CAHABA PSYCHOLOGY CENTER **Today's Date: _____**

CHILD INTAKE FORM

Person Completing Form: _____

Relationship: _____

Name: _____Goes By:_____
First MI Last

DOB: ____/____/_____ Age: _____ School: _____ Grade:_____

Sex: M / F Referred By: _____

Primary Care Physician: _____ Phone #: _____

Your Home Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name: _____Phone: _____ Relationship:_____

Home Phone: _____ Cell: _____ Work: _____

Best contact for reminders, changes to appointments, etc. (circle one): Home/Cell/Work/Email

****If you would like cell phone text reminders, please provide your cellphone carrier: _____**

Email Address: _____

INSURANCE INFORMATION

Primary Insurance: _____	**Secondary Insurance: _____**
Policy #: _____	**Policy #: _____**
Group #: _____	**Group #: _____**
Effective Date: _____	**Effective Date: _____**
Insured's Name: _____	**Insured's Name: _____**
Relationship to Patient: _____	**Relationship to Patient: _____**
DOB: __/___/___Employer: _____	**DOB: __/___/___ Employer: _____**

Brief Statement of Concerns:

_____

_____

Child's Natural or Adopted Parents are: ☐ **Living Together** ☐ **Separated** ☐ **Divorced**

☐ **Father Deceased** ☐ **Mother Deceased** ☐ **Father Remarried** ☐ **Mother Remarried**

Natural or Adopted Father's Full Name: _____

Address if different than above: _____

Natural or Adopted Mother's Full Name: _____

Address if different than above: _____

Stepfather's Full Name: _____

Address: _____

Stepmother's Full Name: _____

Address: _____

This Child Lives With: _____ **Relationship to Child:** _____

If applicable, Child is in Legal Custody of: _____ ☐ **Full** ☐ **Joint**

Family Employment

Name of Employed Person	**Place of Employment**	**Type of Work**
1)		
2)		

Father's Work Phone: _____ **Mother's Work Phone:** _____

Stepfather's Work Phone: _____ **Stepmother's Work Phone:** _____

Siblings Names	**Age**	**Relationship**	**School, Grade**
1)			
2)			
3)			
4)			

HEALTH INSURANCE BENEFITS WORKSHEET

YOU ARE RESPONSIBLE for finding out what your MENTAL HEALTH BENEFITS are and keeping track of what your financial responsibility will be for your therapy! If you do not obtain this information, we will need to collect the full amount for the initial visit which is $187. You will be reimbursed after your insurance has paid.

Insurance Company: _____ (If Blue Cross/Blue Shield see below)

Member# _____ Group # _____

Date Called: _____ whom you spoke to: _____

Copay: $ _____ Deductible: $_____

Does my deductible apply to mental health? _____

If so, how much of my deductible has been met? _____

When does my deductible start over? _____

Do I require a referral from my primary care physician? _____yes _____no

Do I require authorization? _____ Visit Limit? _____

If yes, how many have I used? _____

Where should my claims be mailed?

_____

_____

_____

Blue Cross/Blue Shield specific questions

1. **Do I have EPS benefits? _____yes _____no**
2. **Am I required to use an EPS provider to get in-network benefits? ____ yes _____no**
3. **Am I required to use a community health center? _____yes _____no**
4. **Do I require a referral from my primary care physician?-____yes _____no**

*****If you answer yes to ANY of these questions we are considered out-of-network, in most cases. Your insurance may pay 50% or less of the charges and your deductible may apply to your visit. If so, you will be required to pay any remaining balance.**

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

Cahaba Psychology Center

Gayle S. Janzen, Ph.D.
Patricia Jolly-Fleece, Ph.D.
Mark H. Burge, Ph.D.
Renee Y. Moore, Psy.D..

FINANCIAL POLICY

- **AS A COURTESY TO YOU, WE WILL GLADLY FILE YOUR PRIMARY INSURANCE CLAIMS, FOR WHICH WE ARE IN-NETWORK:** However, it is your responsibility to handle any problems with your insurance company. We will re-file any claims that you request after you have contacted your insurance company to verify that re-filing is necessary.

- **YOU ARE RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAYMENT, AND CO-INSURANCE. CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.**

- **ANY BALANCE NOT PAID BY YOUR INSURANCE COMPANY AFTER 60 DAYS IS YOUR RESPONSIBILITY.** A balance over 90 days is delinquent and you will need to make payment arrangements with us.

- We will do our very best to help you understand your insurance benefits, however, **WE CAN NOT GUARANTEE ANYTHING ABOUT YOUR INSURANCE.** All payment decisions are made by the insurance company upon their receipt of the claim, based on your benefit plan. **It is your responsibility to know your insurance coverage.**

- **IF YOU ARE A SELF-PAY PATIENT, ALL FEES ARE DUE IN FULL AT THE TIME SERVICES ARE RENDERED.**

- **IF YOU MISS OR CANCEL AN APPOINTMENT WITH LESS THAN 24 HOURS NOTICE,** YOU WILL BE CHARGED A $70.00 FEE. THIS FEE IS NOT COVERED BY YOUR INSURANCE (THIS DOES NOT INCLUDE MEDICAID).

I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICY IN ITS ENTIRETY AND AGREE TO ADHERE TO ITS CONDITIONS.

PATIENT'S NAME (please print) _____ Date_____

PATIENT'S SIGNATURE _____Date_____
(Parent/ guardian if patient is a minor)

WITNESS (Office staff only) _____ Date _____

2 Riverchase Office Plaza•Suite 115•Birmingham, AL 35244

Office: (205) 403-0955 •Fax: (205) 403-0956 •cahabaps@bellsouth.net

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to Cahaba Psychology Center. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.
HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information by the end of the first session.
Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

ABOUT PSYCHOTHERAPY
Individuals consult with psychologists for a variety of reasons. We will make every effort to respect your individual needs and goals in treatment. The therapy process involves a working partnership between you and your psychologist. Our work may include a variety of activities, and for optimum outcomes to occur, your active participation is essential. We will attempt to help you achieve your goals, but we cannot guarantee that the outcome will be what you now seek. In addition, change is often accompanied by feeling states that can be distressing. You may experience moments of frustration, anxiety, feelings of depression, self-doubt, and confusion. While we are trained, licensed and experienced psychologists, we cannot guarantee change nor can we promise that all problems will be resolved

PROFESSIONAL FEES

The fee for an initial consultation (approximately 50 to 55 minutes) is $187.00. During the consultation, the client and therapist together will agree on the frequency and length of subsequent appointments. Session length between 16 to 37 minutes is billed at $70.00. Session length between 38 to 52 minutes is billed at $140.00. Sessions over 52 minutes are billed at $187.00. Additional fees may be applied for additional services and interactive complexity (such as play therapy or brief consultation with family members).

Other fees:

1. The fee for returned checks is $30.00.
2. Any court appearance, or deposition, or the provision of documents for any attorney or for the court will be billed at a rate of $200 per hour, and will include preparation and travel time. You will be responsible for all such fees related to your evaluation or treatment, payable at the time any such court-related services are requested.
3. The fee for Medical Records or written communications to you or on your behalf will be a minimum of $20 and can increase depending on time spent.
4. Psychological assessments/evaluations are charged at the rate of $200 per unit of time required for administration, scoring, interpretation, and report.

Payment for services is expected at time of service. You may use a credit card, check or cash to pay for these services. We will file your primary, in-network insurance for those of you who have mental health coverage. Most insurances and managed care organizations require a co-pay and/or deductible for which you are responsible**. If you are using your insurance, you are responsible for verification of coverage and for obtaining pre-authorization for these services prior to your first visit.**

CANCELLATION/MISSED APPOINTMENT POLICY
When someone fails to appear for a scheduled appointment, we are not able to fill that time-slot with another client. If you fail to provide **a 24-hour notic**e, **you will be charged $70.00 (Fee does not apply to Medicaid; however, you are still required to give 24- hour notice)**. We cannot bill your insurance company for a missed appointment. If you give us 24 hours notice of your intention not to use one of your appointments, you will not be charged. If the office is closed or you are unable to get someone to answer the phone, you may leave a voicemail canceling your appointment. After a missed appointment, if you do not contact our office within 10 days to reschedule, your psychologist will accept that as your notice that you have terminated therapy with our office.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If the Alabama Board of Examiners in Psychology is requesting the information for an investigation of our practice, we are required to provide it for them.
- If a patient files a complaint or lawsuit against one of us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, we may disclose information relevant to that claim to the patient's employer or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we know or suspect that a child under the age of 18 has been abused or neglected, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.
- If we know or suspect that an elderly or disabled adult has been abused, neglected, exploited, sexually or emotionally abused, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.
- If we believe that disclosing information about you is necessary to prevent or lessen a serious and imminent threat to the health and safety of an identifiable person(s), we may disclose that information, but only to those reasonably able to prevent or lessen the threat.

If one of these situations arises, we will make every effort to fully discuss it with you before taking any action and we will try to limit our disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, test results, and any reports that have been sent to anyone, including reports to your insurance carrier. If you provide us with an appropriate written request, you have the right to examine and/or receive a copy of your records for a fee, except in unusual circumstances that involve danger to you or others. In those situations, you have a right to have your record sent to another mental health provider. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request. In addition, we may also keep a set of Psychotherapy Notes. These notes are for our own use and are designed to assist us in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client

to client, they can include the contents of our conversations, our analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to us that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We will be happy to discuss any of these rights with you.

MINORS & PARENTS

For therapy with children under the age of 14, it is our policy to request an agreement in which parents (or guardians) consent to give up access to the child's records. If a diagnostic evaluation or assessment is requested, we will discuss findings, results, and treatment plans with you. Most of the minors we see are brought voluntarily by their parents and come with parental knowledge. In such circumstances, parents are often understandably curious about the treatment of their children. It is our position, however, that young people need to develop trust in their therapist and need some degree of security and privacy. Therefore, we specifically request that you limit your inquiry about the details of their therapy. We need you to know that we will, indeed, bring to your attention matters that we believe are important for you to know, and we request that you trust our judgment about this important issue. We also hope that you will refrain from asking your child what has transpired in therapy or diagnostic sessions. If your child is 14 or over, we cannot discuss anything about evaluation or treatment with you without the written Authorization from your child.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, the costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will gladly file your primary insurance to any insurance company for which we are in-network; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, and the accompanying Authorization, you agree that we can provide requested information to your carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above.

CONTACTING US

Our office hours are as follows:

8:30 a.m. to 4:30 p.m., Monday through Thursday
9:00 a.m. to 2:30 p.m., Alternating Fridays
Closed for lunch daily 12 noon to 1:00 p.m.

For **emergencies** after hours, we can be reached through the following numbers:

Dr. Mark Burge	205-447-4255
Dr. Gayle Janzen	205-960-9342
Dr. Patricia Jolly-Fleece	205-533-0851
Dr. Renee Moore	205-578-7003

If you are unable to reach us and feel that you cannot wait for one of us to return your call, contact your family physician or the nearest emergency room, and ask for the psychiatrist on call. If one of us will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Printed name of Patient _____

Signature of Patient (ages 14 & up) Date signed

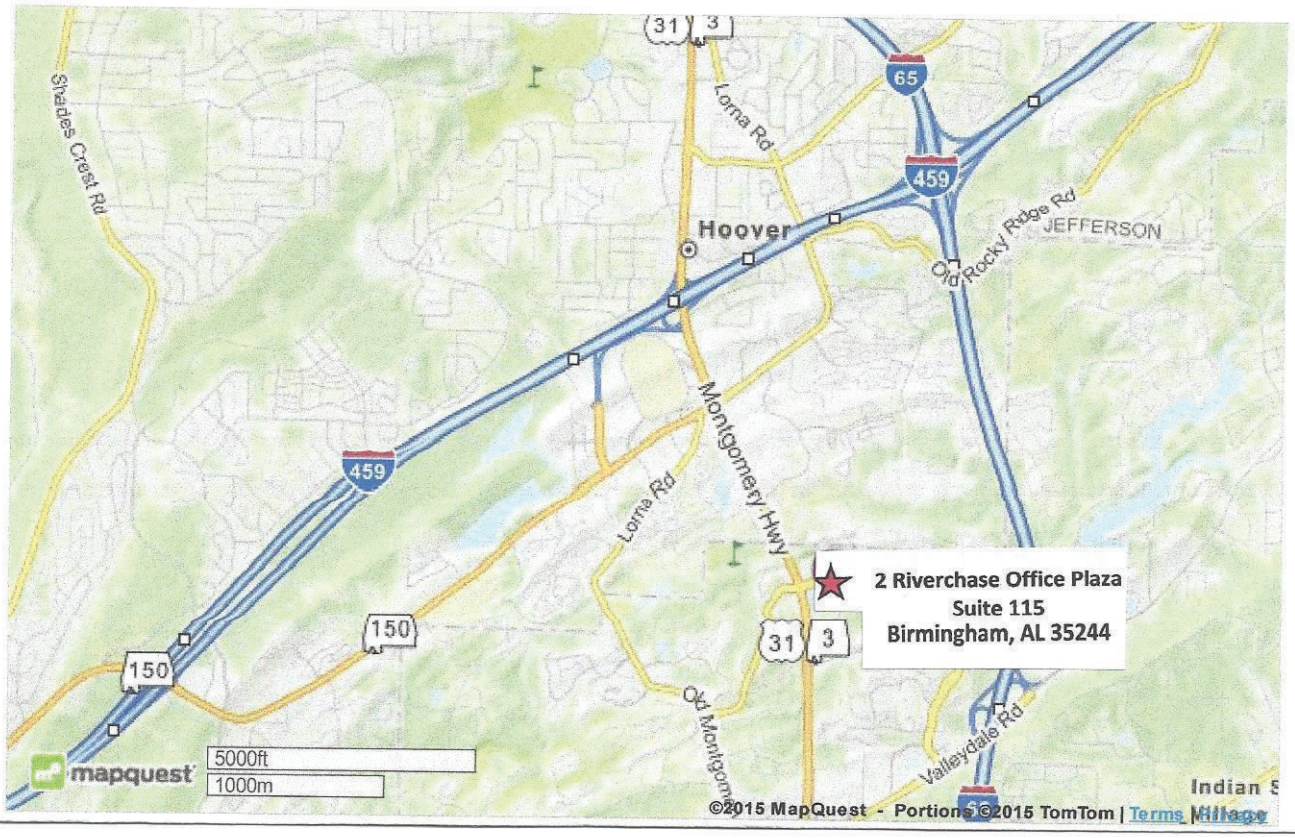
_____

Signature of Parent or Legal Guardian Date signed

_____

Witnessed by Office Staff Date witnessed

Revised 03/2018



Directions to Office (GPS OFTEN TAKES YOU TO THE WRONG PLACE)

Going South on Hwy 31 (Towards Pelham/Alabster)

- Approximately 1 mile South of the Riverchase Galleria
- Turn Left onto Riverchase Parkway
- Turn Right at 1st Light onto Parkway River Road
- Take 3rd Right into Riverchase Office Plaza
- Building 2 in the very back of the complex
- Suite 115 – Downstairs at the Left end of the building

Going North on Hwy 31 (Towards Birmingham)

- Approximately 1 mile North of Valleydale Road
- Turn Right onto Riverchase Parkway
- Turn Right at 1st Light onto Parkway River Road
- Take 3rd Right into Riverchase Office Plaza
- Building 2 in the very back of the complex
- Suite 115 – Downstairs at the Left end of the building