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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 FIVE 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 - Thursday 10:00 - 6:00 and we are typically available during these times. If you need to contact us and no one is available to take your call, please leave a voice mail on the office phone and we will return your call as soon as possible. The first priority and our primary concern is your well-being.

EMERGENCY INFORMATION - If You Are in an Acute Crisis
- Call Behavioral Health Link/GCAL: 800-715-4225 or other 24 hour crisis hotline in your area
- Call the Advantage Behavioral Health Crisis Center direct line: **706.583.7307** located at 240 Mitchell Bridge Road in Athens. This is a Walk-in Center open 24/7 that provides Temporary Observation and Crisis Stabilization Services
- Call 911especially if medical emergency

APPOINTMENTS:
Appointments are most commonly scheduled via telephone or following a session. Initial interview, treatment, and biofeedback sessions typically run 50 - 60 minutes in length.

MISSED APPOINTMENTS:
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 canceled 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, please leave a 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. _____ Initial

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 important that you also understand that you are ultimately responsible for payment of the fees in the event that insurance doesn't pay.

_____ Initial

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. In certain situations there may be additional fees for test scoring services and comprehensive report writing.

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

PLEASE READ THE FOLLOWING STATEMENT AND SIGN THE ACKNOWLEDGEMENT:

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. Information regarding your assessment and treatment here is confidential and private and can only be shared with your explicit authorization.

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) When abuse or harmful neglect of children, the elderly, or disabled or incompetent individual is known or reasonably suspected

(2) When an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist

(3) When the patient is perceived as being in danger of harming themselves by suicidal behavior

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