

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 the 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: Confidentiality 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: \_\_\_\_\_



**Viviana Mahoney, 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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



**Viviana Mahoney, 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



**Viviana Mahoney, Ph.D.**

**Psychological Services Agreement and  
HIPAA Signature Attachment**

I give permission for Viviana Mahoney, 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, Viviana Mahoney, Ph.D. may provide services electronically, including using email, telephone, video conferencing (i.e. doxy.me). 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, Viviana Mahoney, 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. Viviana Mahoney, Ph.D. will make every effort to eliminate any interruptions during video or telephone contact and requests you to 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 Viviana Mahoney, Ph.D., if someone comes into the room in which you are communicating with Viviana Mahoney, 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 Viviana Mahoney, Ph.D. or by her administrative assistant are intended for you and not for others unless agreed 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, laptop or any other electronic devices you have in your household or designed private area etc.) This includes having a confidential password and adequate firewalls.**

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



**Viviana Mahoney, Ph.D.**

If you move out of state, Viviana Mahoney, Ph.D. may not treat you by any means due to State Licensing Laws.

- Viviana Mahoney, Ph.D. does not consent to any recording of electronic sessions. (Mobile phone, tablets, iPad, desktop, laptop, or any other electronic devices you have in your household or designed private area etc.)**

I have read and understand the above policies.

\_\_\_\_\_  
Patient's Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
If applicable (Guardian's Signature)



*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 \_\_\_\_\_

