

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.

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: _____

PATIENTS' RIGHTS AND RESPONSIBILITIES STATEMENT

STATEMENT OF PATIENTS' RIGHTS

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.

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.

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.

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 abuse to appropriate agencies.

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

Signature

Date

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.

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: _____

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)

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

**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)

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

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 CFR 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. _____
(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:

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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Academic Problems | <input type="checkbox"/> Other Emotional Problems | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Developmental Problems | <input type="checkbox"/> Bipolar (Manic-Depression) | <input type="checkbox"/> Drug Problems |
| <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> 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.

- | | | |
|---|---|---|
| <input type="checkbox"/> Ignore the behavior | <input type="checkbox"/> Redirect child's interest | <input type="checkbox"/> Scold your child |
| <input type="checkbox"/> Spank your child | <input type="checkbox"/> Threaten child | <input type="checkbox"/> Reason with child |
| <input type="checkbox"/> Tell child to sit in chair | <input type="checkbox"/> Send child to his/her room | <input type="checkbox"/> Take away privileges |
| <input type="checkbox"/> Don't use discipline | <input type="checkbox"/> 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:

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