this form, but I feel it is very important that you are aware of this information.

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

- (1) where abuse or harmful neglect of children, the elderly, or disabled or incompetent individual is known or reasonably suspected
- (2) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist
- (3) where the patient is perceived as being in danger of harming themselves by

suicidal behavior

MISSED APPOINTMENTS:

An appointment time occupies a significant portion of our professional time. An appointment that is missed or late cancelled keeps us from seeing another patient in need. Therefore, except in the case of an acute emergency, we require a 24-hour notice of any cancellation; otherwise, your account will be subject to a fee. The current charge for a late cancelled or missed session is \$50.00. You are financially responsible for this charge since any

insurance coverage will not apply. If our office is closed or we are not at the phone when you need to cancel an appointment, you can leave a message either with the answering service or on the office voice mail. Please let us know of a need to cancel or reschedule an appointment as soon as possible, since there are other patients who are on a 'call' list who are waiting to get in to see a clinician.

FEES:

Arrangements for payment of fees for professional services need to be made prior to or at the time of the first visit. We will file for payment through your insurance company whenever possible. When we file for insurance payment, it is still your responsibility to pay any deductible and co-payment amounts. It is also important that you also understand that you are ultimately responsible for payment of the fees in the event that insurance doesn't pay. Delinquent accounts over 90 days may be referred to a collection agency.

ASSESSMENT AND/OR TESTING:

Testing is billed on the basis of the type of test and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with the type of test and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. Reports are typically not included in assessment and/or testing fees and will be billed as a separate procedure. The written report summarizing testing results, if requested, is generated after payment in full for testing services is received.

COMPLETION OF FORMS AND ADDITIONAL REPORTS:

Occasionally, situations may come up in which a patient requests that the psychologist complete additional forms or develop additional reports, (ie. disability forms, reports to schools, employers, or insurance companies). The charge for completion of reports or development of reports are billed on the basis of a pro-rated charge of \$130.00 per hour, with a minimum charge of \$25.00.

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to psychological services. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand that the potential benefits of undergoing psychological services may include obtaining a professional opinion, reduction of my psychological symptoms, and an increased understanding of myself. I understand that potential risks may include predictive validity of psychological assessment (when applicable), possible disagreement with the opinions offered to me, and possible emotional distress when addressing my situation. I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with the progress of my treatment.

By signing below, I acknowledge that I have read and accept the above information regarding professional services rendered.

PRINTED NAME OF PATIENT/person responsible for payment

SIGNATURE OF PATIENT/person responsible for payment

DATE

Richard Born, Ph.D. LLC
Applied Psychological Health
•PATIENT INFORMATION•

Patient Name: _____ Gender: M F Date of Birth: _____

Address: _____
Street City State Zip Code

Billing Address if different from above:

_____ Street City State Zip Code

Social Security No: _____ Telephone: Home: _____

Marital Status: Single Work: _____

Married Cell: _____

Divorced Is it OK to call and leave messages at these numbers? Yes No

Separated Responsible party (if patient is a minor): _____

Widowed Address (if different from above): _____

Employer/School: _____

Primary Care Physician: _____ Phone No.: _____

•PRIMARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: M F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Employer Address: _____

INSURANCE COMPANY: _____ MENTAL HEALTH ADMINISTRATOR: _____

Address to send claims: _____ Phone # for authorizations: _____

Phone No.: _____

Policy Holder's Social Security No.: _____ Policy #: _____ Group #: _____

Authorization #: _____ for _____ sessions. Effective dates _____ to _____.

Medicare #: _____ Part B effective date: _____ Primary Secondary

Medicaid #: _____ Effective date(s): _____ Primary Secondary

Worker's Compensation Claim #: _____ Injury date: _____

•SECONDARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: M F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Employer Address: _____

INSURANCE COMPANY: _____ MENTAL HEALTH ADMINISTRATOR: _____

Address to send claims: _____ Phone no. for authorizations: _____

Phone No.: _____

Policy Holder's Social Security No.: _____ Policy #: _____ Group #: _____

The office of Richard Born, Ph.D. LLC will bill your insurance carrier directly for all services. Your signature expresses your agreement that the dates of service, services rendered, and the diagnosis will be provided with the insurance claim as necessary to process the claim. Your signature also indicates that you understand and agree that you are liable for payment of any services not covered by your insurance company.

Signature: _____ Date: _____

OFFICE USE:

Diagnosis:

Treatment Provider:

Financial Notes:

Richard Born, Ph.D. LLC
One Huntington Road #205
Athens, Georgia 30606
Applied Psychological Health Services
Patient Info Sheet - CHILD

Phone: (706) 543-7605
Fax: (706) 543-2397

PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING YOUR CHILD:

Child's Name: _____ Date of Birth: _____

Who referred you to our practice? _____

Who is your child's primary physician? _____
Address: _____
Telephone: _____

What is your child experiencing that led you to seek assistance? _____

What medications is your child taking?

Name of Medication	Date Started	Dosage	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any over-the-counter medications, herbs, or other supplements your child takes:

Does your child have any allergies to medications? ___ Yes ___ No
Please list any allergies your child has: _____

Has your child ever been to a counselor, psychologist, or psychiatrist, or been admitted to a psychiatric hospital?
___ Yes ___ No. If "Yes", please list who your child saw, when, and for what purpose.

Where does your child attend school, and what grade are they in?

Are they receiving special education services? ___ Yes ___ No _____

Other people living in your home: _____

Whom can we contact in case of emergency? _____
Relationship _____ Phone: _____

If we need to call you, can we leave a message? ___ Yes ___ No

Does your child have friends his/her own age? Yes No
 Does your child complain of not having enough friends? Yes No
 Does your child play mostly with friends his/her own age? Yes No

Please list below if your child exhibits any of these problems:

- | | |
|--|--|
| <input type="checkbox"/> Poor Attention Span | <input type="checkbox"/> Temper Outbursts |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Is Heedless to Danger |
| <input type="checkbox"/> Low Frustration Threshold | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Does not Listen when Spoken to | <input type="checkbox"/> Excessive Crying |
| <input type="checkbox"/> Excessive Number of Accidents | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> More Active than peers/siblings | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Sulks/Pouts | <input type="checkbox"/> Excessively Fearful |
| <input type="checkbox"/> Abuse Directed Towards Others | <input type="checkbox"/> Nail Biting |
| <input type="checkbox"/> Interrupts Frequently | <input type="checkbox"/> Bed wetting/bowel control |

Does your child have any health problems? Yes No

If "Yes", please describe what they are: _____

Have any of other family members (parents, grandparents, aunts, uncles, siblings, cousins, etc.) experienced emotional problems? Yes No

If "Yes", who and what type of problem? _____

What would you like to accomplish from your child's treatment here? _____

Please list any specific questions you have for us: _____

Thank you for taking the time to complete this form. It helps us make the best use of our session time.