

Ann McKee Parker, 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 **\$170.00** per therapy hour and **\$190.00** 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 **\$195.00**. 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 the 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 authorized. I can submit additional clinical information to obtain more sessions.
3. Since your appointment time is reserved for you, please notify me as soon as possible if you find that you must cancel an appointment. Appointments not canceled with at least **24 hours notice** will be billed at the usual fee of **\$170.00 or \$190.00**. **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. Full Slate, the calendar I use, will email 72 hrs, 24 hrs in advance to remind you. If it fails to do so you still bear responsibility to cancel.

Statement of Confidentiality: Confidentiality is protected as described in HIPAA regulations (See Attached). Under Georgia law communications between patients and psychologists are confidential and privileged, 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

Ann McKee Parker, Ph.D.

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.

Patient/ Parent or Guardian Signature: _____ Date: _____

Ann McKee Parker, 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 **Ann McKee Parker, Ph.D.** to release any medical or other information necessary for the processing of insurance claims. I authorize payment of medical benefits to **Ann Parker McKee, Ph.D.** 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

Ann McKee Parker, Ph.D.

**Psychological Services Agreement for
Electronic Communication**

I give permission for Ann McKee Parker, Ph.D., and/ or her staff to leave messages regarding appointments on voicemail and/ or send appointment reminders via FullSlate.

With your consent and if not clinically contraindicated, Ann McKee Parker, Ph.D may provide services electronically, including using email, telephone, video conferencing (i.e. Face-time). Routine scheduling occurs by FullSlate or by telephone at 404-847-9560.

Email may be used in the delivery of some services to augment or follow up on face to face or telephone sessions. In these cases, Ann McKee Parker, Ph.D may provide updates, invoices, account statements summaries, memoranda, education resources and/ or exchange information.

When consenting to the provision of services by telephone or electronic platforms, the same degree of confidentiality provided during an in-person session is not possible. The limitation includes the possibility of interceptions of communications. Ann McKee Parker, Ph.D. will make every effort to eliminate any interruptions during video or telephone contact and requests you do the same (e.g. tablets, laptop and or desktop, locking the door, etc.).

Towards this end, You agree to make these efforts and further, to advise Ann McKee Parker, Ph.D., if someone comes into the room in which you are communicating with Ann McKee Parker, Ph.D. or if someone is within earshot.

The benefits of using electronic communications and telephone may include avoiding contending with traffic, taking less time off, convenience and comfort, or you may be out of town and want to continue to receive services. Alternatives to the provision of electronic or telephone services include in-person services only or local services from an available health service provider of the same or different discipline.

Please keep in mind that other individuals (living in your home) may be able to access information, sensitive or otherwise, communicated electronically or by telephone.

Any communications provided by Ann McKee Parker, Ph.D. or by her administrative assistant are intended for you and not for others unless agreed to otherwise. **By signing this Informed Consent, you are confirming to her that you have taken reasonable steps to secure your own electronic devices (mobile phone, tablets, iPad, desktop, laptops, or any other electronic(s) devices you have in your household or designated private area etc.). This includes having a confidential password and adequate firewalls.**

Ann McKee Parker, Ph.D.

You further agree not to allow others (e.g. household members or non-household members, etc.) access to any communications sent to you from Ann McKee Parker, Ph.D. or her administrative assistant, unless agreement is reached in advance that the particular communication is appropriate to share with others.

If you move out of state, Dr. Parker may not treat you by any means due to State Licensing laws.

- Ann McKee Parker, Ph.D. does not consent to any recording of electronic sessions.**
- (mobile phone, tablets, iPad, desktop, laptops, or any other electronic(s) devices you have in your household or designated private area etc.)**

I have read and understand the above policies.

Patient's Signature:

Date:

Print Name:

If applicable Guardian Signature:

Ann McKee Parker, Ph.D.

**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

CONFIDENTIAL MEDICAL HISTORY

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 (doses 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 _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

A. During the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered (0)	Bothered a little (1)	Bothered a lot (2)
1. Stomach pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain in your arms, legs, or joints (knees, hips, etc.)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Menstrual cramps or other problems with your periods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pain or problems during sexual intercourse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Fainting spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling your heart pound or race.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Constipation, loose bowels, or diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Nausea, gas, or indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-15 Score = ____ + ____

B. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous anxiety or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it is hard to sit still.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAD-7 Score = ____ + ____ + ____

C. Questions about anxiety attacks.

a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?.....

NO YES

If you checked "NO", go to question D

b. Has this ever happened before?.....

c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?.....

d. Do these attacks bother you a lot or are you worried about having another attack?.....

e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?.....

D. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)

1. Little interest or pleasure in doing things.....

2. Feeling down, depressed, or hopeless.....

3. Trouble falling or staying asleep, or sleeping too much.....

4. Feeling tired or having little energy.....

5. Poor appetite or overeating.....

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....

7. Trouble concentrating on things, such as reading the newspaper or watching television.....

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.....

9. Thoughts that you would be better off dead or hurting yourself in some way.....

PHQ-9 Score = _____ + _____ + _____

E. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult