Denise Olive, LLC, MS
Licensed Professional Counselor
Certified Biofeedback Therapist
Healing Touch & Reiki Practitioner
404-847-9560

CLIENT INFORMATION

Name: _____

Address: _____

City/State/Zip: _____

Phone: Home: _____ Cell: _____ Work: _____
*Please circle where we may leave messages

Email Address: _____

Date of Birth: _____ Marital Status: _____ Male: ___ Female:___

Employer: _____ Position: _____

Referred By: _____ May I contact this person? Yes ___ No ___

Emergency Contact: _____ Phone: _____

Address: _____

Goals for Coming Here: _____

Responsible Party/Spouse/Parent Caregiver Information:

Name: _____ Date of Birth: _____

Phone: Home: _____ Cell: _____ Work: _____
*Please circle where we may leave a message

Primary Insurance: (Note: I am in-network with BCBS)

Insurance Provider: _____

Policy Holder (You or name of your family member):

_____ Date of Birth: _____

Policy ID Number: _____ Group Number: _____

Insurance Patients: Please read and sign the following assignment of benefits if you would like us to file your insurance for you.

Release of Authorization/Assignment of Benefits:

I authorize the release of any medical/psychological information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to my therapist, Denise Olive, LLC, MS, LPC, for services rendered. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. I understand that I am financially responsible for all charges, including those determined to be "not medically necessary" by my insurance carrier.

Signature: _____ Date: _____

CONSENT TO TREAT

I hereby request and consent to the performance of biofeedback and/or counseling procedures on me (or the patient named below, for whom I am legally responsible).

I understand that the method of treatment may include, but is not limited to, measurement and feedback about various physical symptoms, relaxation training, counseling and/or energy balancing. I understand the results cannot be guaranteed. My file will remain open as long as sessions continue. If for any reason I am not in contact with Denise Olive for over 30 days, my treatment will be considered terminated and my clinical file will be closed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, and I have had an opportunity to ask questions. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I may seek treatment. I have received the Notice of Privacy Policies for Denise Olive, LLC.

Signature: _____ Date: _____

Denise Olive, LLC, MS, LPC, BCB
One Premier Plaza
5605 Glenridge Dr., NE, Suite 620
Atlanta, GA 30342

POLICIES & PROCEDURES

Denise Olive LLC, is a Licensed Counselor and Certified Biofeedback Therapist in private practice. I understand that recommendations may be given for other products or providers if they may be considered beneficial to me. I understand there is neither affiliation between these organizations and Denise Olive, LLC, nor between Denise Olive, LLC and the other therapists at this location. I agree to indemnify and hold each harmless from the actions of the other.

Statement of Confidentiality: Confidentiality is protected as described in HIPPA regulations. Under Georgia law communications between patients and psychotherapists are confidential, and under ordinary circumstances this privilege can be waived only by the patient. However, there are three clear exceptions in which a therapist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to himself or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, and (3) actual or suspected incidents of current child or elder abuse. Although legally and ethically bound to break confidentiality under the aforementioned circumstances, I will not do so without attempting to discuss it with you.

I may occasionally find it helpful to consult with other health and mental health professionals about a case. During consultation I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. I will note consultations in your Clinical Record which is part of your Private Health Information.

The usual therapy session lasts approximately 50 minutes. Payment is due in full at the time of service. My fee is $140.00 per therapy session. The fee for the initial evaluation is $160. Although Denise is in network with BCBS of Georgia, if you have out-of-network benefits with another provider and you would like us to file for you, we will collect from you and file your insurance so that it is reimbursed to you. Please understand insurers have payment policies that enable them to exclude a portion of your expected reimbursement. Please discuss any questions or exceptional circumstances with me at the first session.

Denise Olive
Policies & Procedures
Continued

Some insurance companies continue to require authorization for outpatient psychotherapy. With your permission, I will complete necessary paperwork to obtain authorization for clinical services. However, my office cannot adequately track number of sessions used for each authorization. Therefore, to avoid disruption in your reimbursement, it is your responsibility to monitor the number of sessions we have used and to notify me at least one session prior to exceeding those authorized. I will submit additional clinical information to obtain more sessions.

I understand that if I give less than 24 hours notice of cancellation of an appointment, but more than 2 hours, I will be expected to pay 50% of that session. If I give less than 2 hours notice of cancellation, I will pay 100% of that session. Missed appointments cannot be billed to the insurance company.

PATIENT
SIGNATURE:_____DATE:_____
Spouse/parent/relative (Indicate relationship if signing as patient representative)

Primary Care or Other Physician Information

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

How long have you been a patient of this physician: _____

What is their specialty? _____

For the purpose of continuity of care, may we contact your physician to let him/her know of your visit today?

Yes ____ No ____

If yes,

I, _____, give permission to Denise Olive, LLC, MS, LPC, to send a general statement notifying my physician of my visit today. The information sent will be used for coordination of care, and will be limited to a brief description of the problem area and/or diagnosis, and a general outline of treatment.

_____
Patient Signature

_____
Date