PSYCHOLOGICAL OFFICES

121 Carl Vinson Parkway
Warner Robins, GA 31088
478.922.2365 Office 478.922.1778 Fax

Susan F. Davenport, Ph.D. #1969 **Delvida L. Long, Ph.D. #4463**

Information Pertaining to Client

Last Name:_____ First Name:_____ MI: _____
Address:_____ Email: _____
City:_____ State:_____ Zip Code: _____
Home Phone:_____ Cell Phone:_____ Preferred: ☐Home ☐Cell
Birthdate:_____ Social Security Account Number: _____
Employer:_____ Employer Phone: _____
Marital Status: (Check One) ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

If Patient is a Child: School Attending: _____ Grade _____
Who is bringing the child to the appointment? _____

If Patient is married, include Patient's Spouse Information: N/A ☐

Last Name: _____ First Name: _____ MI: _____
Address:_____ Email: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Preferred: ☐Home ☐Cell
Birthdate: _____ Social Security Account Number: _____
Employer: _____ Employer Phone: _____

Mother/Guardian, If Patient is a Minor: ☐N/A
Last Name: _____ First Name: _____ MI: _____
Address:_____ Email: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Preferred: ☐Home ☑Cell
Birthdate: _____ Social Security Account Number: _____
Employer: _____ Employer Phone: _____

Father/Guardian, If Patient is a Minor: ☐N/A
Last Name: _____ First Name: _____ MI: _____
Address:_____ Email: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Preferred: ☐Home ☐Cell
Birthdate: _____ Social Security Account Number: _____
Employer: _____ Employer Phone: _____

Primary Policyholder's Insurance Information:
Insurance Company Name:_____ Policy #: _____

1. I hereby authorize the therapist whose name appears on my insurance claim form to furnish my insurance company with any requested information concerning my present treatment.
2. I hereby assign to the therapist whose name appears on my insurance claim form all monies to which I am entitled for psychological expense relative to the services reported on my insurance claim form. **I understand that I am financially responsible to said therapist for charges not covered by this assignment.**

_____ _____ _____
Insured/Responsibility Party/Guardian **Client** **Date**

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New Patient: Additional Information

Patient Status:

☑ Child ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Education (*check the highest completed level*)

☐ High School ☐ High School Equivalency ☐ Vocational School ☐ Degree

Present occupation/school: _____

Family Life: With whom do you live?

☐ Alone ☐ Parents ☐ Boyfriend ☐ Girlfriend ☐ Spouse ☐ Other

Do you have any children? ☐ No ☐ Yes, How Many? _____

If Yes, what are their names and ages: _____, _____,

_____, _____, _____

Requesting Services for: ☐ Therapy

☐ Psychiatric Consultation

☐ Evaluation (☐ Disability ☐ School ☐ Legal ☐ Other)

Please mark if you ever had a problem with:

☐Hyperactivity ☐Alcohol ☐Drugs ☐Anger ☐Stealing ☐Hurting Animals
☐Irritableness ☐Headaches ☐Fatigue ☐Pregnancy ☐Illness ☐Appetite Change
☐Sleep ☐Weight Gain/Loss ☐Memory ☐Financial ☐Unemployment
☐Marital Conflicts ☐ Work Relationships ☐Family Relationships ☐Sexual Functioning
☐Disability ☐ Control of Hands ☐Adding/Subtracting ☐Poor Attention Span
☐Slow Learner in School ☐Special Education Classes ☐Recall of written material
☐Experienced Child Abuse ☐Suicidal thoughts ☐Excessive Spending Spree
☐Depression for several days at a time ☐Felt Ashamed about your eating habits
☐Trouble with people in authority ☐Eating large amounts of food very quickly
☐Heard or seen things that no one else could see
☐Felt like your mind was being controlled against your will
☐Distress about the loss of a loved one, job, separation, etc.
☐Periods of excessive energy/talking for several days at a time
☐A lot of physical ailments that doctors have trouble dealing with
☐Sudden panic, nervousness, or strong fear for no particular reason
☐Deliberately lost weight even when others said you were thin enough
☐Anxious, tense, or worried about things for several days at time or off and on for months

Previous Mental Health Care: _____

_____

Past Medical Illnesses and When: _____

_____

Present Health: _____ Last Physical Exam Date: _____

Current Medications: _____

_____

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Permission For Treatment of Services

I, _____ (adult client or guardian of child client), authorize Delvida L. Long, Ph.D., to render treatment or other services to _____ (myself or name of child).

It is my understanding that the client's interaction with Dr. Long will be confidential except when I grant permission for communication to occur with specific agencies/ persons or when communication is required by law.

_____ _____ _____
Client or Adult Representative Date Witness (Office Staff)

If you would like to review our patient policies, they are located in a binder in our waiting area.

NOTICE OF: Psychotherapist-Patient Agreement

I have read and understand the Psychological Offices Psychotherapist-Patient Services Agreement, which includes HIPAA compliance.

_____ _____
Client or Adult Representative Date

_____ _____
Witness (Office Staff) Date

NOTICE OF: Member Rights and Responsibilities and Acknowledgement of Cancellation

Policy I have read and understand the Psychological Offices Members Rights and Responsibilities and the Office Appointment and Procedure Cancellation Policy and agree to be bound by its terms.

_____ _____
Client or Adult Representative Date

_____ _____
Witness (Office Staff) Date

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Authorization to Release/Obtain Information

This form, when completed and signed by you, authorizes me to release protected health information (PHI) from your clinical record to the person you designate.

I, _____, (Print Patient or Adult Representatives name) authorize my psychotherapist, _____, to release and/or obtain the following information and understand that this information is being released at my request (be specific/detailed of the description of information you want disclosed).

_____

_____

This information should only be released and/or obtained to and/or from (name, address and phone number of the person or persons to whom the information is to be released and/or obtained from):

_____

_____

_____

This authorization shall remain in effect until ONE YEAR FROM DATE BELOW unless otherwise specified by me in the following space: _____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address. However, your revocation will not be effective to the extent that I have taken action in reliance of the authorization or of this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychotherapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient OR Adult Representative Patient Name (printed)

_____ _____

Date Witness Name and Signature (In Office)

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be attached.

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Authorization to Disclose Information to Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records 42 CRF Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____ hereby authorize Dr. Delvida L. Long:
(Please Print/Insert Patient's Name)

Please check one:

☐ Release any applicable information to my Primary Care Physician

☐ Release medical information only to my Primary Care Physician

☐ Do not release information to my Primary Care Physician

_____ _____
(Patient's or Patient's Guardian, please sign) (Date)

_____
(Please print the name signed above)

Primary Care Physician's Name: _____

Address: _____
_____
_____
_____
_____

Phone: _____

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Delvida L. Long, Ph.D.
Legal Testimony Agreement

Client Name: _____

Date: _____

Should any legal testimony be required concerning my case/evaluation, I agree to pay **in advance** a minimum fee of **$2,000**, for one full day court in Houston County. Total fee to be available for one full day for court outside Houston County is **$4,000**. The minimum fee is due and payable prior to scheduling any court appearance. This fee is non-refundable. If there is a change in the court date, the office must be notified ten (10) working days prior to the change. If the office is not notified at least ten (10) working days in advance, an additional, non-refundable fee of **$1,000** (**$5,000** if outside of Houston County) must be paid to Delvida L. Long, Ph. D., for testimony for the re-scheduled court appearance. _____
(Initials)

These fees are not contingent upon the outcome of the Court's decision or court appearance. All additional services in regard to your case/evaluation are considered to be of a legal nature, and will be billed at a legal rate of **$150** for the first hour *then* $75 per half hour, or part thereof, after the first hour. These services may include, but are not limited to, the following: legal consultation with attorney, review of related documents, individual psychotherapy, family therapy, or marital therapy. _____
(Initials)

I understand that relevant information obtained by Delvida L. Long, Ph.D. will be available to my attorney, the opposing attorney, if requested and authorized by law, and other court officials involved in litigation. I am participating in psychological assessment and psychotherapy knowing the full extent of the above statements and do so willingly. _____
(Initials)

NONE OF THESE FEES WILL BE FILED WITH YOUR INSURANCE COMPANY.

Please initial each paragraph above, and sign below (patient or parent(s) / legal guardian(s).

Name: _____ _____
(Date)

Name: _____ _____
(Date)

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Financial Policy

All patients must complete our Information and Insurance form before their appointment.
FULL CO-PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS and CREDIT CARDS

Regarding Identity Insurance
We will bill your insurance company as a courtesy. However, we do require 100% of the bill to be paid at time of service for your first visit unless insurance has been pre-approved. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the terms of your insurance contract.

Regarding Insurance Plans where we are a participant as a provider, all copays and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating as a provider, refer to above paragraph. If pre-authorization from your insurance company has not been obtained prior to your appointment, the full fee will be due. _____ Initials

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. _____ Initials

Minor Patients
The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. Unaccompanied minors will only be seen after they have been established as a patient and cleared through the therapist or doctor. Please make sure you send a check or cash to cover the charge. Call ahead if you are uncertain of the amount and the staff will be glad to provide you with the information. _____ Initials

Missed Appointments,
Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of the normal office visit. All future appointments will be canceled and payment will be required before the next appointment will be made with your provider. _____ Initials

Bills
In order to keep costs down, we do not send out bills on a monthly basis. All fees are collected at the time of service. If it is necessary to send a bill, the first bill will be sent as a courtesy to inform you of the balance due. If additional bills are required, a $15.00 administrative charge will be assessed to your account. All balances over 90 days past due will be considered for outside collection. _____ Initials

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I further understand that the therapist reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Psychological Offices change their notice, they will send a copy of any revised notice to the address I've provided.

Please do not release any patient information without a specific signed authorization

OR

I wish to have the following restriction to the use of disclosure of my health information:

_____
_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses; including disclosures via fax/encrypted email.

I authorize the release of any medical or other information necessary to process an insurance claim.

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to the provider of record.

I fully understand and accept the terms of this consent.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

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Standard Charges for Administrative Services

Release of Records:

Administrative Charge:	$10.00
Copy Charge (per page):	$ 0.25
Copy forms to CD	$25.00
Minimum Fee:	$25.00

Letters: $25.00

For any letter requested to Attorneys, Schools, or other entities, the fee will be a minimum of $25.00. If drafting of the letter exceeds 45 minutes, an additional $25.00 will be added to the fee per 30 minute increment.

Client/Doctor Provided Forms:

Completion of Forms (per page):	$ 5.00
Minimum Fee:	$25.00

Consultation Fees: $150.00 for the first hour
+$75.00 for each additional half hour (or part thereof)

Consultation includes any meeting outside of a regularly scheduled appointment where Dr. Long consults with professionals and/or school administrators about clients *on their behalf, and at their request.* **These fees are not billable services to client insurances.**

Minimum Fees for these services will be collected in advance. Remainder of fees will be collected upon completion/delivery of requested services.

Non-Sufficient Funds (NSF) Fees (Returned Checks)

You will be charged a $30.00 fee per returned/dishonored check from your bank. If a check is submitted for payment to your bank a second or subsequent time and is returned for non-sufficient funds or for any other reason, an additional $30.00 fee will be assessed per event.

I understand and agree to the fees outlined above.

Name: _____ _____
(Date)

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Policy and Guidelines

Welcome to our practice of mental health services. There are several guidelines and policies that will facilitate our providing you the best possible evaluation and/or treatment. The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Georgia State Mental Health laws regarding privacy of health records supersede HIPPA rules and regulations. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be release in order to substantiate disciplinary concerns.

Court Order

Health care professionals are required to release records of clients when a court order has been placed.

Minor/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

We will try our best to provide privacy during your visit to our facility. A chance meeting in our lobby with someone who is an acquaintance during an appointment is beyond our control. It is the policy of the clinic to keep the contents of any counseling confidential.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases, the name of the clients, or any identifying information, is not disclosed. Clinical information about the clients is discussed.

I understand all Policies and Procedures presented on this notice:

_____ _____

Patient/Parent/Legal Guardian Signature Date