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.

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.

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.

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 sessions 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.

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.

Electronic Communications: I give permission for Dr. Oppenheimer 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, Dr. Oppenheimer may provide services electronically, including using email, telephone, video conferencing (i.e., Zoom, Doxy, Duo). Routinely, scheduling occurs by FullSlate or by telephone. Please call 404-847-9560 for appointments.

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, Dr. Oppenheimer may provide updates, invoices, account statements, summaries, memoranda, educational resources and/or exchange information. Based on the nature of the service provided, these email communications may include information not only about you, but others including your child(ren) or their other parent.

When consenting to the provision of services by telephone or electronic platforms, it is important to appreciate both the risks and benefits, including insufficiency compared to in-person sessions, misunderstandings due to lack of visual clues and context, and failures in technology. In the event of a technology failure when using electronic platforms (audio or visual), Dr. Oppenheimer will call you by telephone at the number you provide for back up on your Patient Information Form that is entered into FullSlate.

Whereas efforts are made to protect your privacy when providing services by telephone or electronic means, the same degree of confidentiality provided during in-person office sessions is not possible. The limitations include the possibility of interceptions of communications while these are occurring. Dr. Oppenheimer will make every effort to minimize any interruptions during video or telephone contacts and requests you to do the same (e.g., turning off cell phones, locking the door, etc.). Towards this end, you agree to make these efforts and further, to advise Dr. Oppenheimer if someone comes into the room in which you are communicating with Dr. Oppenheimer or if someone is within earshot.

The benefits of using electronic communications and telephone may include avoiding contending with traffic, taking less time off work, 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 (your spouse, new partner, child, adolescent, others living in your home) may be able to access information, sensitive or otherwise, communicated electronically or by telephone.

As noted, the information shared may be about others, not only you. Any communications provided by Dr. Oppenheimer or by her administrative assistants 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 phones, iPads, computers, etc.). This includes having a confidential password and adequate firewalls. You further agree not to allow others (e.g., your children of any age, new partner or spouse, parent, friend, relative, etc.) to access to any communications sent to you from Dr. Oppenheimer or her administrative assistant, unless an agreement is reached in advance that the particular communication is appropriate to share with others.

If you are out of state, it is illegal for a psychologist to practice in a location you may be in at the time service is delivered, even if you are a resident of Georgia, unless the therapist obtains a temporary license. By signing this consent, you agree to advise Dr. Oppenheimer for each telephone or video contact if you are no longer in Georgia.

Dr. Oppenheimer does not consent to any recording of electronic 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

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: