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 ☐ Separated ☐ Widowed ☐

Employed ☐ Unemployed ☐ Full-Time Student ☐ Part-Time Student ☐

Nearest relative NOT living in home: _____ 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 #_____

RESPONSIBLE PARTY SIGNATURE: _____

***** *(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.*
☐ *Stephen P. Farr, Ph.D., BCIA-EEG*
☐ *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 our office*. I also understand that, should a collections process become necessary, I am responsible for all expenses connected with their process. I further authorize the release of information for insurance purposes.

Signed:_____ Referred By:_____

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PATIENTS' RIGHTS AND RESPONSIBILITIES STATEMENT

STATEMENT OF PATIENTS' RIGHTS
Patients have the right to:

- Be treated with dignity and respect.
- Fair treatment, regardless of their race, religion gender, ethnicity, age, disability, or source of payment
- Their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about Magellan, its practitioners. services and role in the treatment process.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- 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.

STATEMENT OF PATIENTS' RESPONSIBILITIES:

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is 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.
- Let their providers know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- 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

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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 the normal hourly rate 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 another 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'll 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., Stephen P. Farr, Ph.D., Janice R. Hughes, Ph.D., and Patricia A. McCoy, Ph.D., Pamela A. Farr, Ph.D., their assistants and/or designees. I am aware that the practice of Clinical Psychology and 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 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 for Affiliated Psychological to 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 <u>Primary Care Physician</u> listed below

_____ DO NOT release information to my <u>Primary Care Physician</u>

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

Primary Care Physician's Name, Address & Phone:

_____

_____

_____

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ADULT INTAKE SURVEY

Confidential

Patient Name: _____ Birthdate: ____/____/____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____)_____ Cell Phone: : (____)_____ Gender: ☐ Female ☐ Male

Reason you are seeking therapy:

_____
_____
_____
_____

PATIENT HISTORY:

Present psychological difficulties – please check any that apply to you at this time.

_____ Generalized anxiety (across many situations)
_____ Specific fears/phobias (list): _____
_____ Panic attacks
_____ Social anxiety
_____ Obsessive thinking or compulsive behaviors
_____ Sadness or depression
_____ Emotionally overwhelmed
_____ Frequent crying
_____ Loss of energy
_____ Loss of pleasure in life
_____ Self-injurious / Self-harm behavior (e.g. hair pulling, cutting self, etc.)
_____ Thoughts of suicide
_____ Problems with eating
_____ Problems falling asleep
_____ Problems sleeping through the night (middle of night waking or early morning waking)
_____ Trouble waking up
_____ Nightmares
_____ Fatigue/tiredness during the day
_____ Problems with attention or concentration
_____ Racing thoughts
_____ Problems making or keeping friends
_____ Problems controlling temper
_____ Relationship/Marriage problems
_____ Problems with intimacy
_____ Problems with job
_____ History of abuse (emotional, physical, sexual)
_____ Alcohol/drug use/abuse
_____ Financial problems
_____ Legal situation

Other (please list below):

_____
_____

Describe any previous mental health services you have received (evaluations and therapy). Include the provider, diagnosis, and length of treatment.

_____
_____
_____
_____

What do you wish to accomplish (what are your goals) in seeking services at this time?

_____
_____
_____
_____

Please rate the overall level of stress in your life:

☐ Very low ☐ Low ☐ Average ☐ High ☐ Very High

What is your greatest source of stress at this time?

_____
_____

Rate your overall level of happiness on a scale of 1-5 (1=Unhappy, 5=Happy) _____

FAMILY INFORMATION:

Marital Status (check one):

☐ Single ☐ Living with partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If separated, how long? _____ If Married, how long? _____

Rate quality of present relationship/marriage (if applicable):

☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very poor

Your occupation: _____

Occupation of spouse/partner: _____

Other persons (in the home):

Name	Relationship	Age	Occupation	Education

Other persons (outside the home):

Name	Relationship	Age	Occupation	Education

If divorced, what are the custody and/or visitation arrangements?

_____
_____
_____

GENERAL HEALTH:

Your current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Primary Physician's name/address/phone number:

_____
_____
_____

Date of last physical exam? Any relevant findings?

_____
_____

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (allergies, surgeries/hospitalizations, asthmas, ulcers, hypertension, diabetes, heart disease, cancer, etc.):

_____
_____
_____
_____

Medications, Supplements
List prescriptions or non-prescription medications you are currently taking. If you are taking health supplements, please include those as well:

Medication	**Reason placed on med**	**Dosage**	**Length of time on med**	**Prescribing physician**

Substance Use History
List any recreational drugs (including alcohol) you are currently using or have used in the past:

Substance	**Amount**	**Frequency**	**Duration**	**First Use**	**Last Use**
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Amphetamines					
Hallucinogens					
Other					

Are you able to stop drinking or using drugs after having a moderate amount? ☐ Yes ☐ No

After drinking/using drugs for a period of time, have you ever had any of the following experiences?

- ☐ A hangover
- ☐ Nausea or vomiting
- ☐ The shakes
- ☐ Blackouts (can't remember)
- ☐ Feelings of fear and anxiety
- ☐ Convulsions or seizures
- ☐ DTs
- ☐ Getting arrested
- ☐ Losing friends
- ☐ Losing job or jobs
- ☐ Divorce or separation
- ☐ Financial problems
- ☐ Serious medical problems
- ☐ Depression

FAMILY HISTORY:

Has anyone in your birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

Yes	Condition	Family Member
	Mental retardation	
	Speech or communication disorder	
Yes	**Condition**	**Family Member**
	Attention-deficit / Hyperactivity / Imsupsivity	
	Learning problems / disabilities	
	Autism spectrum / Asperger's Disorder	
	Sleep disorders	
	Generalized Anxiety (across many situations)	
	Social Anxiety	
	Obsessive-compulsive disorder	
	Phobias	
	Depression	
	Manic-depression / Bipolar disorder	
	Suicide attempts / suicide	
	Schizophrenia or other psychosis	
	Alcohol / Substance abuse	
	Seizures and other neurological disorder	
	Genetic disorder (e.g. Down Syndrome, Fragile X)	
	Other: (please list on back if necessary)	

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:

_____
_____
_____

EDUCATIONAL HISTORY:

Your highest level of education completed: _____

Have you had any problems with attention, learning or behavior in school?

_____
_____
_____

Grades repeated and reason:

_____
_____
_____

Served in Special Education?

_____
_____
_____

Additional comments:

_____
_____
_____

LEGAL HISTORY:

Have you ever filed or been involved in any litigation? Please explain.

_____
_____
_____

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PROBLEM CHECKLIST

(Mke a check mark next to any problems you are having)

☐	Convulsions	☐	Suicidal attempts
☐	Sleep disturbances	☐	Sexual problems
☐	Numbness	☐	Don't like weekends/vacations
☐	Dizziness	☐	Shy with people
☐	Joint pain	☐	Feel lonely
☐	Unable to relax	☐	Can't keep a job
☐	Hear sounds/see visions	☐	Home conditions bad
☐	Fainting spells	☐	Weight loss
☐	Stomach trouble	☐	Weight gain
☐	Bowel disturbances	☐	Difficulty walking
☐	Insomnia	☐	Crying spells
☐	Take sedatives	☐	Paralysis
☐	Feel tense	☐	Loss of interest in work/hobby
☐	Tremors	☐	Sadness
☐	Drugs	☐	Headaches
☐	Unable to have a good time	☐	Palpitations
☐	Over-ambitious	☐	No appetite
☐	Can't make friends	☐	Fatigue
☐	Can't make decisions	☐	Nightmares
☐	Inferiority feelings	☐	Alcoholism
☐	Financial problems	☐	Feel panicky
☐	Tingling	☐	Depressed

Signature of Person completing the form:

_____ Date:_____