AFFILIATED PSYCHOLOGICAL AND MEDICAL CONSULTANTS, LLC
200 W. Academy Street NW, Suite A
Gainesville, Georgia 30501
770-535-1284

INFORMATION COLLECTION FORM

CONFIDENTIAL

Patient Name:____ Today's Date:______________________

Address:____City/State__________________________Zip___________

Home Phone #:_____________________ Work Phone #___________________ Cell# _____________________

Date of Birth: _____/_____/___ Age:_____ SS#: _______________________ Gender: ☐ Female ☐ Male

Married ☐ Divorced ☐ Single ☐ Widowed ☐
Employed ☐ Unemployed ☐ Full-Time Student ☐ Part-Time Student ☐

EMERGENCY CONTACT: _____________________________________ Phone #:____________________

RESPONSIBLE PARTY: (other than insurance) if different from patient:

Name:____SS#:________________________Date of Birth____/_____/______
Address____City/State:_____________________________ Zip___________
Home Phone #:__________________________Work Phone #:__________________ Cell/Mobile #____________________

***** ***(Complete this Section ONLY If We Are to File Your Insurance)*** *****

If Workers Compensation accident-related: Date___/___/___ Employ ☐ Auto ☐

Primary Insurance:_________________________________Policy Holder SS#:______________________
Policy Holder DOB:___/___/___ Policy Holder Name:____
Policy Holder Employer:____

Secondary Insurance: ___________________________Policy Holder SS#:_______________________
Policy Holder DOB:___/___/___ Policy Holder Name:____
Policy Holder Employer:____

Please place a check mark next to the doctor you have an appointment with today:

☐ *David S. Bailey, Ed.D.,ABPP, FAACP* ☐ *Janice R. Hughes, Ph.D.*
☐ *Patricia A. McCoy, Ph.D.* ☐ *Lynn Overton, L.P.C., M.A.*

I, the undersigned, hereby agree that, excluding Worker's Comp and Medicaid, I will guarantee payment for services rendered by the above-named doctor. I hereby authorize payment directly to same, of the benefits otherwise payable to me but not to exceed the doctor's regular charges for this service. *I understand I am financially responsible to the doctor for charges not covered by this agreement, and I agree that the bill will be paid upon receipt of a statement unless other arrangements have been made with this office*. I also understand that, should a collections process become necessary, I am responsible for all expenses connected with the process. I further authorize the release of information for insurance purposes.

Responsible party
Signed:____ Referred By:____

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PATIENTS' RIGHTS AND RESPONSIBILITIES STATEMENT

Patients have the right to:

- Be treated with dignity and respect.
- Fair treatment, regardless of race, religion gender, ethnicity, age, disability, or source of payment
- Privacy of treatment and other member information. Only where permitted by law, may records be released without member permission.
- Easily access timely care in a timely fashion.
- Know about treatment choices, regardless of cost or coverage by the member's benefit plan.
- Share in developing a plan of care.
- Information in a language that is understandable.
- A clear explanation of condition and treatment options.
- Information about clinical guidelines used in providing and managing care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.
- Receive a copy of our HIPAA (Health Insurance Portability and Privacy Act) Practices.

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need, so providers can deliver the best possible care.
- Ask questions about their care, to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and the provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should contact their provider(s) as soon as they know they need to cancel visits, preferably within 24 hours of appt.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with fee payment.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Inform the provider if there is a change of insurance carrier or plan ID, or if the insurance has terminated. This protects both the patient and the provider, by insuring that we file your claims within the insurance carrier's timely filing limit. Not every insurance company uses the same timely filing limit. For instance, Aetna only allows 6 months and Medicare allows 1 year for the provider to submit claims. Thank you for helping us ensure your claims are paid by your insurance provider. If you fail to inform us of a change and we miss the filing limit, you will be responsible for paying the entire allowable amount for the dates of service that are missed due to unintended negligence on your part.

CONFIDENTIALITY, PRIVILEGED COMMUNICATION, AND DUTY TO WARN OR PROTECT

Federal and State of Georgia laws assure that everything a patient tells their mental health professional is to remain confidential and is considered privileged communication. Any information a mental health professional has regarding the patient can only be released with the signed, written consent of the patient (or patient's parent or legal guardian in the case of a child). Thus, confidentiality and privileged communication are your rights, guaranteed under State and Federal laws by the Health Insurance Portability and Privacy Act (HIPAA).

There are, however, two exceptions in which the mental health professional's social responsibility is given precedence over these rights. If a patient intends to harm him or herself, or another individual, the mental health professional has the responsibility and duty to protect the patient, or warn the person to whom harm is intended. Such action by the mental health professional may require that confidentiality be broken. Of course breaching confidentiality would be the last resort, occurring only after all reasonable efforts to resolve the situation had failed, and would be limited to the necessary information required to ensure safety.

State of Georgia law also requires that mental health professionals report all incidents of any type of suspected child or elder abuse to appropriate agencies.

I have read the above and understand my rights and the mental health professional's social responsibility.

____ _____________________________
Signature Date

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BILLING AND FINANCIAL POLICY

Diagnostic Interview - First Visit - $250.00 - based on 45-50 minutes of actual contact time, and additional time being used for developing a treatment plan, charting, reviewing records, etc.

Therapy Sessions - $175.00 - are based on one hour and defined as 45-50 minutes of actual contact time, with the remaining 5-10 minutes being used for charting, writing progress summaries, etc. A half hour - $85.00 - is defined as 25 minutes of actual contact time. Therapy sessions which last longer than 50 minutes will be billed accordingly.

Missed Appointments and Cancellations are not considered for payment by insurance companies, you are, nevertheless, responsible for paying $80 for missed appointments and cancellations if there is less than 24 hours notice. Our telephones are answered 24 hours a day, 365 days a year, either by our office personnel or voice mail. If you arrive late for your appointment, you will be billed for the time scheduled. The appointment will still conclude on time.

Consulting with an attorney or other professional, phone calls and all other services are billed at the hourly rate, to the quarter hour.

Telephone Calls are normally brief and are not usually charged at the time. However, should they accumulate to more than 15 minutes of the psychologist's time, it will be billed accordingly. Most insurance companies do not reimburse for telephone consultations.

Forensic Services (i.e., services used for legal purposes) are billed at a higher rate due to the preparation required and unpredictability of scheduling court appearances. The higher rate applies for all time spent interviewing, assessing, waiting to testify, testifying, and preparation and will be charged when subpoenaed, giving a deposition, and for all other court-related services the psychologist provides. WE CANNOT ACCEPT ASSIGNMENT FOR INSURANCE FOR ANY SERVICES TO BE USED FOR LEGAL PURPOSES OR ANY OTHER NON-MEDICALLY NECESSARY SERVICES.

PAYMENT: Payment in full - less the amount insurance will pay - is required at the time of service. No further services will be scheduled if your account becomes two or more payments behind (i.e., for two hours of service).

INSURANCE: We will file your insurance claims only if we are contracted providers with that company. After you have met your deductible for the year, we will accept the assignment (i.e., reimbursement directly from your insurance company). However, deductibles, co-payments and all fees not covered by your policy are still due at the time of service.

It is your responsibility to inform us if your insurance plan (or company) changes. If you fail to inform us (or provide a copy of your new insurance card) within 30 days of change, you will be responsible for payment of any dates of service your insurance company denies for claims filed after the statute of limitations for your plan. Most plans require claims to be filed within 90 days of the date of service.

PRECERTIFICATION OF INITIAL APPOINTMENT IS YOUR RESPONSIBILITY. Your doctor will take care of any pre-certification necessary for ongoing treatment. It is also your responsibility to know your benefits - co-pay, deductible, authorization requirements, referrals, etc. - prior to your appointment.

NOTE 1: In cases of divorce and/or separation, the parent who originally brought the child in for services is responsible for paying this office, regardless of which parent is legally responsible for insurance coverage and medical bills as established by a divorce or any other agreement. Assignment from the non-custodial parent's insurance carrier will be accepted only after this office has his/her signature on file.

NOTE 2: Former patients returning for treatment who have had an unsatisfactory payment history or have been turned over to our collection agent will be seen on a CASH ONLY basis. We will be glad to give you the necessary forms for reimbursement directly from your insurance company to you.

I HAVE READ AND UNDERSTAND THE ABOVE BILLING POLICY. I AGREE TO PAY FOR SERVICES UNDER THE CONDITIONS AND SPECIFICATIONS SET FORTH IN THIS BILLING POLICY AND ACKNOWLEDGE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES PROVIDED, REGARDLESS OF INSURANCE COVERAGE, EXCLUDING MEDICAID AND WORKER'S COMPENSATION; INCLUDING COLLECTIONS/COURT COSTS SHOULD THAT PROCESS BECOME NECESSARY IN THE SETTLEMENT OF MY ACCOUNT.

Signature: ____ Date:______________________________________

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CONFIDENTIAL

Patient name:_______________________________ **Social Security Number:**____________________

TREATMENT CONSENT FORM

Explanation of Consent Form:

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of Affiliated Psychological & Medical Consultants, LLC (hereafter known as APMC). This form documents that the client has consented to treatment at APMC, including but not limited to psychotherapy and counseling. This allows the professional staff at APMC to provide services to you.

This form provides evidence that no guarantee is made by any professional at APMC concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at APMC. If you have any questions concerning this or any other matters, it is your responsibility to ask your therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment:

I, ______________________________________, for ___________________________________
(*Print your name)* (*Print the client's name)*
do hereby voluntarily consent to care and treatment by David S. Bailey, Ed.D., Janice R. Hughes, Ph.D., and/or Patricia A. McCoy, Ph.D., their assistants and/or designees. I am aware that the practice of Clinical Psychology and/or Neuropsychology is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the counseling process and that I share responsibility for treatment. My responsibilities in treatment include informing the therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

____ __________________________________
(Your Signature) *(Date)*

____ __________________________________
(Witness) *(Date)*

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MEDICAL RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

PATIENT'S NAME:

____

Please print patient's name here, and sign BOTH of the following Authorization Statements below:

I authorize the release of medical records or other information necessary to process this claim with my insurance company:

SIGNED: ____
(Patient or authorized person's signature)

I authorize payment of benefits to the Doctor:

SIGNED: ____
(Insured or authorized person's signature)

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Please complete the form below if you agree that Affiliated Psychological may contact your Primary Care Physician.

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 Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state of 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._____________________________________
(Please Print Patient's Name) ***(Please Print Treating Clinician's Name)***

*****Please check one*****

_____ **RELEASE any applicable information to my Primary Care Physician listed below**

_____ **DO NOT release information to my Primary Care Physician**

____ ___________________
(Patient or Patient's Guardian, please sign) ***(Date)***

Primary Care Physician's Name, Address & Phone:

____

____

____

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CHILD & ADOLESCENT INTAKE SURVEY

Confidential

Child's Name: ____ Birthdate: ____/____/____

Grade: ______ Age: _______ Gender: ☐ Female ☐ Male School: _________________________________

Who has legal custody of the child? (check one)

______ Mother and father married to each other and have custody

______ Mother

______ Father

______ Joint Custody

______ Foster Care

______ Other (please specify): ____

Name of Primary Care Physician or Pediatrician: ____

Phone # of PCP or Pediatrician: ____

Mother's Name: ____________________________________ Age: ____ Education Level: _______________________
Occupation: _______________________________________ Telephone #: _____________________________________

Father's Name: ____________________________________ Age: ____ Education Level: _______________________
Occupation: _______________________________________ Telephone #: _____________________________________

Stepmother's Name: ________________________________ Age: ____ Education Level: _______________________
Occupation: _______________________________________ Telephone #: _____________________________________

Stepfather's Name: _________________________________ Age: ____ Education Level: _______________________
Occupation: _______________________________________ Telephone #: _____________________________________

Briefly summarize the problems that bring you and your child here today: ________________________________
____
____
____

How long has this been a problem?: ____

What helps the problem improve?: ____
____

What causes it to get worse?: ____
____

List all people living the household:

Name	Relationship to Child	Age
______________________________	_________________________	____________
______________________________	_________________________	____________
______________________________	_________________________	____________
______________________________	_________________________	____________
______________________________	_________________________	____________
______________________________	_________________________	____________

If any brothers, sisters, or significant others are living outside the home, list their names, relationship to the child, and ages:

______________________________ _________________________ ____________

______________________________ _________________________ ____________

______________________________ _________________________ ____________

What issues does the family have that are important regarding your child? (Examples: Separation, family conflict, visitation, divorce issues, abuse issues, etc.) ____

____

____

____

MEDICAL HISTORY

Has your child ever suffered from:

High fevers ☐ Yes ☐ No

If yes, please explain: ____

____

Chronic or serious illnesses (asthma, diabetes, epilepsy, etc.) ☐ Yes ☐ No

If yes, what illnesses: ____

____

Serious accidents: ☐ Yes ☐ No If yes, please describe: __________________________________

____

____

Is your child on medication?: ☐ Yes ☐ No If yes, what medication and for what reason: ____________

____

____

Does your child have any allergies? ☐ Yes ☐ No If yes, what type?: ________________________

____

____

DEVELOPMENTAL HISTORY

Were there any problems during pregnancy?:

☐ Yes ☐ No If yes, please explain: ____

____

____

Age of mother at time of birth: ____________

During pregnancy, did the mother?

Smoke: ☐ Yes ☐ No If yes, how many cigarettes per day? ______________________________________

Drink alcoholic beverages: ☐ Yes ☐ No If yes, how much per day? ________________________________

Use drugs? (including prescribed, over-the-counter, and/or recreational)? ☐ Yes ☐ No

If yes, what kind and how often? ____

____

____

Type of delivery: ☐ Vaginal ☐ C-Section Birth Weight: _______________

Was the child premature? ☐ Yes ☐ No If yes, how many weeks? _________________________________

Were there any complications during delivery? ☐ Yes ☐ No If yes, please describe: _____________________

____

____

Was there anything unusual about your child's development (walking, talking, toilet training, sleeping, feeding, etc.) during the first years? Please describe: ____

____

____

OTHER INFORMATION

Have any members of your child's family suffered from any of the following:

☐ Academic Problems	☐ Other Emotional Problems	☐ Alcoholism
☐ Schizophrenia	☐ Anxiety	☐ Depression
☐ Developmental Problems	☐ Bipolar (Manic-Depression)	☐ Drug Problems
☐ Suicide Attempt	☐ ADHD/ADD	☐ Other Mental Illness

If you answered yes to any of the above, please list which family member and briefly describe the problem: ______________

____

____

____

Has your child previously received psychological testing, therapy, or counseling? ☐ Yes ☐ No

If yes, please explain the reason, when, and from whom: ____

____

____

Has your child ever been in trouble with the law? ☐ Yes ☐ No If yes, please describe briefly: ____________

____

Have there been any family stresses that have occurred in the last 12 months? For example, moves, job or school changes, financial changes, divorce, separations, deaths, or other losses? ____

____

____

What type of discipline do you use with your child? Please check all that apply.

☐ Ignore the behavior	☐ Redirect child's interest	☐ Scold your child
☐ Spank your child	☐ Threaten child	☐ Reason with child
☐ Tell child to sit in chair	☐ Send child to his/her room	☐ Take away privileges
☐ Don't use discipline	☐ Other techniques (describe): ____________________________________	

Which type is most effective?: ____

Which type is least effective?: ____

Who usually administers the discipline?: ____

What does your child like to do most/least?: Most: ________________________ Least: _____________________________

What chores does your child do around the house?: ____

What are your child's strengths or assets?: ____

What one question do you most want answered as a result of this assessment?: ___________________________________

____

Is there any other information that you think may help us in working with your child?: __________________________________

____

SOCIAL AND BEHAVIORAL CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits:

- ☐ difficulty with speech
- ☐ difficulty with hearing
- ☐ difficulty with language
- ☐ difficulty with vision
- ☐ difficulty with coordination
- ☐ difficulty making friends
- ☐ difficulty keeping friends
- ☐ prefers to be alone
- ☐ does not get along well with brothers or sisters
- ☐ does not get along well with other children
- ☐ is aggressive
- ☐ is shy or timid
- ☐ tires easily, has little energy
- ☐ is more interested in things than in people
- ☐ engages in behavior that could be dangerous to self or others (describe) ____________________________
- ☐ lies
- ☐ steals
- ☐ injures self often
- ☐ runs away
- ☐ has low self-esteem
- ☐ blames others
- ☐ is argumentative
- ☐ shows wide mood swings
- ☐ exhibits anxiety when separated from parent
- ☐ unusual fears, habits or mannerisms (describe) ___________________________
- ☐ wets bed
- ☐ bites nails
- ☐ frequent temper tantrums
- ☐ frequent nightmares
- ☐ trouble sleeping (describe) ____________________________
- ☐ rocks back and forth
- ☐ bangs head
- ☐ eats poorly
- ☐ is stubborn
- ☐ is much too active
- ☐ is fidgety
- ☐ is easily distracted
- ☐ is disorganized
- ☐ is clumsy
- ☐ has blank spells
- ☐ daydreams too much
- ☐ is impulsive
- ☐ takes unnecessary risks
- ☐ gets hurt frequently
- ☐ has too many accidents
- ☐ doesn't learn from experience
- ☐ feels that he or she is bad
- ☐ is slow to learn
- ☐ is not toilet trained
- ☐ shows sexually provocative behavior
- ☐ is fearful of strangers
- ☐ does not understand other's feelings
- ☐ difficulty following directions
- ☐ gives up easily
- ☐ takes drugs (describe) ______________ ___________________________________
- ☐ complains of aches & pains
- ☐ is disobedient
- ☐ constantly seeks attention
- ☐ is restless
- ☐ is jealous
- ☐ feels hopelessness
- ☐ is nervous
- ☐ does not show feelings
- ☐ is immature
- ☐ is easily frustrated
- ☐ requires constant attention
- ☐ can't resist peer pressure
- ☐ shows anger easily
- ☐ worries a lot
- ☐ doesn't accept criticism
- ☐ feels sad, unhappy
- ☐ has poor attention span
- ☐ has poor memory
- ☐ sets fires
- ☐ is afraid of new situations
- ☐ eats inedible objects
- ☐ fights with other children
- ☐ refuses to sleep alone
- ☐ refuses to go to bed
- ☐ has fear at bedtime
- ☐ fearful of visiting a relative
- ☐ other problems ____