Complete for All Adults (18 years of age and older)

Atlanta Pediatric Psychology Associates and Northlake Psychology Associates
3580 Habersham at Northlake, Tucker, Georgia 30084
Phone: 770-939-3073 Fax: 770-939-3275

Adult Patient Information
(Four Pages)

Patient Name: _____
Last First Middle Date

Address	Street:			Apt. #:
City:		County:	State:	Zip:
Home Phone:		Work Phone:		Fax:
Cell Phone:		E-mail:		
Birth Date:	Age:	Sex:	Ht.:	Wt.:
Relationship Status (check one):	Married: ☐	Single: ☐	Divorced: ☐	Separated: ☐
	Widowed: ☐	In Relationship: ☐	Not In Relationship: ☐	
	If married, Name of Spouse:			Years Married:
	In relationship, Name of Partner:			Years Together:
Legal Status:	Competent Adult: ☐	Other:		
Emergency Contact Person:			Relationship:	
Contact Person's Phone	Home:	Work:		Cell:
Employer/School:			If in School, Grade:	
Occupation or Major:				
If not in school, Years of Education:			Degree(s):	
Please explain the reason patient is seeking services.				
Is patient currently taking **Psychotropic Medications**, i.e., medication for emotional or behavioral problems?			Yes: ☐	No: ☐
Has patient had previous Psychological/Psychiatric Treatment?			Yes: ☐	No: ☐
Who referred patient?				
Who is responsible for paying for services?				
Name of Insurance Company:				

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FAMILY		
Please explain patient's current family and living situation. [For example: I am a married mother of three living with my husband and three children. Or, I am a junior living in a dorm at UGA, and I live with my parents when not in school.]		
People living with patient	Relation	Age
People who are significant to patient but do not live with patient, e. g., children, parents, friends, etc.		
Father:		
Mother:		

Current Evaluation and/or Treatment

If not already given on the previous page, please explain your problems or symptoms that caused you to seek treatment at the current time.

Symptom Checklist

Check "Yes" if you have experienced a symptom in the past 6 weeks.

Symptom	Yes	Symptom	Yes	Symptom	Yes
Depression	☐	Panic Attacks	☐	Distractible	☐
Loss of Appetite	☐	Low Self-Esteem	☐	Suicidal Thoughts	☐
Sleep Problems	☐	Paranoid Thoughts	☐	Suicidal Acts	☐
Feeling "flat"	☐	Tearful	☐	Hallucinations	☐
Feeling Helpless or Hopeless	☐	Sudden Changes in Feelings	☐	Homicidal Thoughts	☐
Little Enjoyment in Life	☐	Social Withdrawal	☐	Alcohol Abuse	☐
Decreased Energy	☐	Aggressive Behavior	☐	Drug Abuse	☐
Anxiety/Worry	☐	Temper Outbursts	☐	Poor Judgment	☐
Phobias	☐	Manic/Hyperactive	☐	Thinking Problems	☐
Binge Eating	☐	Short Attention Span	☐	Memory Problems	☐
Vomiting	☐	Impulsive	☐	Compulsive Behavior	☐

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CURRENT AND PAST TREATMENT

Current *Mental Health* Treatment: Please list any services being received from a Mental Health Professional or Group such as psychologist, psychiatrist, social worker, AA, etc.

Type of Treatment (e.g. "counseling" or "medication")	Doctor's or Provider's Name

Past *Mental Health* Treatment: Include hospitalizations.

Type of Treatment (e.g. "counseling", "medication", or Hospitalization)	Doctor's, Provider's or Hosptial's Name

Current Psychotropic Medications (Drugs for ADHD, Depression, Anxiety, etc.

Drug Name	Dose & Frequency	Start Date	Purpose	Prescribing Doctor

Past *Psychotropic* Medications

Drug Name	Dates	Purpose and Response	Prescribing Doctor

Medical History

Primary Care Physician:	**Phone:**
Address:	**Date of Last Physical:**

Current Health (Medical Problems/Conditions):

Current *Non-Psychotropic* Medications, i.e., for medical conditions.

Drug Name	Dose & Frequency	Purpose	Prescribing Doctor

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Allergies: Yes ☐ No ☐
Please describe and list all allergies.
Past Significant Medical Problems/Injuries/Hospitalizations and Dates

Other Information:

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Authorizations and Notification Form

This AUTHORIZATIONS AND NOTIFICATION FORM is designed as a simplified way to present you with summaries of relevant authorizations and policies/procedures, most of which are contained in the Outpatient Services Contract. Please read the source document when one is referenced.

Patient Name:_____

Person Signing Authorizations if other than client:_____

Signer's Relationship to client/patient:_____

For each Authorization, please check the appropriate box indicating if you Authorize or Do Not Authorize the described activity.

AUTHORIZATIONS

1. Authorization for Treatment

I authorize and give permission for an APPA/NPA psychologist to provide treatment for me or the patient for whom I am the legal guardian. (References: Outpatient Services Contract: Treatment Policies and Procedures)

☐ **Yes. I authorize treatment.**
☐ **No. I do not authorize treatment.**

2. Authorization to File Insurance: Insurance Information and Payment (References: Outpatient Services Contract: Treatment Policies and Procedures)

All billing and insurance filing for APPA and NPA are handled by an off-site billing company (800.789.5761). All patients or their guardians (e.g., parents) should call this number to provide the necessary information for self-payment or insurance. Please mark this form below, if you do or do not authorize APPA or NPA to file insurance.

Some insurance companies pay fixed allowances for treatment and others pay a percentage of the charge. It is your responsibility to pay for any deductible amount, co-pay, any non-covered service, or service for which you are ineligible under your policy. Authorization of service and payment by the insurance company is contingent on eligibility and benefits available. *I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits directly to the doctor or group indicated on the claim.* ***I understand and agree that I am responsible for any balance (charges) not covered by my insurance.***

☐ **Yes. I authorize filing for insurance.**
☐ **No. I do not authorize filing for insurance.**

3. **Authorization to Release Information to Insurance or Managed Care Company** (References: Outpatient Services Contract: Confidentiality & Privilege Policy)

   Managed Care Companies require that initial evaluations and treatment plans be submitted on a regular basis in order for them to certify treatment. *I hereby authorize release of information requested by insurance or managed care companies for processing of claims for insurance reimbursement.*

   ☐ **Yes. I authorize release of information.**
   ☐ **No. I do not authorize release of information.**

4. **Authorization to Release Information to Primary Care Physician** (References: Outpatient Services Contract: Confidentiality & Privilege Policy)

   If you have a Primary Care Physician, you may wish to authorize your psychologist to share relevant information about your case. This is not required. *I hereby authorize release of relevant information to my primary care physician.*

   ☐ **Yes. I authorize release of information to my Primary Care Physician.**
   ☐ **No. I do not authorize release of information to my Primary Care Physician.**

Primary Care Physician		
Name:		
Address:		
Phone:	Fax:	Email:

ACKNOWLEDGEMENT: **By signing at the end of this document**, you acknowledge that you have read and are in agreement with the policies and procedures referenced below. You should read the Outpatient Services Contract in its entirety for a complete understanding.

5. **Failed/Missed Appointments** (References: Outpatient Services Contract: Page 2, Missed Appointment Policy) It is very important you read and understand this policy in its entirety.

   I agree to notify APPA/NPA at least twenty-four (24) hours prior to my scheduled appointment (48 hours for testing) if I decide to cancel. I understand and agree that I will be charged a minimum of $25.00 up to a maximum of the full-session fee for any appointment not kept or canceled at least 24 hours in advance. (For testing, the charge for not giving 48-hour notice is one hour of service.) I also understand and agree that this charge is not reimbursable by my insurance company.

6. Confidentiality and Privilege Policy: (References: Outpatient Services Contract)**.**

   I have read and understand the Confidentiality and Privilege Policy and the sections in the Outpatient Services Contract: that relate to confidentiality. As part of this policy I have read the *HIPAA Privacy Rules*. I understand that I may discuss this policy with my psychologist and may wish to discuss it with my attorney.

7. Terminating Patients from Practice Policy (References: Outpatient Services Contract: Page 3, Termination Policy)

I have read and accept the APPA/NPA Treatment Termination Policy. I understand that I may discuss this policy with my psychologist.

8. Outpatient Services Contract

I have read and accept the Outpatient Services Contract. I understand that this is a legal document and represents a binding agreement between my doctor and myself. I have the right to discuss any aspects that I do not understand and to request any modifications, which I desire. **[Note: The signed copy of the Outpatient Services Contract will be retained in your medical file. If you want a copy for your home records, please ask your psychologist to provide one for you.]**

My signature (or typed name) below signifies that I have read and agree with the Outpatient Services Contract, and that I have authorized the services described in this document.

_____ _____

Adult Patient or Legal Guardian Date

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INSURANCE INFORMATION

Patient's Name: _____
Last First Middle Date

Parent's Name: _____
(If patient is under 18) Last First Middle

Street Address:			
City:	State:	County:	Zip:
Referred by:			
Social Security Number:		Patient's Birth Date:	
Patient's Marital Status:		Spouse's Name:	
Home Phone:		Work Phone:	
Cell Phone:			
Primary Care Physician:		Pediatrician:	
Emergency Contact Person:			
Relationship to Patient:			
Emergency Person's Phone Numbers			

Employment Information	
Responsible party's employer:	
Address of Employer:	
Work Phone Number:	
Spouse's Employer:	
Address of Employer	
Work Phone Number:	

Primary Insurance Information	
Name of Insured:	
Date of Birth:	SSN#:
Group #:	Plan #:
Name of Insurance Co.:	
Address:	
Phone # (Ins.):	

Secondary Insurance Information

Name of Insured:	
Date of Birth:	SSN#:
Group #:	Plan #:
Name of Insurance Co.:	
Address:	
Phone # (Ins.):	

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OUTPATIENT SERVICES CONTRACT

I welcome you to my practice[1]. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting. Once you sign this, it will constitute a binding agreement between us.

I know that reading and completing this and other documents seems like a lot of work. However, if I am to provide you the services you want and need, it is important that I know as much as possible about your problems and that you understand the nature of the relationship between doctor and patient.

Name of Patient[2]: _____

If patient is a minor,
Name(s) of legal guardian representing patient:

_____

PSYCHOLOGICAL SERVICES

Psychological evaluation and treatment, whether for you or a family member, is not easily described in general statements. What constitutes an *evaluation* (which may or may not include testing) will vary depending upon the nature of the presenting problem, the age of the patient, and the questions, which you want answered. Likewise, *treatment* takes many forms and may include individual, family, couples, or group approaches. In deciding on what is the best approach, both your personality and that of the therapist must be carefully considered. Psychological treatment is not like visiting a medical doctor, in that psychological treatment requires a very active effort on your part. In order to be most successful, you will have to work on things we talk about both during our sessions and at home. This is true if you are the patient or if you are seeking services for a child or other family member.

Psychological treatment[3] has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychological treatment often requires discussing unpleasant aspects of your life. Psychological treatment has also been shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. But there are no guarantees about what will happen.

Our first few sessions will involve an evaluation of your needs. For many children and some adults, the evaluation phase will involve formal psychological testing—in some cases an evaluation and recommendations are the only services that are requested. Whatever the nature of the evaluation, by the end of the evaluation phase, I will be able to offer you some initial impressions of what our work will include and an initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with me. Therapy involves a significant commitment of time, money, and energy, so you should be very careful

[1]When "I" is used in this contract, it refers to your psychologist: Carol P. Kleemeier, Ph.D. or Robert B. Kleemeier, Ph.D.

[2]Who is designated as the patient(s) has implications in terms of who has "privileged communication" under the law. If more than one person will be involved in therapy, please discuss this with me. The person Named as Patient does not officially become a patient of mine until: (1) the Outpatient Services Contract is signed, and (2) I have evaluated the patient, either face-to-face or via telehealth.

[3]In this document, unless stated otherwise, "psychological treatment" will be used to refer to both evaluation and treatment. Likewise, "you, your" etc. will be used to refer to the patient, who may be you or a minor child.

about the doctor you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you to secure an appropriate consultation with another mental health professional.

TREATMENT POLICIES AND PROCEDURES

Ages of patients treated: Within our practice, I (or one of my colleagues) treat children, adolescents, and adults.

Disorders treated: I (or one of my colleagues) treat most behavioral, emotional, and relationships problems. However, it is best to inquire at the time of your initial contact if you have any doubts about my ability to treat your particular condition.

Psychological Treatment: The first phase of treatment involves an evaluation, which will last from 1 to 4 sessions (this is not the same as "testing" which, if needed, will be a recommendation). During this time, I will gather information about you, or your child, and you will have an opportunity to get to know me. I will make recommendations to you that are based on the information gathered during the assessment. then propose a treatment plan to you that is based on the information gathered during the assessment. If you agree with my recommendations, we will schedule a time when the service can be provided through our office, or if the service is to be provided elsewhere, I will help you make any needed referrals.

Psychological Testing: When the primary need is for psychological testing, my normal practice is to meet with you (and your child if your child is the patient) for one session prior to the testing. This is to allow me to gather information about the problem, and to allow you and/or your child to become comfortable with the office and me. Unless I tell you otherwise, I will be directly involved in giving all or some of the tests; however, I may have a qualified assistant administer some parts. For some types of evaluations, my assistant will administer all of the tests. In such cases, I will analyze the findings and prepare the report. If you have any questions, please discuss them with me prior to the testing.

There are several phases to the psychological testing process, all of which are important if you are to receive maximum benefits:

i. Initial meeting to gather information and familiarize you with the testing procedure.
ii. Test administration (usually three to six hours) conducted on a single day but it may require more time and extend over several days.
iii. Test scoring and interpretation.
iv. Review of test findings and recommendations with you.
v. Preparation of final written report. Signed copies of this report will be given or mailed to you.

Missed Appointment Policy

Psychological Treatment: If you do not keep a scheduled appointment, you will be charged a minimum of $25.00 up to a maximum of the full session fee unless you provide 24 hours advance notice of cancellation or unless we both agree that you were unable to attend due to circumstances that were beyond your control. Canceling can be done 24 hours a day by calling the main office number and leaving a message of the cancellation. I would also appreciate your calling the office on the next working day to set up a new appointment time.

I understand that "things happen," and **I want you to reschedule if you or your child have an acute physical illness (there is no charge if this is the case).** However, please be aware that it is very hard for me to fill an appointment slot at the last minute, and for this reason I expect you to pay if you "forget" or have scheduling conflicts. There is no charge if this is the case.

Psychological Testing: Since testing is usually scheduled in three to six hour blocks of time, missing an appointment causes a major disruption in my schedule plus it inconveniences other patients who are waiting for an appointment. My standard policy is to charge you for one hour of testing time (my standard hourly fee) if I am not notified 48 hours in advance. If there is insufficient justification for missing the appointment or if it occurs more than once, I reserve the right to terminate our service contract and refer you to another doctor. (Please note that this rarely happens, but there are a few individuals who have chronic problems with missing appointments.) As stated above, I understand that there are serious and unanticipated crises, which arise in all of our lives. If such a crisis arises let me know as soon as possible and I will reschedule you without a charge. Examples of legitimate reasons for cancellation include the illness of the person to be tested (I do **not want** to test you or your child if the patient is sick as the results may be invalid), and the death or serious illness of a relative.

Office Policy and Procedure for Missed Appointments: If you miss or cancel an appointment, and you do not contact me within one working day, the office staff will attempt to call you to learn the reason and to reschedule. However, it is you responsibility to reschedule by calling the office.

TERMINATION POLICY

All relationships have a beginning, a middle, and an end. This is true in friendships, business, and psychological treatment. Successful relationships are those in which the participants agree on how each phase will be handled, work together to increase the probability of success, and accept when it is time to end. Translating this philosophy to therapy, **it is the position of APPA/NPA that the patient and doctor should mutually agree when it is time to terminate the therapeutic alliance**. Ideally this time comes when the patient's treatment goals have been achieved and there is a reasonable expectation that the gains will be maintained. There are, however, circumstances in which there is not mutual agreement, and it is these situations that the Treatment Termination Policy addresses.

Patient Initiated Terminations

Policy: A patient may termination treatment at any time. At the patient's request, the treating psychologist shall furnish referral sources for individuals or agencies that could continue the patient's treatment. In those rare cases in which the psychologist judges the patient to be a danger to himself, herself or others, appropriate parties shall be notified in accordance with the APPA/NPA Confidentiality Policy and state or federal laws. The patient shall remain obligated for any unpaid balances or other contractual agreements.

Doctor/Psychologist Initiated Terminations

It is extremely rare that the psychologist would decide to terminate treatment without the patient's consent, but it could happen under the following conditions:

- The goals of treatment have been met and treatment is no longer needed.
- The goals of treatment have not been met, and are unlikely to be within a reasonable time.
- The patient fails to pay fair and negotiated fees
- The patient refuses to cooperate with treatment
- Lack of progress despite appropriate treatment
- Conflict of interest
- Illness or disability of psychologist or family member requiring a reduction in or absence from work

Policy: If the psychologist judges that there are reasons to justify termination of treatment (and the patient does not agree), the psychologist shall:

- Discuss the issues with the patient and give the reasons for termination
- Attempt to correct the problem
- Give the patient sufficient notice to assure a smooth termination
- Provide the patient with appropriate referrals to qualified individuals, if requested by patient.
- Offer the patient a termination session
- Mail the patient a letter explaining the termination

PROFESSIONAL FEES

Each psychologist sets his/her fees independently, so please clarify the fees you will be charged prior to receiving any services. (Fees may be changed at any time. If this happens, you will be notified in writing and asked to sign a document agreeing to the new fees. You will not be charged new fees unless you have so agreed in writing.) In addition to treatment, it is my practice to charge this amount on a prorated basis for other professional services you may require such as writing letters and treatment summaries, telephone conversations which last longer than 5 minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries, or the time required to perform any other service which you may request of me. If your become involved in litigation which requires my participation, you will be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, I charge 1.5 to 2 times my self-pay hourly fee per hour for preparation for and attendance at any legal proceeding—this charge applies to travel and waiting time in addition to direct testimony, etc.

BILLING AND PAYMENTS

In the spring of 2020, we transferred all billing to an off-site agency. Consequently, after talking with our office (770.939.3073), all new patients should call the billing service (800.789.5761) before their first appointment. The service will explain the process, fees, insurance, etc. and notify us once all information has been obtained. You can call the billing service number listed above or for more specific questions call that number plus extension 106 for Insurance and extension 107 for general billing.

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, which requires another arrangement. Payment schedules for other professional services will be agreed to at the time these services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or installment payment plan.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In most cases, the only information, which I release about a client's treatment would be the client’s name, the nature of the services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will provide you with whatever assistance I can in facilitating your receipt of the benefits to which you are entitled including filling out forms as appropriate. However, you, and not your insurance company, are responsible for full payment of the fee that we have agreed to, unless this policy is covered in my contract, if any, with your insurance company. Therefore, 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, you should call your plan administrator and inquire. Of course, I will provide you with whatever information I can based on my experience and will be happy to try to assist you in deciphering the information you receive from your carrier. If necessary to resolve confusion, I am willing to call the carrier on your behalf.

The escalation of the cost of health care has resulted in an increasing level of complexity about insurance benefits, which sometimes makes it difficult to determine exactly how much mental health coverage is available. Managed Health Care Plans such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. These plans are often oriented towards a short-term treatment approach designed to resolve specific problems that are interfering with one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In my experience, quite a lot can be accomplished in short-term therapy, but many clients feel that more services are necessary after insurance benefits expire.

You should also be aware that most insurance agreements require you to authorize me to provide the Insurance Company with a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, I have no control over what they do with it. In some cases, they may share the information with a national medical information data bank.

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 the insurance benefits run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself and avoid the complexities, which are described above.

Insurance coverage for testing: Many insurance plans do not pay for psychological testing or limit the amount of payment. This is especially true for testing which they consider academic, but some companies also exclude ADHD testing. In these cases, testing is considered a "non-covered benefit". **I do not accept insurance for some types of testing and my contract with the insurance company may exclude other types.** There is much confusion about testing because many patients are told by their insurance companies that *evaluations* are covered—this often means a clinical interview *but not testing*. If you plan to use insurance for testing it is best to let my office manager check on your coverage for you. We will then let you know, to the best or our knowledge, what portion of the testing your insurance will cover and how much will be your responsibility. Your portion of the testing will be billed at my standard professional fee for "non-covered benefits" plus any co-payment or deductible for your insurance. **Self-Pay for testing:** Many people prefer to self-pay for testing rather than filing insurance, and in other cases people self-pay for a portion. Whether you agree to self-pay for all or part of an evaluation, once the testing has been completed, no insurance coverage/payments will be accepted for the self-pay services.

CONTACTING ME

Routine, non-emergency situations: I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I usually will not answer the phone when I am with a client. **When I am unavailable,** my telephone is answered by my secretary, an automated answering device, my answering service who usually knows where to reach me, or voice mail. In all cases, you will be able to speak with a "real person" if you so desire. I will make every effort to return your call on the same day you make it with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available.

Emergency/Crisis situations: If you experience an emergency, please follow the above procedure and inform my office staff or answering service that you need immediate help. If I am not available, one of my colleagues in my practice will return your call. Should you feel that you cannot wait for me or one of my colleagues to return your call, you should call your family physician or the emergency room at the nearest hospital and ask for the physician on call. If you are covered by a managed care policy, and the situation allows you the time, you should contact your plan's emergency number and learn which hospitals in the area are covered by your policy. If I am unavailable for an extended time, I will arrange for emergency coverage.

Emergency Commitments (Hospitalizations): It rarely happens, but in extreme emergencies it may be necessary to require a patient to be transported to a psychiatric hospital for an evaluation. If the patient is willing to go, a responsible adult can take the patient to the appropriate evaluation center. If the patient is unwilling to go, I (or another doctor) can complete the necessary orders, and the police can transport the patient. I will work with you to assure that all necessary steps are taken to assure the patient's safety and that of others. Depending upon the immediacy of the crisis the following resources may be contacted: 911-emergency services, psychiatric hospital, medical emergency room, managed care crisis care manager.

***Medical Emergencies*:** In the case of a medical emergency, the patient should be taken to the nearest emergency room or 911 should be called. Should the emergency occur in my office, and the patient's spouse, parent, or other responsible adult is not present, 911 will be called.

***Phone Crisis*:** If the crisis is one that can be handled by phone, please call the office and inform the operator of the nature of the problem. I will return your call and/or you should call your doctor, 911, your local community mental health center, private psychiatric hospitals or hospital emergency room.

CONFIDENTIALITY AND PRIVILEGE

(Confidentiality and Privilege are very important and the laws covering it quite complex. Please read this section with care. (6-10-2020 EDITION)

GENERAL STATEMENT

What a client tells a therapist has always been treated as private. Our society recognizes that this is the foundation of the trust we must have for therapy to work. However, the situation is not so simple that I can promise you that *everything* you tell me will *never* be revealed to anyone else. It is more complicated because there are some times when the law requires me to tell others, and there are some other limitations on our confidentiality. We need to discuss all of these so that there are no misunderstandings and no incorrect assumptions and we are as clear as we can be about the limits of confidentiality. Because you can't unsay what you have told, you must know about these rules at the beginning so that you don't tell me something you wish you had kept secret. These are important issues, so please read these pages carefully. Then we can them discuss, at our next meeting, any questions or concerns you might have.

What you tell me, since I am a **licensed psychologist**, is *almost* always **confidential**. That is, my professional ethics prevent me from telling anyone else what you told me. Furthermore, it may also be **privileged**; that is, protected by law much like the communication between a client and a Lawyer. Ultimately the courts decide what is privileged and what isn't, so if in doubt, consult an attorney. The use and disclosure of patient information is also covered by the ***Health Insurance Portability and Accounting Act (HIPAA)***, which is presented below.

Importance of Identifying "who is the patient": While it is my policy to protect the confidentiality of all my professional communications, legal protection—**privilege**—is only provided between doctor/psychologist and patient. For this reason, it is important to be clear about who is the patient. (For children [<18 years of age], the parent or legal guardian should fill out all forms, unless the courts have modified guardianship in some fashion.) This may be confusing when doing family or couples therapy. It is the "patient" who has privilege, so if only one partner in couples' therapy is the patient, then only that person can authorize the release of the record. If both are patients, then both would have to agree to release the information. **Each identified patient must complete all new patient documents** and in most cases must schedule an individual appointment to complete the intake process. Also, a person does not officially become a patient of mine until: (1) the *Outpatient Services Contract* is signed, and (2) I have evaluated the patient.

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. (Note: As a general rule, I do not take Psychotherapy Notes.)

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- *Adult and Domestic Abuse* – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- *Health Oversight Activities* – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will inform you by mail or phone.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Robert B. Kleemeier, Ph.D., President Tekna P.C., 3580 Habersham at Northlake, Tucker, Georgia 30084, 770-939-3073.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to Robert B. Kleemeier, Ph.D., President Tekna P.C., 3580 Habersham at Northlake, Tucker, Georgia 30084, 770-939-307.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on 4/14/2003 and was revised on 11/1/2020.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or phone. (A written copy will be mailed to you on your request.)

My signature (or typed name) below signifies that I have read and agree with the terms and conditions of this contract. **Typing your name is the same as signing this document. If you have read the document and agree with it, please type your name in the appropriate place.**

Other ways to sign the documents:

1. Print the document on paper. Sign the document (or the Signature Document Form) by hand. Mail of fax the document to our office.
2. Sign the Signature Document Form by hand. Take a picture of the signature page with your cell phone. Text the picture to our office. Send the completed documents to our office via email, fax or USPS.
3. Use a commercial service such as GlobalSign to produce a Digital Signature for the document. (Note: This is the best/safest way to sign electronic documents, but there is often a cost, and it adds some complexity.)

If you have any concerns or questions about any of the documents, please call the office and speak to the office manager or one of the psychologists.

Signature:_____ Date:_____
Adult Patient or Legal Guardian of a Minor

Signature:_____ Date:_____
Adult Patient or Legal Guardian of a Minor

(Note: When "I" is used in this contract, it refers to your psychologist: Carol P. Kleemeier, Ph.D. or Robert B. Kleemeier, Ph.D.)

Tekna P.C.
d/b/a
Atlanta Pediatric Psychology Associates and Northlake Psychology Associates 3580
Habersham at Northlake
Tucker, Georgia 30084

Informed Consent Form for Telehealth Services

I agree to receive Telehealth Services[1] with the following provisions:

- There are potential benefits and risks of telehealth services, including videoconferencing (e.g., ease of access and limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality applies to telehealth services, which among other things means that nobody can record the session without the permission of the other parties.
- All parties agree to use the telehealth platform selected by Drs. Robert and Carol Kleemeier, for all relevant services[2].
- Drs. Robert and Carol Kleemeier or their representative will explain how to use the platform for tele-conferencing.
- For tele-conferencing (on-line therapy), each client will need to have: (1) a computer with a camera with microphone plus a web connection; or (2) a smartphone with visual capability, (e.g., Facetime). Please note, communication is much clearer through a computer. This also improves confidentiality.
- It is important for the client to be in a quiet, private space that is free of distractions during the session.
- Parents: If your child is to be part of the treatment session, it is important that he/she have a private place to talk.
- It is important to use a secure internet connection to assure confidentiality. Often free /public Wi-Fi, facebook, skype, etc. may not be confidential. This is one reason why doxy.me was selected as the platform for telehealth.
- It is important to keep all scheduled appointments and to be on time. If you need to change an appointment, you must notify Drs. Bob or Carol in advance by phone with our office manager, Jordan Morgo, (770-939-3073).
- There must be a back-up plan (e.g., a phone number where you can be reached), if the session needs to be restarted or rescheduled, or if here are technical problems.
- A safety plan is essential that includes: (1) at lease one emergency contact person (with phone number), (2) the closest Emergency Room to your location, and (preferred), (3) the number of other emergency services or persons who can respond if needed in a crisis.
- If you are not an adult, (i.e., under 18 years of age in most cases), we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth (or any other) sessions.

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[1]For the purposes of this document, Telehealth Services refers to any psychological services that are: (1) delivered outside of the clinic offices, and (2) via electronic means, (e.g., video conferencing, e-mail, telephone, the internet, or any other electronic means). Some Telehealth Services will be delivered by secure lines and some are not. If you are in doubt, please check with the provider.

[2]As of 3/23/20 the platform is doxy.me. Please visit their web site for more information.

- Your psychologist may determine that telehealth is not or no longer appropriate for you. If this is the case, in-person sessions may be an option.
- If you plan to use insurance (third party coverage) to pay for your telehealth services, please check with us to make sure that we are on your insurance plan, we accept their payments, etc. A good way to do this is to call our billing company and ask them (800.479.5761). If you are not covered for any reason, you are always welcome to self-pay, but whatever the reason, if you will not be using insurance, you are responsible for full payment.

Robert Kleemeier, Ph.D. Carol P. Kleemeier, Ph.D.

My typed signature below means that I have reviewed the document and, if reviewed, I agree with the content and, if I entered information, it is correct.

Name of Patient (please print):_____

Signature of Parent/Guardian if patient is less than18 years of age, or signature of patient if patient is an adult (18 years of age or older):

_____ Date: _____

Tekna P.C.
d/b/a
Atlanta Pediatric Psychology Associates and Northlake Psychology Associates 3580
Habersham at Northlake
Tucker, Georgia 30084

Telehealth Supplemental Information

Patient Name (please print): _____

Parent or Guardian Name (please print): _____
(If patient is under 18 years of age)

Address where patient will be during telehealth session:

_____

Number and Street City State Zip

Contact information for location where patient will be during telehealth session:

Telephone:_____Cell Phone:_____

E-mail:_____

Emergency Contact Person (Name): _____Phone: _____

Other Emergency Contact Person or Service:_____Phone: _____

Closest ER to patient's telehealth session location: _____

To be signed and returned for ALL Clients.