NEW PATIENT INFORMATION
CONSENT AND AGREEMENT

PSYCHOLOGICAL SERVICES. Psychological services vary depending on the reason for referral. In all cases, the initial appointment is set up with the parents/guardians of the child and it is spent gathering background information and relevant information regarding the current concerns or difficulties. After sufficient information is gathered, the next appointment is scheduled with the child. All therapy provided is based on empirically-validated and/or well researched methods and determined based on the presenting problem. Art and play may be integrated into therapy depending on the age of the child. If you have any questions about the procedures, please discuss them as they arise. Often times, therapy requires active participation and there may be times when work outside of the therapy session is recommended to ensure that improvements in behavior will be seen in the home and school environments. Openness and honesty are recommended to ensure that I have as much information as possible to help you and/or your child.

SESSIONS. The initial diagnostic interview typically lasts from one to two hours depending on scheduling and availability. Recurrent psychotherapy sessions last approximately 45 minutes. Weekly appointments are recommended in most cases, but sessions every other week can be scheduled depending on the situation or need of the client. Once an appointment is scheduled, you will be expected to pay for the entire session unless you provide a 24-hour advance notice of cancellation. It is important to note that most insurance companies will not reimburse me for a missed or canceled appointment, so the full $150 fee will be your responsibility. Since your appointment time is reserved for you, please notify me as soon as possible if you will be unable to attend the appointment. You may leave a message with my answering service after hours or on weekends if you need to cancel an appointment.

PROFESSIONAL FEES. My hourly fee is $150.00 for psychotherapy and assessment. The fee for the initial diagnostic session is $175. Charges for consultation outside of the therapy session (i.e., school observations, hospital visits, depositions, etc.) will be determined on an individual basis. Fees should be paid at the end of every session. If you are unable to pay for a session and/or have an exceptional circumstance, this should be discussed at the beginning of the session. Cash, check, Visa, and MasterCard are accepted for your convenience. Any balances unpaid after 60 days are subject to a 1.5% per month finance charge.

INSURANCE. If you choose to use insurance, preauthorization is usually required. It is your responsibility to contact your insurance company to determine your outpatient mental health benefits. If I am not on the panel for your insurance company, it is possible that they will reimburse you for a percentage of the fee for “out-of-network” providers. I will file out-of-network claims on your behalf. A receipt is available to help you submit insurance claims. In addition, the office manager will kindly verify your insurance and benefits. If you are a member of a managed care company in which I participate, I will file insurance for you. I certify that all information given is true and correct and that I have no other coverage applicable to these services. After the office

manager has verified your insurance eligibility and level of benefits, I will gladly accept only the co-payment. Until that time, please plan on paying the full contracted amount. Regarding insurance, it is important to note that the amount collected is based on information provided from your insurance company and it is common for insurance companies to deny coverage at a later date. For that reason, you may receive a bill for services after a session because your insurance company does not reimburse as anticipated or requests a refund for previously paid services. Please also note that insurance companies often may authorize a certain number of sessions per year. You will be responsible for keeping track of the number of sessions utilized and you must notify me when we approach the end of these authorized sessions. If notified in a timely manner, I am more than happy to submit paperwork for additional sessions if needed. However, I cannot guarantee the authorization of these sessions.

THERAPIST CONTACT. Due to patient appointments, I am not always immediately available by telephone. When unavailable, my telephone is answered by the office manager who can take a message for me or direct you to my voicemail. I will make every effort to return your phone call the same business day or first thing the next morning, with the exception of weekends or holidays. If you are difficult to reach by phone, please leave me the best times when you will be available. If you are unable to reach me and feel the matter cannot wait for me return your call, please call your physician and/or go to the nearest emergency room and ask for the psychologist on call. When I will be away for an extended period, the answering service can provide you with one of my colleagues if needed. After making initial contact, I can offer my email address if it is determined that this will be the best mode of communication. However, it is important to note that confidentiality cannot be ensured over the internet. Every effort will be made to keep your information confidential, but communicating via email has some disadvantages. If this is the case, for your own protection, please do not include any private identifying information in any of your emails.

LIMITS OF CONFIDENTIALITY. All communication between a psychologist and a patient will remain confidential as provided by the Georgia Law. This privilege can be waived by the patient under normal circumstances. However, there are three exceptions to the law, and under these circumstances, a psychologist ethically and legally would need to break confidentiality: (1) the patient is imminently dangerous to him 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 child abuse. If any of the above situations arise, I will make every effort to discuss this with you first before taking the appropriate and necessary actions and I will limit my disclosure to what is only absolutely necessary. Children and adolescents will have the same confidentiality as adults, with one exception. Parents and guardians will be made aware of their child’s progress in non-specific terms, but they will not be informed of specific details of what is discussed in therapy. However, this psychologist will inform parents of any serious health or safety issues of which their child may be at risk, with the understanding that this determination will be made by the psychologist.

CONSENT FOR SERVICES. I hereby authorize and voluntarily consent for Dr. Eric Hartman to provide psychological services considered reasonably necessary for myself and/or my minor child, _____
(DOB____/____/_____).

CONSENT FOR RELEASE OF INFORMATION FOR PAYMENT PURPOSES. I authorize Dr. Eric Hartman to release any medical or psychological information necessary to any representative or agent of any entity that may pay for any part of the expenses incurred in connection with the permitted services (including any insurance company, health maintenance organization, employer, or government or social agency) for the purpose of evaluating or processing claims for payment for services rendered. I also hereby authorize any representative or agent or any entity mentioned above that may pay part of expenses incurred in connection with permitted services to release any documentation to apply for said payment. I acknowledge that this consent is valid until such time as bills related to the permitted services have been paid in full.

CONSENT FOR RELEASE OF INFORMATION TO CARE PROVIDERS. I hereby authorize Dr. Eric Hartman to release any and all information contained in the medical record to the care providers listed below in connection with permitted services for continuity of care. I hereby release Dr. Hartman from any and all liabilities, responsibilities, damages, and claims that might arise from the release of information authorized above. I hereby waive any privilege with respect to records released as authorized above. I further understand that I can withdraw this consent for release of information at any time by contacting Dr. Hartman except to the extent that action has been taken in reliance thereon. Provider Names _____,
_____, _____.

GUARANTOR AGREEMENT. For and in consideration of the professional services rendered by Dr. Eric Hartman, I hereby guarantee payment of all fees and charges incurred by said patient for permitted services. I accept personal responsibility for paying in full any balance that may remain after my insurance has processed the claims, including those that may be determined as "not medically necessary" by my insurance carrier.

ASSIGNMENT OF MEDICAID BENEFITS, PATIENT CERTIFICATION, AND PAYMENT REQUEST. I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request that payment of authorized benefits be made and assign the benefits payable for the permitted services to Dr. Eric Hartman I am responsible for and agree to pay charges not covered by this agreement including any Medicare deductibles and/or co-insurance.

CERTIFICATION AND SIGNATURE. I certify that I have received a copy of my HIPPA rights, have read and understand this consent, and have signed this consent in the capacity indicated below as of the date indicated below:

___ As an independent (adult) consenting for myself.
___ As a parent (whether adult or minor) consenting for his or her minor child.
___ As a guardian consenting for his or her ward.
___ As a person temporarily standing in loco parentis consenting for the minor under his or her care.

_____
Name (print full name)

_____ _____
Patient or Parent/Guardian Signature Date

_____
Witness Name (print full name)

_____ _____
Witness Signature and Date Date

Patient Information:

NAME:_____
First Middle Last
ADDRESS:_____
Street City State Zip
PHONE:_____ _____ _____
Home Work Cell
SOCIAL SECURITY#:_____ SEX: _____ Male _____ Female

MARITAL STATUS:_____ DATE OF BIRTH:_____
AGE:_____

EMPLOYER:_____ POSITION:_____

Can a message be left at Home? ___Yes ___No; Work? ___Yes __No; Cell? ___ Yes ____ No

REFERRED BY:_____ May I contact this person?___Yes ___ No

Have you been in therapy before? __Yes __No For your current problem?___Yes ___ No

If so, Where?_____When?_____

Next of Kin not living with you:_____ Phone #:_____

Address:_____

Responsible Party/Spouse/Parent Information:

Name:_____ Date of Birth:_____ SS #: _____

Phone:_____ _____ _____
Work Home Cell

Primary Insurance:

Name of Carrier:_____

Name of Insured:_____ Phone #:_____

ID#:_____ Group #: _____

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 Dr. Eric Hartman for services rendered. I agree that this authorization will cover all services rendered until I revoke the authorization. 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. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed: _____ Date:_____

INTAKE QUESTIONNAIRE

Confidential and Privileged Information

Please complete the following form to help us understand your child. This will decrease the time needed to make an accurate evaluation of your child's needs. Please print or type information.

Identifying Information

From Completed By: _____ Date:_____

Child's Name: _____Gender: Male Female

Current Age: _____ Date of Birth: _____ Grade: _____

Race/Ethnicity: _____

Home Address: _____

City _____State _____ Zip code _____

Home Phone Number: _____ Okay to leave a message? Yes No

Cell Phone Number: _____ Okay to leave a message? Yes No

Work Phone Number: _____ Okay to leave a message? Yes No

Email Address: _____

Who has legal custody: _____

Pediatrician: _____ Phone Number:_____

Family Information

Parent #1's Name _____ Birth date _____

Highest school grade completed by Parent #1 _____

Parent #1's occupation/place of employment _____

(IF APPLICABLE) Spouse/Partner's Name _____ Birth date_____

Highest school grade completed by spouse/partner _____

Spouse's/Partner's occupation/place of employment _____

Is your child adopted? Yes_____ No _____ If yes, for how long and any information known about biological parents?:_____

_____

_____

_____

Are parents married? Yes_____ No _____ If yes, when? _____

Are parents separated? Yes _____ No _____ If yes, when? _____

Are parents divorced? Yes _____ No _____ If yes, when? _____

Are there step-parent(s) involved? Yes _____ No _____

If yes, when was the remarriage for either parent? _____

Step-Parent(s) or Legal Guardian(s) Names:_____

Birthdate(s) _____ Occupation(s) _____

Highest grade completed by step-parent(s) _____

Is there any important information about the parents' relationship which might be helpful to know?_____

_____

List all siblings (full, half, step, living or deceased) Name;Age; Sex; Relationship to child; Grade; Living with Child?

1. _____
2. _____
3. _____
4. _____

Please give the name and relationship of anyone else currently living in the home

_____

History of Current Problem

What are your current concerns regarding your child?_____

_____

_____

_____

At what age was the problem first noted? _____ Please describe any illness or injury that may have been associated with the problem. _____

_____

_____

Has your child ever had treatment for this problem? _____

If so, Where? _____ When? _____

Has your child ever had psychological services for any other problem? Yes____ No ___

If yes, when and where? _____

_____

Have there been any significant changes, events, or losses in your child's life?

_____

_____

_____

_____

Please circle any of the following areas of concern, past or present.

Anger Management School Problems Problems Completing Work

Obsessions/Compulsions Body Image Physical Complaints/Pain Family Problems

Motor/Vocal Tics Poor Concentration Sleeping Problems Excessive Worry

Depressed Mood Lying Suicidal Thoughts Hallucinations/Delusions

Bullying/Teasing Nightmares Separation Anxiety Hyperactivity Sexual Abuse

Bedwetting/Soiling Self-Injurious Behavior Aggression Medical Issues

Helplessness Shyness Impulse Control Problems Low Self-Esteem

Food Issues Irritability Opposition Distractibility Cruelty to Animals

Birth, Developmental, & Medical History of Child

Birth History: Did mother use any of the following during pregnancy?

Tobacco	Alcohol	Drugs
____ Yes	____ Yes	____ Yes
_____ No	____ No	_____ No

Describe any complications during pregnancy_____

_____

_____

_____

Length of pregnancy: _____ Full Term _____ Premature (at _____ weeks)_____ Late

Type of delivery _____ Birth weight_____

Describe any complications during delivery_____

_____

_____

Were there any medical problems noted at or immediately following birth? _____

_____

_____

Developmental History of Child: Please note the age at which your child reached the following developmental milestones. If unsure of the exact age, give the approximate age. Sat alone _____ Walked alone _____ Potty Trained _____

Started using single words (other than "mama" or "dada") _____

Used 3 word-sentences _____

Infancy or Toddler concerns?_____

_____

Developmental Concerns? _____

_____

Please note any difficulties your child has experienced with the following:

If you are bringing your teenager (12 and over) to the office, does your child have any problems with alcohol or drugs?

Tobacco	Alcohol	Drugs
_____ Yes	_____ Yes	_____ Yes
_____ No	_____ No	_____ No
_____ Unsure	_____ Unsure	_____ Unsure

Medical History of Child: Describe any serious accident, illness, or injury that your child experienced and what age: _____

_____

_____

_____

_____

Please list any operations your child has undergone and when:_____

_____

_____

Please list any allergies that your child has:_____

_____

List any medications your child is currently taking (name of medication and dosage):

_____

_____

_____

Please list any significant medical problems of anyone in the family.

_____

_____

_____

Please list any family mental health history (Include immediate and extended family members). _____

_____

_____

_____

Educational History of the Child/Teen

Attended Daycare? _____ (*Circle one)* In home daycare Daycare facility At home

Attended Pre-school? Yes ____ No____ Attended Kindergarten? Yes ____ No_____

In gifted program? Yes _____ No _____ If yes, describe: _____

Receive special education or additional support? Yes _____ No _____

Is there an Individualized Education Plan (IEP) or 504 plan? Yes _____ No _____

If yes, why does your child have an IEP? _____

_____

Ever had psychoeducational testing? _____ Ever repeated a grade? _____

Ever been suspended or expelled?_____ If yes, what grade and why?_____

_____

Current School: _____ Grade: _____

Type of School: _____ Public _____Private _____Home Schooled

What grades does your child receive? _____

Any recent changes in grades? _____

School Phone Number:_____ Name of primary teacher: _____

Feelings about school work (circle all that apply): Anxious Passive Enthusiastic Fearful No expression Bored Rebellious Tedious

Other: _____

Approach to school work (circle all that apply): Organized Industrious Responsible Interested Self-directed Noinitiative Refuses Does only what is expected Sloppy Disorganized Cooperative Does not complete work

Other: _____

Strengths & Assets of the Child & Family:

What are your child's strengths? _____

_____

_____

_____

_____

What are your family's strengths? _____

_____

_____

_____

_____

What are your family's favorite activities? _____

_____

What does your child do with unstructured time? _____

_____

Please use the space below to note anything else you feel the psychologist should know in helping your child. Feel free to add your own page if needed.

_____

_____

_____

_____

_____

_____