Viviana Mahoney, 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 do 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 of this form for your records, I will be happy to provide one for you.

1. My fee is **$200** per therapy hour and **$220** for couples or family sessions, **payable at the end of each session**. The usual therapy hour consists of 45-50 minutes. **The fee for the initial diagnostic session is $230.00.** Charges for consultations outside the usual therapy hour (i.e., school observations, hospital visits, depositions, etc.) will be determined on an individual basis.

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. After the office manager verifies your insurance eligibility and level of benefits, I will gladly accept only the co-payment. Until that time, please plan on paying the full amount. My office verifies insurance benefits in an attempt to obtain accurate information regarding your co-payment and/or deductibles. However, it is very common for insurance companies to pay differently than what they quoted at the time of your visit. For that reason, you may receive a bill for services rendered if your insurance company does not reimburse as anticipated. If your managed care company requires authorization for our sessions, I will complete all necessary paperwork to obtain them. 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 the number of sessions we have used and to notify me when we are about to exceed those authorize. I can submit additional clinical information to obtain more sessions.

Initial Here _____

***NOTE**: **FOR NEW PATIENT(S)** SINCE YOUR APPOINTMENT TIME IS RESERVED SOLELY FOR YOU, PLEASE NOTIFY ME AS SOON AS POSSIBLE IF YOU FIND THAT YOU MUST CANCEL AN APPOINTMENT. APPOINTMENTS NOT CANCELLED WITH AT LEAST **24 HOURS' NOTICE** YOU WILL BE BILLED THE FEE OF $75. **FOR CURRENT PATIENT(S)** APPOINTMENTS NOT CANCELLED WITH AT LEAST **24 HOURS' NOTICE** YOU WILL BE BILLED THE FEE OF YOUR CO-PAY OR CO-INSURANCE RATE. **MISSED APPOINTMENTS CANNOT BE BILLED TO THE INSURANCE COMPANY.** YOU MAY LEAVE A MESSAGE ON MY CONFIDENTIAL VOICEMAIL AFTER HOURS AND ON WEEKENDS IF YOU NEED TO CANCEL AN APPOINTMENT.*

Statement of Confidentiality: Confidentially is protected as described in HIPAA regulations (See Attached). Under Georgia law communications between patients and psychologists are confidential, and 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 acknowledge responsibility for all fees incurred, and if it is necessary, I consent to have my account collected through an attorney or collection agency. I also agree that I will be responsible for all costs of litigation, including attorney's fees. I have read and understand the above policies.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian's Signature of minor Date

Viviana Mahoney, Ph.D.

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

Assignment of Benefits

I authorize Dr. Viviana Mahoney to release any medical or other information necessary for the processing of insurance claims. I authorize payment of medical benefits to Dr. Viviana Mahoney for services rendered. I accept personal responsibility for any balance remaining for services rendered, including those that may be determined "not medically necessary" by my insurance carrier.

_____ _____

Patient/ Parent or Guardian Signature Date

Primary Care Physician Information

Name: _____

Address: _____

_____

Phone: _____

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

For purposes 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_____
to send a general statement notifying my primary care 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

Viviana Mahoney, Ph.D.

Patient Information:

NAME: _____
First Middle Last (Name prefer to be called)
ADDRESS: _____
Street City State Zip
PHONE: _____
Home Work Cell

Can a message be left at Home? ___Yes ___No Work? ___Yes ___No Cell? ____Yes ____No

E-MAIL ADDRESS: _____ Last four of your ssn: _____

Gender Identity:
Male / Female/ TransMale / TransFemale / Genderqueer/ Gender nonconforming / Decline

MARITAL STATUS: S M P D W S DATE OF BIRTH: _____ AGE: _____

EMPLOYER: _____ POSITION: _____

How Did You Find Me?

- Referral from _____
- Internet search engine _____
- Psychology Today _____
- Other _____

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 my psychologist/psychiatrist. 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: _____

Psychological Services Agreement and HIPAA Signature Attachment

I have read, understand, and agree to abide by the terms and conditions set forth in the Psychological Services Agreement, and do hereby consent to participation in the treatment as described in the Agreement. I also understand that my participation is entirely voluntary and that I may withdraw my consent and treatment at any time

I have been provided with the Georgia HIPAA Notice and understand.

I understand HIPAA is a federal law that provides privacy protections and assures 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 I provide you with a complete printed copy of the Georgia HIPAA Notice for use and disclosure of PHI for treatment, payment and health care operations. The Georgia HIPAA Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. We can discuss any questions that you may have about the procedures outlined in the Georgia HIPAA Notice.

_____ _____

Patient Signature Date

_____

Patient's Printed Name

Viviana Mahoney, Ph.D.

Confidential Patient Information

NAME _____

Medical History – Please list all medical conditions, surgeries, major illnesses or injuries

_____
_____
_____

Medications – Please list all current medications and dosages (medical or psychiatric)

_____
_____
_____

Past Medications – List all past psychiatric meds (dosages and duration taken, if known)

_____
_____
_____

Family Psychiatric History – Please specify which relative(s) for each condition

□ depression _____
□□anxiety/panic _____
□ bipolar disorder _____
□ schizophrenia _____
□ alcoholism _____
□ drug abuse _____
□ suicide _____
□□other (specify) _____

Substance Use History – Please specify amount and frequency

	Past	Current
alcohol	□	□_____
tobacco	□	□_____
marijuana	□	□_____
cocaine	□	□_____
opiates	□	□_____
stimulants	□	□_____
ecstasy	□	□_____
other	□	□_____