Kim Oppenheimer, Ph.D.

New Patient Information

The following information pertains to my financial policy. I hope this will answer any questions you may have, but if you have any questions or special concerns, please do not hesitate to discuss them with me **at the first session**. Please acknowledge your understanding of this policy by signing at the end of this form. If you would like a copy for your records, I will gladly provide one for you.

1. My fee is $260.00 per therapy hour for individual, couples or family sessions, **payable at the end of each session.** The usual therapy hour consists of 45 – 50 minutes. Charges for services outside the usual therapy hour (i.e., forensic evaluations, depositions, court appearances, parent coordination, etc.) will be determined on an individual basis depending upon the complexity of the referral question.

2. Payment is expected at the end of each session. **Please discuss exceptional circumstances with me at the first session.** Collection of insurance benefits or any other arrangement regarding third party payment is your responsibility. However, I will file insurance on your behalf at no cost to you, and my office will assist you in every way possible to help you obtain your reimbursement. My office manager will call your insurance company to obtain your benefits. However, it is very common for insurance companies to pay differently that what they quote at the time of your visit. For that reason, my office collects each visit in full and assigns payment to you. You will receive reimbursement directly from your insurance company. If you have any difficulty obtaining payment from your carrier, my office will gladly follow-up with them and re-submit claims on your behalf if necessary. My office can provide you with a superbill showing charges and payments if you choose to file your own insurance or for reimbursement from your medical savings account.

3. Despite changes to the health care law which prohibit mental health services from being treated differently than those for physical health, some insurance companies continue to require authorization for outpatient psychotherapy. With your permission, I will complete all necessary paperwork to obtain authorization for clinical services. However, my office cannot adequately track number of sessions used for each authorization. Therefore, to avoid any disruption in your reimbursement, it is your responsibility to monitor number of session we have used and to notify me when we are about to exceed those authorized. I will submit additional clinical information to obtain more sessions.

4. Since your appointment time is reserved for you and cannot be offered to another patient without adequate notice, please notify me as soon possible if you find that you must cancel appointments. **Appointments not canceled with at least 24 hours will be billed at the usual fee of 260.00.** Missed appointments cannot be billed to the insurance company. You may leave a message with my answering service after hours and on weekends if you need to cancel an appointment. In the event of circumstances beyond your control that prevent you from coming to the office, we can have a phone session at the appointed time to avoid a missed appointment

charge. Please be advised that phone sessions generally are not as effective as face-to-face sessions.

Statement of Confidentiality: Confidentiality is protected as described in HIPAA regulations (per attached HIPAA policy). Under Georgia law, communications between patients and psychologists are privileged and confidential. Under ordinary circumstances this privilege can be waived only by the patient. However, there are three clear exceptions in which a psychologist 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 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 consent for treatment from Kim Oppenheimer, Ph.D. (per attached Psychotherapy Services Agreement). I acknowledge responsibility for all fees incurred. To offset billing costs, any balances 60 days past due are subject to a $10.00 per month billing fee. If necessary, I consent to have my account collected through an attorney or collection agency. I also agree that I am responsible for all costs of litigation, including collecting past due balances through an attorney or collection agency.

I have read and understand the above policies.

_____ _____

Patient's Signature Date

_____

Printed Name

_____

Parent or Guardian's Signature for Minor

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

I authorize Dr. Kim Oppenheimer to submit insurance claims on my behalf and release any medical, diagnostic, or other information necessary for processing insurance claims. I agree that a photocopy of this form may substitute for the original. I agree that this authorization will remain in effect unless revoked in writing. I accept personal responsibility for any balances for services rendered, including those that may be determined "not medically necessary" by my insurance carrier.

_____ _____

Patient/Parent or Guardian Signature Date

Patient Information:

Name: _____
First Middle Last

Preferred Name: _____

Address: _____
Street City State Zip

Phone: (_____) _____-_____ (_____)_____-_____ (_____)_____-_____
Home Cell Work

Can a message be left for you at Home? Yes/ No Cell? Yes /No Work? Yes/ No

E-mail Address: _____

Last four digits of your Social Security: _____ Gender: ____Male ____Female

Marital Status: S M D W Birth Date: _____ Age: _____

Employer: _____ Position: _____

Referred by: _____ May I contact this person? ____Yes ___ No

Have you previously been in therapy? ___Yes ___No For current problem? ____Yes ____No

If yes, Where_____ Approximate Dates: _____

Emergency Contact: _____

Relationship: _____ Phone#: _____

Responsible Party/Spouse/Parent Information:

Name: _____ Birth Date: _____

Last four digits of your Social Security _____ Phone: (_____) _____-_____

Primary Insurance:

Name of Carrier: _____ Name of Insured: _____

ID#: _____ Group #: _____

Primary Care Physician Information:

Name: _____

Address: _____

_____

Phone: (_____) _____-_____ How long have you seen this physician? _____

For purposes of continuity of care, may I contact your physician to let him/her know of your visit today? _____Yes _____No

If yes,

I, _____, give permission to Kim Oppenheimer, Ph.D. to send a general statement notifying my physician of my visit today. The information will 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's Signature: Date: